IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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**CERTIFIED MAIL: 7000 1670 0011 3315 1507**

September 1, 2015



Dr. Michael James, Administrator
Sunnyside Surgery Center
3345 S Holmes Avenue, Suite B
Idaho Falls, ID 83404

RE: Sunnyside Surgery Center, Provider #13C0001055

Dear Dr. James:

Based on the survey completed at Sunnyside Surgery Center, on August 18, 2015, by our staff, we have determined Sunnyside Surgery Center is out of compliance with the Medicare ASC Condition for Coverage of **Quality Assessment and Performance (42 CFR 416.43)**. 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 Sunnyside Surgery Center, 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.

An acceptable Plan of Correction 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 each form.

**Such corrections must be achieved and compliance verified by this office, before October 2, 2015. 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 22, 2015.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 14, 2015**.

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, option 4.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Lynnette Osias, CMS Region X Office

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13C0001055 | A. BUILDING _____ B. WING _____ | 08/18/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNNYSIDE SURGERY CENTER | 3345 S HOLMES AVENUE, SUITE B IDAHO FALLS, ID 83404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| Q 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the Medicare recertification survey of your Ambulatory Surgery Center conducted from 8/17/15 through 8/18/15. Surveyors conducting the recertification were:<br><br>Gary Guiles, RN, HFS, Team Leader<br>Teresa Hamblin, RN, MS, HFS<br><br>Acronyms used in this report include:<br><br>ASC - Ambulatory Surgery Center<br>CNA - Certified Nursing Assistant<br>CNS - Central Nervous System<br>CPAP - Continuous Positive Airway Pressure<br>CRNA - Certified Registered Nurse Anesthetist<br>DNS - Director of Nursing Services<br>DPM - Podiatrist<br>HEENT - Head, Eyes, Ears, Nose, and Throat<br>H&P - History and Physical<br>Hx - history<br>N/A - not applicable<br>n/c - not charted<br>Op - operative<br>PIP - Performance Improvement Projects<br>QA - Quality Assurance<br>QAPI - Quality Assessment Performance Improvement<br>Q.I. - Quality Improvement<br>Rx - reaction | Q 000 | RECEIVED<br>SEP 14 2015<br>FACILITY STANDARDS | |
| Q 080 | 416.43 QUALITY ASSESSMENT AND PERFORMANCE<br><br>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: | Q 080 | See included PoC. | 9/14/15 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] DPM | ADMINISTATOR | 9/10/15

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 080 | Continued From page 1<br>Based on staff interview and review of QAPI policies, meeting minutes, and QAPI documents, it was determined the ASC failed to ensure a comprehensive QAPI program was developed, implemented, and maintained. This impeded the ability of the ASC to evaluate its practices and improve care. Findings include:<br><br>1. Refer to Q81 as it relates to the ASC's failure to ensure a QAPI program was developed and implemented that measured, analyzed, and tracked quality indicators and focused on high risk, high volume, and problem-prone areas.<br><br>2. Refer to Q82 as it relates to the ASC's failure to ensure quality indicator data was used to monitor the effectiveness of its services and quality of its care.<br><br>3. Refer to Q83 as it relates to the ASC's failure to ensure PIPs were conducted.<br><br>4. Refer to Q84 as it relates to the Governing Body's failure to ensure the QAPI program was defined, implemented, and maintained.<br><br>The cumulative effect of these systemic practices prevented the ASC from evaluating its practices in order to improve care. | Q 080 | | |
| Q 081 | 416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES<br><br>(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 | Q 081 | See included PoC | 9/14/15 |

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| Q 081 | Continued From page 2<br>the identification and reduction of medical errors.<br><br>(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.<br><br>(c)(1) The ASC must set priorities for its performance improvement activities that -<br>(i) Focus on high risk, high volume, and problem-prone areas.<br>(ii) Consider incidence, prevalence, and severity of problems in those areas.<br>(iii) Affect health outcomes, patient safety, and quality of care.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of policies, meeting minutes, and quality documents, it was determined the ASC failed to ensure a QAPI program was developed and implemented that measured, analyzed, and tracked quality indicators and focused on high risk, high volume, and problem-prone areas. This prevented the ASC from analyzing its processes in order to improve them. Findings include:<br><br>1. The policy "QUALITY ASSURANCE PLAN," not dated, did not identify any high risk, high volume, problem-prone areas to be used to develop quality indicators or PIPs. The policy did not include any specific quality indicators or mention data collection. The policy stated "Twelve patient charts will be reviewed annually to determine recurring medical record deficiencies | Q 081 | | |

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| Q 081 | Continued From page 3<br>to assure complete and accurate records."<br><br>A document titled "CHART REVIEW," dated 4/30/15, was reviewed. The document included 11 questions for each of 5 charts which were reviewed. The chart review instructions stated each box was to be marked as "Adequate, Inadequate, Not Applicable N/A." No boxes were marked adequate or inadequate. For example, on the lines for "EVIDENCE OF PATIENT CHECK LIST COMPLETED...IV ANTIBIOTIC GIVEN ON TIME [and] LIST OF CURRENT MEDICATION, DOSAGES, AND USAGE," all boxes were marked with checks. Three lines, "GLUCOSE CHECKS ON DIABETICS...DIAGNOSTIC SUMMARY ON CASES WITH 3 OR MORE SURGERIES [AND] LOCAL SEDATION WITH DISCHARGE PER SURGEON" were all marked with a minus sign. No boxes were marked as "Adequate" or "Inadequate" per the chart review instructions.<br><br>The chart review document stated "Interventions needed: Improvements seen in all areas. Times noted for check list. Dr. [name of peer review physician] recommends H&P to state summary of Physical Findings-This was complete on the charts reviewed. Continue working on Rx to allergies." It also stated "Reported to QA Committee and Governing Body? Yes Both 5/27/15."<br><br>The chart review did not state why only 5 records were reviewed when the policy stated 12 records would be reviewed. The document listed raw data. There were no percentages or other means of quantifying the data.<br><br>No other chart review documents were present | Q 081 | | |

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| Q 081 | Continued From page 4<br>between 8/01/14 and 8/17/15. No other data had been gathered from quality indicators during this time except counting the number of infections.<br><br>The DNS was interviewed on 8/18/15 beginning at 10:45 AM. She also served as the QAPI Coordinator. She stated 5 charts were reviewed in the past year. She stated separate peer review was conducted but this did not result in data for specific quality indicators. She confirmed no other quality indicator data had been gathered in the past year.<br><br>The ASC failed to gather data for its QAPI program.<br><br>2. Two QA Committee meetings were documented from 8/01/14 through 8/17/15. They were dated 2/25/15 and 5/27/15. Neither set of minutes mentioned quality indicators or defined high risk, high volume, and problem-prone areas the ASC would evaluate.<br><br>The DNS was interviewed on 8/18/15 beginning at 10:45 AM. She stated high risk, high volume, and problem-prone areas were not documented.<br><br>The ASC failed to identify high risk, high volume, and problem-prone areas for its QAPI program to focus on. | Q 081 | | |
| Q 082 | 416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES<br><br>(b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. | Q 082 | See included PoC. | 9/14/15 |

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| Q 082 | Continued From page 5<br>(b)(2) The ASC must use the data collected to -<br>(i) Monitor the effectiveness and safety of its services, and quality of its care.<br>(ii) Identify opportunities that could lead to improvements and changes in its patient care.<br><br>(c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.<br><br>(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.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of policies, meeting minutes, and quality documents, it was determined the ASC failed to ensure quality indicator data was used to monitor the effectiveness of its services and quality of its care. The ASC also failed to use data to identify opportunities that could lead to improvements and changes in its patient care. This prevented the ASC from identifying ways to improve processes. Findings include:<br><br>The policy "QUALITY ASSURANCE PLAN," not dated, did not address the collection of data or the use of data. The policy did not identify how data would be collected and would be analyzed in a systematic fashion.<br><br>The only data the ASC collected between 8/01/14 and 8/17/15 was the number of infections that occurred during that time frame and a review of 5 patient medical records on a document titled | Q 082 | | |

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| Q 082 | Continued From page 6<br>"CHART REVIEW," dated 4/30/15. The document included 11 questions for each of 5 charts reviewed. The form consisted of raw data. The data was not quantified.<br><br>Two QA Committee meetings were documented from 8/01/14 through 8/17/15. They were dated 2/25/15 and 5/27/15. One Governing Body meeting, dated 2/25/15, was also documented. None of these meeting minutes contained a discussion of data from the ASC's QAPI program. None of these meeting minutes stated decisions were made based on data analysis.<br><br>The DNS was interviewed on 8/18/15 beginning at 10:45 AM. She stated no meeting minutes were available to show data was evaluated or decisions were made based on data.<br><br>The ASC failed to use data to make decisions and improve care. | Q 082 | | |
| Q 083 | 416.43(d) PERFORMANCE IMPROVEMENT PROJECTS<br><br>(1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.<br><br>(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<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of quality | Q 083 | See included PoC | 9/14/15 |

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| Q 083 | Continued From page 7<br>documents, it was determined the ASC failed to ensure PIPs were conducted. This interfered with the ASC's ability to analyze its processes in depth. Findings include:<br><br>Two "Quality Improvement Studies" were completed in 2014, on 8/05/14 and on 8/14/14. No PIPs were documented for the past year, between 8/14/14 and 8/17/15. No specific plans to conduct more PIPs were documented.<br><br>The DNS was interviewed on 8/18/15 beginning at 10:45 AM. She stated no PIPs had been conducted since 8/14/14. She stated the ASC was going to conduct more PIPs but she stated there were no specific plans or time frames for this. | Q 083 | | |
| Q 084 | The ASC failed to conduct PIPs.<br>416.43(e) GOVERNING BODY RESPONSIBILITIES<br><br>The governing body must ensure that the QAPI program-<br>(1) Is defined, implemented, and maintained by the ASC.<br>(2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness.<br>(3) Specifies data collection methods, frequency, and details.<br>(4) Clearly establishes its expectations for safety.<br>(5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.<br><br>This STANDARD is not met as evidenced by: | Q 084 | See included PoC | 9/14/15 |

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| Q 084 | Continued From page 8<br>Based on staff interview and review of QAPI plans and meeting minutes, it was determined the ASC's Governing Body failed to ensure the QAPI program was defined, implemented, and maintained. This resulted in a lack of direction to staff responsible for the program. Findings include:<br><br>1. The policies "QUALITY MANAGEMENT AND IMPROVEMENT," not dated, and "QUALITY ASSURANCE PLAN," not dated, outlined the Governing Body's responsibilities for Risk Management and Infection Control. Neither policy defined the Governing Body's responsibilities for the QAPI program.<br><br>The DNS was interviewed on 8/25/15 beginning at 11:30 AM. She confirmed the policies did not specify the Governing Body's role in overseeing the QAPI program.<br><br>The Governing Body did not define its role in relation to the QAPI program.<br><br>2. The document "2014 Annual Review of Q.I. Program," not dated, stated QA Committee meetings were held monthly. The "2015 Annual Review of Q.I. Program," not dated, did not mention QA Committee meetings. Only 2 QA Committee meetings were documented from 8/01/14 through 8/17/15. These were dated 2/25/15 and 5/27/15. No documentation was present to explain why the number of QA Committee meetings had been reduced.<br><br>The 2 QA Committee meeting minutes noted above did not contain a discussion of data from the ASC's QAPI program. Neither of the meeting minutes stated decisions were made based on | Q 084 | | |

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| Q 084 | Continued From page 9<br>data.<br><br>Minutes documented 1 Governing Body meeting between 8/01/14 and 8/17/15. The minutes, dated 2/25/25, did not mention the QAPI program or data or quality indicators.<br><br>The DNS was interviewed on 8/18/15 beginning at 10:45 AM. She stated no meeting minutes documenting Governing Body oversight of the QAPI program were available.<br><br>The Governing Body failed to ensure minutes documented QAPI activities and Governing Body involvement in those activities. | Q 084 | | |
| Q 162 | 416.47(b) FORM AND CONTENT OF RECORD<br><br>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:<br><br>(1) Patient identification.<br>(2) Significant medical history and results of physical examination.<br>(3) Pre-operative diagnostic studies (entered before surgery), if performed.<br>(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.<br>(5) Any allergies and abnormal drug reactions.<br>(6) Entries related to anesthesia administration.<br>(7) Documentation of properly executed informed patient consent.<br>(8) Discharge diagnosis. | Q 162 | See included PoC. | 9/14/15 |

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| Q 162 | Continued From page 10<br>This STANDARD is not met as evidenced by:<br>Based on review of policy and medical records and staff interview, it was determined the ASC failed to ensure medical record documentation was completed as it related to pain assessment prior to discharge for 13 of 13 patients (#1 - #13) whose medical records were reviewed. This resulted in a lack of clarity regarding patient readiness at discharge. Findings include:<br><br>1. An undated ASC policy, "Anesthesia Procedure," included a section "POST SEDATION MONITORING." The section included, but was not limited to, the expectation "an Aldrete score will be observed," which included assessment of activity, respiration, vital signs, mental status, and pain. Pain was to be assessed as follows:<br><br>"2 - Absent or mild (0-3)<br>1 - Moderate (4-6)<br>0 - Severe (>7)"<br><br>A form "SUNNYSIDE SURGERY CENTER OPERATING RECORD/SAFE SURGERY CHECKLIST" was included in each patient record. There was a section "Post-Anesthesia Recovery Score" that did not include an assessment of pain. There was a section "DISCHARGE" that included a section for pain, to be rated on a scale of 1-10.<br><br>The following patients' medical records did not include documentation of pain assessment prior to discharge:<br><br>a. Patient #1, who was a 73 year old female who had surgery on 8/10/15 to repair a torn tendon. | Q 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 13C0001055 | A. BUILDING _____ B. WING _____ | 08/18/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNNYSIDE SURGERY CENTER | 3345 S HOLMES AVENUE, SUITE B IDAHO FALLS, ID 83404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| Q 162 | Continued From page 11<br>b. Patient #2, who was a 51 year old male who had podiatric surgery on 6/22/15 to fuse bones in his right foot.<br><br>c. Patient #3, who was a 35 year old female who had podiatric surgery on 6/22/15 to excise a heel spur.<br><br>d. Patient #4, who was a 71 year old female who had podiatric surgery on 8/10/15 to remove a bunion.<br><br>e. Patient #5, who was a 72 year old female who had podiatric surgery on 8/03/15 related to a bunion and a bone spur.<br><br>f. Patient #6, who was a 71 year old male who had a bunionectomy on 8/03/15.<br><br>g. Patient #7, who was a 32 year old female who had podiatric surgery on 7/27/15 related to a ganglion cyst.<br><br>h. Patient #8, who was a 45 year old male who had podiatric surgery on 8/17/15 related to plantar fasciitis.<br><br>i. Patient # 9, who was a 49 year old female who had a bunionectomy on 7/27/15.<br><br>j. Patient # 10, who was a 60 year old female who had podiatric surgery on 7/13/15 for hammertoe correction.<br><br>k. Patient # 11, who was a 7 year old female who had podiatric surgery on 7/20/15 related to a muscle resection.<br><br>l. Patient # 12, who was a 9 year old female who | Q 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| Q 162 | Continued From page 12<br>had podiatric surgery on 8/10/15 to remove a foreign body in her foot.<br><br>m. Patient #13, who was an 82 year old male who had podiatric surgery on 7/20/15 related to a hammertoe and warts.<br><br>The DNS and the DPM were interviewed together on 8/17/15 beginning at 3:26 PM. The DNS and DPM both stated pain was always assessed prior to discharge but may not necessarily be documented.<br><br>The ASC failed to document assessments for pain after surgery. | Q 162 | | |
| Q 241 | 416.51(a) SANITARY ENVIRONMENT<br><br>The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, staff interview, and policy review, it was determined the ASC failed to adhere to professional standards of practice as they related to handwashing practices and disposal of sharps. This directly impacted 1 of 1 patient (#8), whose surgery was observed and had the potential to impact all patients receiving services at the ASC. This resulted in an increased risk of patient infection. Findings include:<br><br>1. An undated ASC policy "Universal Precautions" included a section titled "Handwashing." The section stated staff were to | Q 241 | See included PoC | 9/22/15 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| SUNNYSIDE SURGERY CENTER | 3345 S HOLMES AVENUE, SUITE B IDAHO FALLS, ID 83404 |

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| Q 241 | Continued From page 13<br>wash their hands at various times which included immediately after taking gloves off, immediately before and after each contact and before invasive procedures.<br><br>An undated policy, "Hand Washing," stated staff were to decontaminate their hands at various times which included before having direct contact with a patient's intact skin and after removing gloves.<br><br>Patient #8 was a 45 year old patient who was observed on 8/17/15 from time of arrival in the ASC at 12:31 PM, through pre-op, surgery, and post-op until discharge at 2:50 PM. During the observation, the "Universal Precautions" and "Hand Washing" policies were not consistently implemented, as follows:<br><br>a. The CNA was observed in pre-op at approximately 12:35 PM. She was not observed to sanitize her hands prior to taking Patient #8's vital signs. She was not observed to sanitize her hands after shaving Patient #8's foot and removing her gloves.<br><br>b. The DPM was observed in pre-op at approximately 1:15 PM. He was not observed to sanitize his hands prior to marking the surgical site on Patient #8's foot.<br><br>c. The CRNA was observed in pre-op at approximately 1:30 PM. He was not observed to sanitize his hands prior to listening to Patient #8's heart and lungs.<br><br>d. At 1:35 PM, the CRNA performed hand hygiene, donned gloves, injected Patient #8's arm with a local anesthetic, and started his IV. He | Q 241 | | |

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| Q 241 | Continued From page 14<br>then got oxygen tubing from a drawer and placed it on Patient #8. He placed a pulse oximeter on Patient #8's finger. He placed a blood pressure cuff and monitor leads. He administered 2 separate IV medications. He retrieved items from the anesthesia cart at least 3 times, wrote on a chart and placed the pen in his pocket. He then touched Patient #8, touched medication vials on a tray, and charted in a 3 ring binder. The CRNA then drew up medication from a multidose vial on his anesthesia cart and administered it via the IV. He adjusted Patient #8's sheet and assisted to drape Patient #8. He touched Patient #8's chin, charted, then touched Patient #8's face again. He drew up a medication in a syringe, deflated the blood pressure cuff, administered the medication, documented information and wasted the remainder of the medication.<br><br>At 2:10 PM, the CRNA removed his gloves and performed hand hygiene. This was the first time he removed his gloves or performed hand hygiene during the observation.<br><br>At 2:20 PM on 8/17/15, the CRNA was interviewed. He stated he should have performed hand hygiene and changed his gloves during the procedure.<br><br>e. The DPM was observed in the surgical suite. He was not observed to sanitize his hands prior to donning gloves and injecting Patient #8's foot in preparation for surgery.<br><br>The ASC's employee files and infection control training was reviewed and did not include specific documentation of handwashing training.<br><br>The DNS was interviewed on 8/18/15 at 8:30 AM. | Q 241 | | |

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| Q 241 | Continued From page 15<br>The DNS stated she had reviewed handwashing expectations with staff many times but may not have documented the training. She stated she had not been able to observe handwashing to assess compliance with ASC policy because she was working at the same time patients were being seen in the surgery center.<br><br>The ASC failed to adhere to professionally acceptable standards of practice.<br><br>2. During observations conducted on 8/17/15 from 12:31 PM until 2:50 PM, it was noted that the Sharps container was approximately 2 inches above the fill line.<br><br>At 2:20 PM on 8/17/15, the CRNA was interviewed. He confirmed the Sharps container was above the fill line and should have been changed. | Q 241 | | |
| Q 261 | 416.52(a)(1) ADMISSION ASSESSMENT<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of medical records and ASC policy, it was determined the ASC failed to ensure a comprehensive H&P was completed within 30 days prior to the scheduled surgery for 13 of 13 patients (#1 - #13) whose | Q 261 | See included PoC. | 9/14/15 |

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| Q 261 | Continued From page 16<br>records were reviewed. This had the potential to interfere with assessment of the patient's readiness for surgery. Findings include:<br><br>1. The "Medical Staff Bylaws" were reviewed. Section VIII, Medical Staff Responsibilities, stated "Medical records will include significant medical history and results of physical examination." The bylaws or ASC policy did not define significant history and physical examination or specify the requirement for it to be completed within 30 days prior to surgery.<br><br>The National Center for Biotechnology Information website, accessed 8/24/15, defined a Physical Examination as "...the process of evaluating objective anatomic findings through the use of observation, palpation, percussion, and auscultation."<br><br>Documentation of a Physical Examination was lacking as part of a comprehensive H&P in the following records:<br><br>a. Patient #1 was a 73 year old female who had podiatric surgery on 8/10/15 to repair a torn tendon. The "Pre-operative Medical History & Physical," dated 7/30/15, did not include a comprehensive physical examination. There was one line on the H&P form for "physical findings." It was blank. In addition, the H&P did not include a history of her foot problem.<br><br>b. Patient #3 was a 35 year old female who had podiatric surgery on 6/22/15 to excise a heel spur. The "Pre-operative Medical History & Physical," dated 6/03/15, did not include a comprehensive physical examination. There was one line on the H&P form for "physical findings." | Q 261 | | |

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| Q 261 | Continued From page 17<br>It was blank. In addition, the H&P did not include a history of her foot problem.<br><br>c. Patient #4 was a 71 year old female who had podiatric surgery on 8/10/15 to remove a bunion. The "Pre-operative Medical History & Physical," dated 7/30/15, did not include a comprehensive physical examination. There was one line on the H&P form for "physical findings." It stated "Please use paper tape." No additional information was provided. In addition, the H&P did not include a history of her foot problem.<br><br>d. Patient #5 was a 72 year old female who had podiatric surgery on 8/03/15 related to a bunion and a bone spur. The "Pre-operative Medical History & Physical," dated 7/22/15, did not include a comprehensive physical examination. There was one line on the H&P form for "physical findings." It stated "breast cancer right side. No BP Cuff on right side. Chrone's [sic] Disease. Aortic Stenosis." In addition, the H&P did not include a history of her foot problem.<br><br>e. Patient #7 was a 32 year old female who had podiatric surgery on 7/27/15 related to a ganglion cyst. The "Pre-operative Medical History & Physical," dated 6/23/15, did not include a comprehensive physical examination. There was one line on the H&P form for "physical findings." It stated "unremarkable." The date of the H&P was greater than 30 days. In addition, the H&P did not include a history of her foot problem.<br><br>f. Patient #13 was an 82 year old male who had podiatric surgery on 7/20/15 related to a hammertoe and warts. The "Pre-operative Medical History & Physical," dated 6/30/15, did not include a comprehensive physical | Q 261 | | |

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| Q 261 | Continued From page 18<br>examination. There was one line on the H&P form for "physical findings." It was blank. In addition, the H&P did not include a history of his foot problem.<br><br>g. Patient #8 was a 45 year old male who had podiatric surgery on 8/17/15 related to plantar fascia. The "Pre-operative Medical History & Physical," dated 8/14/15, did not include a comprehensive physical examination. There was one line on the H&P form for "physical findings." It stated "CPAP @ night." In addition, the H&P did not include a history of his foot problem.<br><br>h. Patient #9 was a 49 year old female who had a bunionectomy on 7/27/15. The "Pre-operative Medical History & Physical," dated 8/14/15, did not include a comprehensive physical examination. There was one line on the H&P form for "physical findings." It stated "Anes/hard to wake." In addition, the H&P did not include a history of her foot problem.<br><br>i. Patient #10 was a 60 year old female who had podiatric surgery on 7/13/15 for hammertoe correction. There was one line on the H&P form for "physical findings." It stated "Hx of stones (kidney)." In addition, the H&P did not include a history of her foot problem.<br><br>j. Patient #11 was a 7 year old female who had podiatric surgery on 7/20/15 related to a muscle resection. There was one line on the H&P form for "physical findings." It was blank. In addition, the H&P did not include a history of her foot problem.<br><br>k. Patient #12 was a 9 year old female who had podiatric surgery on 8/10/15 to remove a foreign | Q 261 | | |

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| Q 261 | Continued From page 19<br>body in her foot. There was one line on the H&P form for "physical findings." It stated she had a history of meningitis. In addition, the H&P did not include a history of her foot problem.<br><br>l. Patient #2 was a 51 year old male who had podiatric surgery on 6/22/15 for a bone fusion. There was one line on the H&P form for "physical findings." It was blank. In addition, the H&P did not include a history of his foot problem.<br><br>m. Patient #6 was a 71 year old male who had bunionectomy surgery on 6/22/15. There was one line on the H&P form for "physical findings." It stated he had a history of blood clots and a pancreatic tumor. In addition, the H&P did not include a history of his foot problem.<br><br>None of the above records contained documentation of a physical examination related to HEENT, Neck, Heart, Lung, Abdomen, Extremities, CNS, and skin condition.<br><br>The DNS was interviewed on 8/18/15 at 11:45 AM. The DNS confirmed the results of the physical examinations were not documented.<br><br>The ASC failed to ensure comprehensive H&Ps were performed prior to surgery. | Q 261 | | |

**SUNNYSIDE SURGERY CENTER, LLC** **PLAN OF CORRECTION**

## DEFICIENCY: Q-80—QUALITY ASSESSMENT AND PERFORMANCE

| DIRECTIVE | PLAN |
|---|---|
| WHAT CORRECTIVE ACTION(S) WILL BE TAKEN TO CORRECT EACH DEFICIENCY? | • To aid in communication and understanding with the survey process, all documents and forms relating to this topic will be updated to include "QAPI".<br>• The Governing Body will attempt to define a plan for receiving notice of changes to the standards so that updates can be made in a timely manner. The Governing Body hopes to be able to receive information via fax, phone, email, or mail regarding changes to the standard thus allowing for better preparation during the next survey.<br>• A Quality Assessment and Performance Program plan will be created by the Governing Body of the ASC using the State Operations Manual Appendix L as a guide.<br>• Additionally, the Governing body will create Plans of Correction for all deficiencies in this area (Q-81 through Q-84). |
| HOW THE ACTIONS TAKEN WILL IMPROVE THE PROCESS THAT LED TO THE DEFICIENCY? | The actions taken will improve the process by:<br>• Allowing the Governing Body and the Nurse Administrator of the facility to be better prepared for a survey, improve communication with the surveyors by the implementation of common terminology.<br>• Allowing for updates to the standards to be received in a timely manner.<br>• Allowing the facility to meet the standard of Quality Assessment and Performance in its entirety. |
| WHAT THE PROCESS IS FOR IMPLEMENTING THE CORRECTIVE ACTION FOR EACH DEFICIENCY? | The process for the implementation of this corrective actions is:<br>• The governing body will dissect the results of the survey, study the State Operations Manual, compare the standard to the previous plan of the facility (formerly known as QA or Quality Improvement), and update or rewrite the plan as needed.<br>• The Governing Body will verify that all standards are met by thorough review.<br>• The Governing Body will approve the changes/new plan. |
| HOW THE CORRECTIVE ACTION(S) WILL BE TRACKED AND MONITORED TO ENSURE THE PoC IS EFFECTIVE? WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE? | This corrective action will be tracked/monitored by the Governing Body. The effectiveness of the plan will be determined by whether the surveyors consider it to be adequate. The new plan for the Quality Assessment and Performance Program of the ASC will be submitted to the state with this PoC. |
| THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE PoC? | Governing Body |
| DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED? | 09/14/2015 |

ADMINISTRATOR SIGNATURE _____ DATE 9/10/15

**SUNNYSIDE SURGERY CENTER, LLC** **PLAN OF CORRECTION**

## DEFICIENCY: Q-81—PROGRAM SCOPE; PROGRAM ACTIVITIES

| DIRECTIVE | PLAN |
|---|---|
| WHAT CORRECTIVE ACTION(S) WILL BE TAKEN TO CORRECT EACH DEFICIENCY? | The Governing Body will:<br>• Review its current list of Quality Indicators and amend the list, if necessary, to meet this standard.<br>• Verify that the indicators used focus on high risk, high volume, and problem-prone areas, by considering incidence, prevalence, and severity of problems in those areas, and assuring that they are relevant to health outcomes, patient safety and quality of care.<br>• Consider Quality Indicators in each of these categories: outcome, process of care, and patient perception with consideration given to those considered of highest priority by the Governing Body.<br>• Create a table for tracking data collectively which will simplify the analyzing process at Governing Body meetings and will aid in the QAPI Project planning/decision process.<br>• Gather data to enter into this table to use as a baseline.<br>• Define when and how data will be collected and who will be responsible for collecting the data.<br>• Define how data will be represented (example: Patients Falls/All patients)<br>• Establish when the Governing Body will review data and how often. |
| HOW THE ACTIONS TAKEN WILL IMPROVE THE PROCESS THAT LED TO THE DEFICIENCY? | These actions will improve the process that led to the deficiency by:<br>• Helping the facility to meet the newest standard.<br>• Assuring that this standard is covered in meetings, that our procedures measure, analyze, and track quality indicators, and that focus is placed on high risk, high volume, and problem-prone areas.<br>• Allowing the facility to analyze its processes in order to improve them. |
| WHAT THE PROCESS IS FOR IMPLEMENTING THE CORRECTIVE ACTION FOR EACH DEFICIENCY? | The Governing Body will:<br>• Meet and work together on this corrective action.<br>• Establish Quality Indicators for the facility based on the standards in the State Operations Manual Appendix L.<br>• Create a table/document that describes the plan for data collection which will include: who, what, when, and how.<br>• Include the table/document with this PoC. |
| HOW THE CORRECTIVE ACTION(S) WILL BE TRACKED AND MONITORED TO ENSURE THE PoC IS EFFECTIVE? WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE? | The corrective action will be tracked and monitored by the Governing Body but the effectiveness will be determined by the surveyors. The quality assurance program that will be put into place is the Quality Assessment and Performance Program (QAPI). |
| THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE PoC? | Governing Body |

| | |
|---|---|
| DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED? | 09/14/2015 |

ADMINISTRATOR SIGNATURE [signature] DATE 9/10/15

09/2015

**SUNNYSIDE SURGERY CENTER, LLC** **PLAN OF CORRECTION**

## DEFICIENCY: Q-82—PROGRAM DATA; PROGRAM ACTIVITIES

| DIRECTIVE | PLAN |
|---|---|
| WHAT CORRECTIVE ACTION(S) WILL BE TAKEN TO CORRECT EACH DEFICIENCY? | The Governing Body will:<br>• Incorporate quality indicator data and use that data to monitor effectiveness and safety of its services and quality of its care.<br>• Implement performance improvement activities that track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.<br>• Implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies |
| HOW THE ACTIONS TAKEN WILL IMPROVE THE PROCESS THAT LED TO THE DEFICIENCY? | The actions taken will improve the process that led to the deficiency by:<br>• Ensuring that quality indicator data is used to monitor effectiveness and safety of its services and quality of its care.<br>• Ensure that performance improvement activities are effective and improvements are sustained over time<br>• Ensuring that all staff are familiar with these strategies. |
| WHAT THE PROCESS IS FOR IMPLEMENTING THE CORRECTIVE ACTION FOR EACH DEFICIENCY? | The Governing Body will:<br>• Use the data table and data collected as part of PoC for standard Q-81 and create a well defined QAPI plan.<br>• Make sure the QAPI plan includes all requirements listed in the State Operations Manual with specifics on the indicator to be measured (with detailed dates, purpose, involvement, and staff education, for example).<br>• The Quality Assessment Performance Improvement Program Plan Outline will be created, approved by the Governing Body and included with this PoC. |
| HOW THE CORRECTIVE ACTION(S) WILL BE TRACKED AND MONITORED TO ENSURE THE PoC IS EFFECTIVE? WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE? | The Governing Body will monitor the progress of this PoC through active involvement. The program that will be put into place will be the Quality Assessment Performance Improvement Program Plan. Effectiveness of this Corrective Action will be determined by the surveyors involved. |
| THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE PoC? | Governing Body |
| DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED? | 09/14/2015 |

ADMINISTRATOR SIGNATURE _____ DATE 9/10/15

**SUNNYSIDE SURGERY CENTER, LLC** **PLAN OF CORRECTION**

## DEFICIENCY: Q-83—PERFORMANCE IMPROVEMENT PROJECTS

| DIRECTIVE | PLAN |
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| WHAT CORRECTIVE ACTION(S) WILL BE TAKEN TO CORRECT EACH DEFICIENCY? | These corrective actions will be taken:<br>• A performance improvement project plan will be created and implemented.<br>• Based on information in the State Operations Manual, the Facility will conduct no less than 1 performance improvement project per calendar year.<br>• A plan outline was included with the PoC for Q-82 and this plan outline will be implemented according to the Program Outline included with the PoC for Q-80. This form will be used to document projects. |
| HOW THE ACTIONS TAKEN WILL IMPROVE THE PROCESS THAT LED TO THE DEFICIENCY? | These actions will improve the process that led to the deficiency by ensuring that performance improvement projects are carried out and that the Governing Body of the ASC is actively involved. |
| WHAT THE PROCESS IS FOR IMPLEMENTING THE CORRECTIVE ACTION FOR EACH DEFICIENCY? | The process for implementing the corrective action is:<br>• The Governing Body will use indicator data collected and any other relevant data to determine which projects to perform.<br>• The Governing body will use the form it has created for the projects to verify that all requirements are met. |
| HOW THE CORRECTIVE ACTION(S) WILL BE TRACKED AND MONITORED TO ENSURE THE PoC IS EFFECTIVE? WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE? | The Governing Body will track the progress of the PoC by being actively involved and approving all of the PoC's regarding QAPI. The final measure of its effectiveness will be the approval of the Medicare surveyors. The quality assurance program put into place will be performance improvement. |
| THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE PoC? | The Governing Body |
| DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED? | 09/14/2015 |

ADMINISTRATOR SIGNATURE M. James DPM DATE 9/10/15

**SUNNYSIDE SURGERY CENTER, LLC** **PLAN OF CORRECTION**

## DEFICIENCY: Q-84—GOVERNING BODY RESPONSIBILITIES

| DIRECTIVE | PLAN |
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| WHAT CORRECTIVE ACTION(S) WILL BE TAKEN TO CORRECT EACH DEFICIENCY? | QAPI will be added to the regular Governing Body meeting agenda to ensure that it isn't missed in the discussions that occur. The Governing Body will be an active part of the QAPI program and review data, analyze data, and decide on the improvements projects to implement. The Governing Body's role in this standard will be outlined in the Quality Assessment and Performance Program Plan that is included with the PoC for Q-80. |
| HOW THE ACTIONS TAKEN WILL IMPROVE THE PROCESS THAT LED TO THE DEFICIENCY? | Having the QAPI program listed as an item on the standard meeting agenda will ensure that it isn't missed and that the Governing Body is discussing it. |
| WHAT THE PROCESS IS FOR IMPLEMENTING THE CORRECTIVE ACTION FOR EACH DEFICIENCY? | Again, it will be discussed in meetings. The Governing Body will review and sign every project at its beginning and its end and determine if the data reveals a need for a subsequent project on the same indicator。 |
| HOW THE CORRECTIVE ACTION(S) WILL BE TRACKED AND MONITORED TO ENSURE THE PoC IS EFFECTIVE? WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE? | The Governing Body will approve this plan in a meeting on 09/08/2015. It's effectiveness will be determined by the surveyors. The quality assurance plan will be QAPI as a whole with full involvement of the Governing Body evidenced by signatures on forms, projects, and meeting agendas. |
| THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE PoC? | The Governing Body |
| DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED? | 09/14/2015 |

ADMINISTRATOR SIGNATURE  DATE 9/10/15

**SUNNYSIDE SURGERY CENTER, LLC** **PLAN OF CORRECTION**

## DEFICIENCY: Q 162(b) Form and Content of Record: Pre- Discharge Pain Assessment

| DIRECTIVE | PLAN |
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| WHAT CORRECTIVE ACTION(S) WILL BE TAKEN TO CORRECT EACH DEFICIENCY? | Pre-operatively our patients will be taught a pain scale so as to be able to identify their level of pain to the medical staff. The patient's level of pain will be discussed and assessed with the patient before discharge by the DPM, CRNA or RN and recorded on the discharge sheet. A scale of 0-10 will be used to determine the level of pain experienced when a patient is experiencing pain post-operatively. The anesthetist and the surgeon will determine if a pain control will be added to the patient I.V. or if additional local medication is required. |
| HOW THE ACTIONS TAKEN WILL IMPROVE THE PROCESS THAT LED TO THE DEFICIENCY? | Pain was always discussed with our patients post-operatively. Our error came in not recording when a patient did not experience pain. We have implemented a system to document that the discussion with the patient has taken place and if there is no pain experienced this will be recorded. |
| WHAT THE PROCESS IS FOR IMPLEMENTING THE CORRECTIVE ACTION FOR EACH DEFICIENCY? | A Discussion among the CRNA, DPM, and RN as to what could be done to verify we have carried out this assessment with the patient lead to changing our Post Operative Recovery Form. We have changed our Policy and Procedures for Management of Pain. All staff has been notified of this change. |
| HOW THE CORRECTIVE ACTION(S) WILL BE TRACKED AND MONITORED TO ENSURE THE PoC IS EFFECTIVE? WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE? | On the "Operating Record-Post-Anesthesia Recovery" form we have added an area for "Pre-Discharge Pain Assessment" with a scale of 0-10 as a guide. The CRNA, DPM or RN will initial that this conversation took place and if interventions of pain control were necessary. |
| THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE PoC? | The Director of Nursing |
| DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED? | The POC was approved 9/2/2015 by the Governing Body and re-evaluated with the QAPI staff on 9/9/2015. Corrective action will be completed on our next day of surgery 9/14/2015. |

ADMINISTRATOR SIGNATURE _____ DPM DATE 9/10/15

**SUNNYSIDE SURGERY CENTER, LLC** **PLAN OF CORRECTION**

## DEFICIENCY: Q241 416.51 (a) Sanitary Environment-Hand washing and Disposal of sharps

| DIRECTIVE | PLAN |
|---|---|
| WHAT CORRECTIVE ACTION(S) WILL BE TAKEN TO CORRECT EACH DEFICIENCY? | Patients will receive quality of care in a sanitary environment for the provision of surgical services to prevent the spread of infection.<br><br>All sharps containers will be sealed according to the manufactures directions and replaced when they are ¾ full.<br><br>Hand washing will be carried out according to the Policies and Procedures of the Center: Before and after patient contact, invasive procedure, upon entering and exiting a patient room, and after removing gloves.<br>Employee files will be updated to training given. |
| HOW THE ACTIONS TAKEN WILL IMPROVE THE PROCESS THAT LED TO THE DEFICIENCY? | An established time for sharps container review will assure containers are looked at weekly. Each individual using the container will also assess when the container needs to be changed.<br><br>Education and review of individual actions will help each re-commit to how, when and where they should be washing their hands to prevent patient contamination or spread of infection. |
| WHAT THE PROCESS IS FOR IMPLEMENTING THE CORRECTIVE ACTION FOR EACH DEFICIENCY? | **All sharps containers** will be evaluated by each individual using them and upon the terminal cleaning process weekly.<br><br>**Hand Hygiene:** (08/31/2015) An unannounced employee hand hygiene observation was done during a day of surgery. This was done without individuals knowing they were being evaluated. At the end of the day each was asked how they think they did re; hand hygiene. They all had questions and recognized they needed to improve.<br><br>Each healthcare associate was given a "Reflection of Patient Contacts and Hand Washing opportunities" in which they were asked to think about their role in patient care and patient contact. They were to determine when during that contact they should wash their hands. Then they were given a link to two videos. One to help them learn how to observe others in hand hygiene and the second through WHO that shows the importance of hand hygiene. Literature from WHO was also provided to each employee. A hand potion demonstration using a black light was provided. They were then asked to complete the Reflection of Patient contact form again.<br><br>We plan on re-evaluating the employees as a follow-up on our next surgery day to complete the learning process. Documentation of the training will be placed in the employees files.<br><br>More hand sanitizers will be installed throughout the facility. Additional posters and signs will act as a reminder.<br><br>In-services such as these will be completed at least annually or as the Governing body sees the Quality Indicators may indicate. The DON will update employee files with training received. |

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| HOW THE CORRECTIVE ACTION(S) WILL BE TRACKED AND MONITORED TO ENSURE THE PoC IS EFFECTIVE? WHAT CONTINED:<br><br>QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE? | Hand Hygiene has been added to our "Ongoing Measures of Quality Indicator Data"<br><br>It will be reviewed annually for a minimum. The review process will not only include in-service but evaluations by other employees to help us all recommit ourselves to the frequency needed to protect our patients. |
| THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE PoC? | Director of Nursing, DPM, Governing Body |
| DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED? | 9/22/2015 |

ADMINISTRATOR SIGNATURE M. James DPM DATE 9/10/15

09/2015

**SUNNYSIDE SURGERY CENTER, LLC** **PLAN OF CORRECTION**

## DEFICIENCY: Q261 416.52 (a)(1) Admission Assessment- Medical History and Physical

| DIRECTIVE | PLAN |
|---|---|
| WHAT CORRECTIVE ACTION(S) WILL BE TAKEN TO CORRECT EACH DEFICIENCY? | A comprehensive history and physical examination will be completed on each patient pre-operatively within 30 days of surgery by the DPM and licensed nursing staff. A Diagnosis will be included on the H & P. A review of the patient's condition and any changes of their condition will be assessed by the DPM on the day of surgery. Our Bylaws have been updated to the policy as it states in our Policies and Procedures. |
| HOW THE ACTIONS TAKEN WILL IMPROVE THE PROCESS THAT LED TO THE DEFICIENCY? | A comprehensive history and physical examination completed within 30 days of the date of surgery and reviewed on the day of surgery for any changes will assure the physician of the patient's readiness for surgery. |
| WHAT THE PROCESS IS FOR IMPLEMENTING THE CORRECTIVE ACTION FOR EACH DEFICIENCY? | A comprehensive history and physical form has been revised and approved by the Governing Body to assure a review of patient systems have been assessed pre-operatively. A physical exam will be completed by the DPM during the pre-op appointment. At this time the patient will complete a history. It will then be reviewed and any questionable conditions will be discussed.<br><br>The DPM will complete the Physical and diagnosis at this time. |
| HOW THE CORRECTIVE ACTION(S) WILL BE TRACKED AND MONITORED TO ENSURE THE PoC IS EFFECTIVE? WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE? | The chart will be reviewed before surgery for completion by the DON. The H&P will be re-evaluated with the patient for any changes in their health on the day of surgery by the DPM and licensed staff.<br><br>As a Quality Indicator, an annual chart review will be completed in which we will determine how complete the history is and if changes are necessary. We will review the physical section with the doctor to determine its effectiveness. |
| THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE PoC? | DPM & RN and Governing Body |
| DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED? | 9/14/2015 |

ADMINISTRATOR SIGNATURE C Johnson RN DATE 9/10/15