IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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DIVISION OF LICENSING & CERTIFICATION
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December 30, 2015

Wendy Binegar, Administrator
Pain Care Center Boise
301 West Myrtle
Boise, ID 83702

RE: Pain Care Center Boise, Provider #13C0001049

Dear Ms.. Binegar:

This is to advise you of the findings of the Medicare survey of Pain Care Center Boise, which was conducted on December 15, 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 **January 12, 2016,** and keep a copy for your records.

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

Sincerely,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13C0001049 | A. BUILDING _____ B. WING _____ | 12/15/2015 |

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| Q 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the annual recertification survey conducted from 12/08/15 through 12/15/15.<br><br>The survey was conducted by:<br><br>Susan Costa, RN, HFS, Team Leader<br>Teresa Hamblin, RN, MS, HFS<br><br>Acronyms used in this report include:<br><br>ACLS - Advanced Cardiac Life Support<br>AHIMA - American Health Information Management Association<br>ASC - Ambulatory Surgical Center<br>DC - discharge<br>EMR - Electronic Medical Record<br>Inj - Injection<br>IV - Intravenous<br>LESI - Lumbar Epidural Steroid Injection<br>H&P - History and Physical Examination<br>MA - Medical Assistant<br>mcg - micrograms<br>mg - milligrams<br>ml - milliliter<br>RN - Registered Nurse<br>VORB - Verbal Order Read Back | Q 000 | | |
| 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. | Q 162 | See attachment. | |

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Nurse Administrator | (X6) DATE: 1/7/16

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 162 | Continued From page 1<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.<br>This STANDARD is not met as evidenced by:<br>Based on review of medical records, incident reports, and ASC policy, observation, and staff interview, it was determined the ASC failed to ensure complete, accurate medical records entries were maintained for 17 of 17 patients (#s 1-17) whose medical records were reviewed. This resulted in a lack of clarity as to the course of patient care. Findings include:<br><br>1. Patient #2 was a 57 year old female was seen for a steroid injection on 9/02/15. An incident report, dated 9/02/15, completed by an RN, documented a patient fall.<br><br>The description of the incident included, but was not limited to, the following: "Pt [patient] tried 3 times to step up and R [right] leg gave out and pt fell back, taking RN. Pt arm hit tray with sterile supplies and fell on back. RN moved over by pt and helped her up."<br><br>The incident was not referenced or described in Patient #2's medical record. This was confirmed by the RN Administrator on 12/15/15 at approximately 4:30 PM. | Q 162 | | |

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| Q 162 | Continued From page 2<br><br>The medical record did not include documentation of an adverse patient event.<br><br>2. An undated policy, "Complete and Accurate Documentation of Patient Treatment" was reviewed. It included, but was not limited to, the following information:<br><br>- "The signed surgical consent will identify the patient, physician and planned procedure. The patient or legal guardian must sign the consent form prior to procedure. The signature must be witnessed to include signature and date of the consent." The policy did not include the documentation requirement to time the surgical or procedural consent.<br><br>- "The history and physical must include "Any known medication reactions, allergies or intolerance, existing comorbid conditions..."<br><br>a. Procedural consents were reviewed for Patients #1-17. All of the procedural consents were dated on the same dates the procedures were performed. However, the procedural consents were not timed. It could not be verified that the consents were signed prior to the procedure for the following patients and dates:<br><br>Patient #1 was admitted to the ASC on 11/23/15 for a lumbar epidural steroid injection.<br><br>Patient #2 was admitted to the ASC on 9/02/15 for a steroid injection.<br><br>Patient #3 was admitted to the ASC on 8/20/15 for an intercostal nerve injection. | Q 162 | | |

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| Q 162 | Continued From page 3<br>Patient #4 was admitted to the ASC on 6/19/15 for a steroid injection.<br><br>Patient #5 was admitted to the ASC on 10/01/15 for a lumbar epidural steroid injection.<br><br>Patient #6 was admitted to the ASC on 11/02/15 for a lumbar epidural steroid injection.<br><br>Patient #7 was admitted to the ASC on 10/05/15 for a lumbar sympathetic block.<br><br>Patient #8 was admitted to the ASC on 10/08/15 for a radio frequency ablation of L4-5.<br><br>Patient #9 was admitted to the ASC on 10/21/15 for a lumbar sympathetic block.<br><br>Patient #10 was admitted to the ASC on 10/28/15 for a caudal epidural steroid injection.<br><br>Patient #11 was admitted to the ASC on 11/12/15 for a thoracic epidural steroid injection.<br><br>Patient #12 was admitted to the ASC on 11/16/15 for a radio frequency ablation of C2-3.<br><br>Patient #13 was admitted to the ASC on 11/18/15 for cervical facet injections.<br><br>Patient #14 was admitted to the ASC on 11/02/15 for a steroid injection.<br><br>Patient #15 was admitted to the ASC on 11/18/15 for a steroid injection.<br><br>Patient #16 was admitted to the ASC on 12/07/15 for a nerve root injection. | Q 162 | | |

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| Q 162 | Continued From page 4<br>Patient #17 was admitted to the ASC on 12/14/15 for a caudal epidural steroid injection.<br><br>The RN Administrator was interviewed on 12/08/15 at 9:45 AM. She stated patients always signed consents prior to the procedure. She confirmed the time the consents were signed were not included on the procedural consent forms.<br><br>Additionally, procedure start and end were not included in the patient records for Patients #1-17. This resulted in a lack of clarity as to the duration of the procedure and when the patient went to the recovery area. RN Administrator confirmed the procedure start and end were not included in the patient records during an interview on 12/15/15 beginning at 8:45 AM.<br><br>b. Patient #6 was a 52 year old female admitted to the ASC on 11/02/15 at 1:35 PM, for a lumbar epidural steroid injection. Her medical record information was incomplete/inaccurate, as follows:<br><br>i. Patient #6 was admitted at 1:35 PM, however, the preprocedural documentation in the record was signed by the MA at 1:28 PM, prior to the admit time.<br><br>ii. Patient #6's medication list included glipizide, (a medication to treat Type II diabetes). However, her H&P, dated 10/26/15, included documentation under the entry "Endocrine," as "feeling hot when others do not." It did not include diabetes.<br><br>During an interview on 12/15/15 beginning at 8:45 AM, the Administrator reviewed Patient #6's | Q 162 | | |

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| Q 162 | Continued From page 5<br>record and confirmed the times of Patient #6's admission and pre-procedural documentation were not accurate. She confirmed the documentation of the H&P was not clear to indicate if Patient #6 had diabetes, although she was on Glipizide.<br><br>Patient #6's record was not complete and accurate.<br><br>c. Patient #7 was a 46 year old female admitted to the ASC on 10/05/15 at 12:32 PM, for a lumbar sympathetic block with conscious sedation. Her medical record information was incomplete/inaccurate, as follows:<br><br>i. Patient #7's record documented she had an IV placed in her right forearm. Her IV was necessary for administration of conscious sedation. Her record did not include documentation of when or if the IV was discontinued before she was discharged.<br><br>ii. Patient #7's pre procedural assessment noted she had hepatitis, however it stated "Unspecified type," which lacked clarity as to a complete health history.<br><br>iii. Patient #7's pre procedural assessment by the physician noted she had diabetes, however it stated "Type uncertain." Her medication list did not include diabetic medications.<br><br>iv. The pre procedural assessment noted "Past Surgeries, Treatments and Hospitalizations: no information provided." However, the H&P for Patient #7 dated 9/08/15, included documentation she was in a car accident in 2014, which resulted in her right leg amputation and a femoral rod in | Q 162 | | |

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| Q 162 | Continued From page 6<br>her left leg. Additionally, the H&P noted Patient #7 had complications related to wound infections and cellulitis in her left leg.<br><br>During an interview on 12/15/15 beginning at 8:45 AM, the Administrator reviewed Patient #7's record and confirmed the documentation of the H&P was not clear to indicate Patient #7's past medical and surgical history.<br><br>Patient #7's record was not clear and accurate.<br><br>d. Patient #8 was an 84 year old female admitted to the ASC on 10/08/15 at 8:09 AM, for a radio frequency ablation in her lumbar region, with IV conscious sedation. Her medical record information was incomplete/inaccurate, as follows:<br><br>i. Patient #8's pre procedural assessment by the physician noted she had diabetes, however it stated "Type uncertain." Her medication list did not include diabetic medications.<br><br>During an interview on 12/15/15 beginning at 8:45 AM, the Administrator reviewed Patient #8's record and confirmed the documentation of the H&P was not clear to indicate Patient #8's type of diabetes.<br><br>Patient #8's record did not include complete documentation.<br><br>e. Patient #11 was an 85 year old female admitted to the ASC on 11/12/15 at 1:46 PM, for a cervical thoracic epidural steroid injection. Her medical record information included allergy to iodine, it caused blisters. | Q 162 | | |

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| Q 162 | Continued From page 7<br>Patient #11's medical record indicated Betadine was used as the skin prep before her procedure. Additionally, the Nursing Procedure Report, dated 11/12/15, had a pre printed statement of "Topical Iodine/Betadine Allergy? Yes or No" The "No" was circled. Her record included conflicting information related to the iodine allergy.<br><br>During an interview on 12/15/15 beginning at 4:30 PM, the RN who provided care for Patient #11 during her procedure stated Patient #11 would get blisters if the iodine/Betadine was not removed from her skin. She stated Patient #11 had multiple procedures performed at the ASC, and if the prep solution was thoroughly removed, she did not have a problem. The RN stated she should have included more information related to the documented allergy to iodine.<br><br>Patient #11's record was not clear to include additional documentation related to an identified allergy.<br><br>3. Refer to Q266 as it relates to the ASC's failure to ensure timed and dated discharge orders. | Q 162 | | |
| Q 181 | 416.48(a) ADMINISTRATION OF DRUGS<br><br>Drugs must be prepared and administered according to established policies and acceptable standards of practice.<br><br>This STANDARD is not met as evidenced by:<br>Based on medical record review, policy review, and staff interview, it was determined the ASC failed to ensure complete documentation and | Q 181 | See attachment. | |

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| Q 181 | Continued From page 8<br>authentication of treatment orders for 4 of 4 patients (#7, #8, #9 and #12) who received conscious sedation. This resulted in procedures provided without a valid physician's order. Findings include:<br><br>1. Patient #7 was a 46 year old female admitted to the ASC on 10/05/15 at 12:32 PM, for a lumbar sympathetic block with conscious sedation.<br><br>Patient #7's record documented she had an IV placed in her right forearm. Her IV was necessary for administration of conscious sedation. However, her record did not document orders for an IV to be placed.<br><br>During an interview on 12/15/15 beginning at 8:45 AM, the Administrator reviewed Patient #7's record and confirmed there was no order for an IV.<br><br>2. Patient #8 was an 84 year old female admitted to the ASC on 10/08/15 at 8:09 AM, for a radio frequency ablation in her lumbar region, with IV conscious sedation.<br><br>Patient #8's record documented she had an IV placed in her left arm for administration of IV conscious sedation. However, her record did not include documentation of orders for an IV to be placed.<br><br>During an interview on 12/15/15 beginning at 8:45 AM, the Administrator reviewed Patient #8's record and confirmed there was no order for an IV.<br><br>3. Patient #9 was a 73 year old female admitted to the ASC on 10/21/15 at 8:47 AM, for a lumbar | Q 181 | | |

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| Q 181 | Continued From page 9<br>sympathetic block with IV conscious sedation. Her medical record information was incomplete as follows:<br><br>i. Patient #9's record documented she had an IV placed in her left arm, for administration of IV conscious sedation. However, her record did not include documented orders for an IV to be placed.<br><br>ii. Patient #9's record included documentation she received a total of 300 ml IV fluid. The type of IV fluid was unspecified, and there was no documented order for IV fluids.<br><br>iii. Patient #9's record included documentation she was on oxygen during her procedure, and remained on oxygen during part of her recovery. However, there was no documented order in her record for oxygen.<br><br>During an interview on 12/15/15 beginning at 8:45 AM, the Administrator reviewed Patient #9's record and confirmed the record did not include valid orders for oxygen, IV fluids, or placement of an IV.<br><br>4. Patient #12 was a 66 year old male who was admitted to the ASC on 11/16/15, for a radio frequency ablation of C 2-3 with IV conscious sedation.<br><br>Patient #12's record documented he had an IV placed in her left arm, for administration of IV conscious sedation. However, his record did not include documented orders for an IV to be placed.<br><br>During an interview on 12/15/15 beginning at 8:45 | Q 181 | | |

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| Q 181 | Continued From page 10<br>AM, the Administrator reviewed Patient #12's record and confirmed the record did not include an order for an IV.<br><br>The ASC did not ensure that treatments that were performed were accompanied by physicians orders. | Q 181 | | |
| Q 184 | 416.48(a)(3) VERBAL ORDERS<br><br>Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of facility policies, patient records, and staff interview, it was determined the ASC failed to ensure verbal orders were written and signed by the recipient of the order and the physician for 4 of 4 patients (#7, #8, #9, and #12) who received medications and whose records were reviewed. This failure had the potential to result in patients receiving medications and treatments without valid orders. Findings include:<br><br>A policy titled "Verbal Orders," undated, stated "Physician verbal and telephone orders shall be documented as follows: Instructions/order, include name of medication, strength, dose increment, frequency, route, quantity or duration." Additionally, the policy stated "Verbal and telephone orders shall be signed or initialed by the prescribing practitioner as soon as possible, but not later than twelve days after being given."<br><br>An additional policy titled "Administration of Intravenous Conscious Sedation," undated, | Q 184 | See attachment. | |

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| Q 184 | Continued From page 11<br>stated "All intravenous sedation medications will be given with verbal orders from physician."<br><br>A policy titled "Authentication," undated, stated "Orders given orally for drugs must be followed by a written order signed by the prescribing physician."<br><br>A policy titled "Medical Record Entries," undated, stated "Medications given should be authenticated by the administering personnel, and documentation will show name, date, time, dosage, and site of injection."<br><br>A policy titled "Chart Requirements," undated, noted that each record would include a "Physician's order sheet." However, during an interview on 12/15/15 beginning at 8:45 AM, the Administrator stated that policy was outdated, it was written when the ASC had paper records, and presently the ASC used EMR.<br><br>The nursing staff at the ASC did not follow the policies when receiving and documenting verbal orders, as follows:<br><br>1. Patient #7 was a 46 year old female who was admitted to the ASC on 10/05/15, for a lumbar sympathetic block with IV conscious sedation. Her record included documentation she was administered Versed, Fentanyl, and Alfenta during her procedure. Patient #7's record did not include documentation of orders for the medications according to the ASC policies in the following examples:<br><br>The following was documented on the "Nursing Procedure Note," for 10/05/15. | Q 184 | | |

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| Q 184 | Continued From page 12<br>a. At 1:15 PM, "1 V, 1 F, 1 A, VORB [physician name]."<br>b. At 1:17 PM, "1 V, 1 F, VORB [physician name]."<br><br>The legend indicated V stood Versed, F stood for Fentanyl, A stood for Alfenta. It could not be determined whether "1" meant 1 ml or 1 mg. The nursing documentation did not specify the route and the amount. Additionally, the Nursing Procedure Note did not indicate it was also an order sheet. Patient #7's record did not include a written order signed by the physician.<br><br>During an interview on 12/15/15 beginning at 8:45 AM, the Administrator reviewed Patient #7's record. She stated the record indicated 1 ml of Versed was administered, 1 ml of Fentanyl was administered, and 1 ml of Alfenta was administered, and verbal order repeated back to the physician. She confirmed the RN did not document the administration of medications as per the ASC policy, and the orders were not signed by the physician.<br><br>Patient #7's record did not include properly executed physician orders for medications.<br><br>b. Patient #8 was an 84 year old female who was admitted to the ASC on 10/08/15, for a radio frequency ablation of L 4-5 with IV conscious sedation. Her record included documentation she received Versed, Fentanyl, and Alfenta during her procedure. Patient #8's record did not include documentation of orders for the medications according to the ASC policies in the following examples:<br><br>The following was documented on the "Nursing | Q 184 | | |

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| Q 184 | Continued From page 13<br>Procedure Note," for 10/08/15.<br><br>a. At 8:43 AM, "2 Versed, 1 Fentanyl, 1 Alfenta IV, VORB [physician name]."<br>b. At 8:50 AM, "1 Fentanyl IV, VORB [physician name]."<br>c. At 8:58 AM, "1 Alfenta IV, VORB [physician name]."<br><br>The nursing documentation did not specify the route, and the amount. Additionally, the Nursing Procedure Note did not indicate it was also an order sheet. Patient #8's record did not include a written order signed by the physician.<br><br>During an interview on 12/15/15 beginning at 4:30 PM, the RN who provided care to Patient #8 reviewed the record and confirmed her entries in the medical record indicated 2 ml of Versed were administered, a total of 2 ml of Fentanyl were administered, and a total of 2 ml of Alfenta were administered. The RN confirmed that the components of a complete order were not present in the documentation, and the orders were not signed by the physician.<br><br>Patient #8's record did not include properly executed physician orders for medications.<br><br>c. Patient #9 was a 73 year old female who was admitted to the ASC on 10/21/15, for a lumbar sympathetic block with IV conscious sedation. Her record included documentation she received Versed, Fentanyl, and Alfenta during her procedure. Patient #9's record did not include documentation of orders for the medications according to the ASC policies in the following examples: | Q 184 | | |

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| Q 184 | Continued From page 14<br>At 9:22 AM, "2 ml Versed, 1 ml Fentanyl, 1 ml Alfenta IV, VORB [physician name]."<br><br>The Nursing Procedure Note did not indicate it was also an order sheet. Patient #9's record did not include a written order signed by the physician<br><br>During an interview on 12/15/15 beginning at 4:30 PM, the RN who provided care to Patient #9 reviewed the record and confirmed her entries in the medical record indicated 2 ml of versed were administered, 1 ml of Fentanyl was administered, and 1 ml of Alfenta was administered. Additionally, she confirmed that the components of a complete order were not present in the documentation, and the orders were not signed by the physician.<br><br>Patient #9's record did not include properly executed physician orders for medications.<br><br>d. Patient #12 was a 66 year old male who was admitted to the ASC on 11/16/15, for a radio frequency ablation of C 2-3 with IV conscious sedation. His record included documentation he received a total of 2 ml Versed, 2 ml Fentanyl, and 2 ml Alfenta, the order was not signed by the physician.<br><br>During an interview on 12/15/15 beginning at 8:45 AM, the Administrator reviewed Patient #12's record and confirmed the nursing documentation was difficult to read, and was not written according to the ASC policies.<br><br>Patient #12's record did not include properly executed physician orders for medications. | Q 184 | | |
| Q 221 | 416.50(a) NOTICE OF RIGHTS | Q 221 | See attachment. | |

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| Q 221 | Continued From page 15<br><br>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 Medicare Beneficiary Ombudsman.<br>This STANDARD is not met as evidenced by:<br>Based on observation and patient and staff interviews, it was determined the ASC failed to ensure 2 of 2 patients (#16 and #17) who were observed were provided patient rights information prior to their procedures. This had the potential to interfere with exercise of patient rights. Findings include:<br><br>1. Patient care was observed, as follows:<br><br>a. Patient #17 was observed upon arrival on 12/14/15 at 2:32 PM until discharge at approximately 3:48 PM. She was not observed to be provided with patient rights information verbally or in writing. When asked on 12/14/15 after check-in and prior to being escorted to the procedure room, if she had been provided rights information, Patient #17 stated "I think they had me sign something saying I received rights information, but I don't recall receiving anything."<br><br>b. Patient #16 was a 38 year old male with low back pain scheduled to have a steroid injection on 12/14/15. He was observed upon arrival on 12/14/15 at 12:54 AM while being checked in and | Q 221 | | |

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| Q 221 | Continued From page 16<br>during the visit with the physician until returning to the waiting area at 1:17 PM. He was not observed to be provided with patient rights information verbally or in writing. When asked on 12/14/15 after check-in and prior to being escorted to the procedure room, if he had been given rights information upon arrival or during a prior visit, he stated he did not recall being provided any rights information. The planned procedure for 12/14/15 was suspended after patient evaluation and determination that the prior procedure had not been effective.<br><br>The RN Administrator was interviewed on 12/15/15 at 8:42 AM. She stated they did not give written patient rights information routinely but they had the information available on a laminate for review and paper copies were available for patients to take if they wanted them.<br><br>The ASC did not provide Patient #16 and #17 with verbal and written notice of their rights as patients, prior to the start of their surgical procedures. | Q 221 | | |
| Q 224 | 416.50(c)(1)(2)(3) ADVANCED DIRECTIVES<br><br>The ASC must comply with the following requirements:<br><br>(1) Provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.<br><br>(2) Inform the patient or, as appropriate, the patient's representative of the patient's rights to | Q 224 | See attachment. | |

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| Q 224 | Continued From page 17<br>make informed decisions regarding the patient's care.<br><br>(3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. This STANDARD is not met as evidenced by:<br>Based on policy review, record review, observation, and patient and staff interview, it was determined the ASC did not provide written information concerning its policies on advance directives, including a description of applicable State health and safety laws to 17 of 17 patients (#s 1-17) whose records were reviewed. This resulted in potential interference with the patients' ability to exercise their rights. Findings include:<br><br>1. An undated ASC policy, "Life Saving Measures and Advanced Directives" was reviewed. The policy included the following information.<br><br>"Purpose - To be sure that the patient is fully aware of our policy that suspends an advance directive in the unlikely event of a need for life saving measures or resuscitation.<br><br>Policy - In the event that a patient experiences respiratory or cardiac arrest, we will perform life saving measures according to ACLS guidelines and transfer patient to a hospital. Any living will or Advanced Directive that the patient may have in place will be suspended.<br><br>Procedure - The patient is notified upon registration and initials that they were informed."<br><br>The policy did not state patients would be informed in writing of the ASC policies related to advance directives. | Q 224 | | |

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| Q 224 | Continued From page 18<br><br>A patient handout, "Patient's Rights & Responsibilities," dated 2/2014, was reviewed. It did not include information regarding the ASC's Advance Directive policies.<br><br>Patient #16 was observed upon arrival on 12/14/15 at 12:54 AM while being checked in and during the visit with the physician. The planned procedure was suspended. He was not observed to be provided any patient rights information, including information on advance directives. When asked if he had been given rights information upon arrival or during a prior to the visit, he stated he did not recall being provided any rights information.<br><br>Patient #17 was observed upon arrival on 12/14/15 at 2:32 PM until discharge from the facility. She was not observed to be provided any patient rights information. When asked if she had been provided rights information in writing, she stated, "I think they had me sign something saying I received rights information, but I don't recall receiving information."<br><br>The medical records for Patients #1-#17 were reviewed and did not include documentation that the patients had been provided with the ASC's written policies for the following dates:<br><br>Patient #1 was admitted to the ASC on 11/23/15.<br><br>Patient #2 was admitted to the ASC on 9/02/15.<br><br>Patient #3 was admitted to the ASC on 8/20/15.<br><br>Patient #4 was admitted to the ASC on 6/19/15. | Q 224 | | |

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| Q 224 | Continued From page 19<br>Patient #5 was admitted to the ASC on 10/01/15.<br><br>Patient #6 was admitted to the ASC on 11/02/15.<br><br>Patient #7 was admitted to the ASC on 10/05/15.<br><br>Patient #8 was admitted to the ASC on 10/08/15.<br><br>Patient #9 was admitted to the ASC on 10/21/15.<br><br>Patient #10 was admitted to the ASC on 10/28/15.<br><br>Patient #11 was admitted to the ASC on 11/12/15.<br><br>Patient #12 was admitted to the ASC on 11/16/15.<br><br>Patient #13 was admitted to the ASC on 11/18/15.<br><br>Patient #14 was admitted to the ASC on 11/02/15.<br><br>Patient #15 was admitted to the ASC on 11/18/15.<br><br>Patient #16 was admitted to the ASC on 12/07/15.<br><br>Patient #17 was admitted to the ASC on 12/14/15.<br><br>The RN Administrator was interviewed on 12/08/15 at 9:15 AM. She stated that if patients report having an advance directive, the ASC would verbally inform them of the ASC's policy to suspend advance directives. She stated patients acknowledge with a signature they have been informed (verbally). She confirmed that information was not provided in writing related to the ASC's policy.<br><br>The ASC did not provide Patients #1 - 17 with written information concerning its policies on advance directives. | Q 224 | | |

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| Q 265 | 416.52(c)(1) DISCHARGE - SUPPLIES AND INFORMATION<br><br>The ASC must -<br>Provide each patient with written discharge instructions and overnight supplies. When appropriate, make a followup appointment with the physician, and ensure that all patients are informed, either in advance of their surgical procedure or prior to leaving the ASC, of their prescriptions, post-operative instructions and physician contact information for followup care.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review, policy review, and staff interview, it was determined the ASC failed to ensure written discharge instructions were provided to 16 of 16 patients (#s 1-16) who had procedures and whose records were reviewed. This resulted in patients not having written reminders of post-operative instructions and physician contact information for followup care. Findings include:<br><br>1. An undated ASC policy, "Complete and Accurate Documentation of Patient Treatment" was reviewed. It stated "Upon discharge a copy of the discharge instructions will be given to the patient. The instructions will include information regarding activity, how to contact the Center, and any specific instructions physician may have left for the patient."<br><br>An ASC policy, "Patient Discharge Criteria," dated 2014, included a section "Discharge Standing Orders." The section stated "A copy of the (discharge) instructions are given to the patient/family." | Q 265 | See attachment. | |

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| Q 265 | Continued From page 21<br>Medical records for Patients #1-16 included documentation that "Discharge instruction given verbally. Paper copy of DC instructions offered." There was no documentation to indicate written discharge instructions were provided, per ASC policy, for the following procedure dates:<br><br>Patient #1 was admitted to the ASC on 11/23/15.<br><br>Patient #2 was admitted to the ASC on 9/02/15.<br><br>Patient #3 was admitted to the ASC on 8/20/15.<br><br>Patient #4 was admitted to the ASC on 6/19/15.<br><br>Patient #5 was admitted to the ASC on 10/01/15.<br><br>Patient #6 was admitted to the ASC on 11/02/15.<br><br>Patient #7 was admitted to the ASC on 10/05/15.<br><br>Patient #8 was admitted to the ASC on 10/08/15.<br><br>Patient #9 was admitted to the ASC on 10/21/15.<br><br>Patient #10 was admitted to the ASC on 10/28/15.<br><br>Patient #11 was admitted to the ASC on 11/12/15.<br><br>Patient #12 was admitted to the ASC on 11/16/15.<br><br>Patient #13 was admitted to the ASC on 11/18/15.<br><br>Patient #14 was admitted to the ASC on 11/02/15.<br><br>Patient #15 was admitted to the ASC on 11/18/15.<br><br>Patient #16 was admitted to the ASC on 12/07/15. | Q 265 | | |

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| Q 265 | Continued From page 22<br>During a tour of the post-operative area of the ASC on 12/08/15 at 2:50 PM, the RN Administrator pointed out a laminated copy of discharge instructions. She stated they reviewed discharge instructions with patients verbally and offered a written copy. She stated they did not routinely provide a written copy of instructions.<br><br>Discharge instructions were not provided in writing to Patients #1 - 16. | Q 265 | | |
| Q 266 | 416.52(c)(2) DISCHARGE - ORDER<br><br>[The ASC must -]<br>Ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of medical records, ASC policies, standards of practice and staff interview it was determined the facility failed to ensure patients were discharged based on a complete physician's order for 17 of 17 patients (#s 1-17) whose records were reviewed. This resulted in orders that lacked clarity and validity. Findings include:<br><br>"Nursing Procedure Reports" reviewed for Patients #1-17 included "Discharge per protocol" at the bottom of each form. The orders were not dated or timed in the following medical records:<br><br>Patient #1 was admitted to the ASC for a lumbar epidural steroid injection on 11/23/15. | Q 266 | See attachment. | |

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| Q 266 | Continued From page 23<br>Patient #2 was admitted to the ASC on 9/02/15 for a steroid injection.<br><br>Patient #3 was admitted to the ASC on 8/20/15 for an intercostal nerve injection.<br><br>Patient #4 was admitted to the ASC on 6/19/15 for a steroid injection.<br><br>Patient #5 was admitted to the ASC on 10/01/15 for a lumbar epidural steroid injection.<br><br>Patient #6 was admitted to the ASC on 11/02/15 for a lumbar epidural steroid injection.<br><br>Patient #7 was admitted to the ASC on 10/05/15 for a lumbar sympathetic block.<br><br>Patient #8 was admitted to the ASC on 10/08/15 for a radio frequency ablation of L4-5.<br><br>Patient #9 was admitted to the ASC on 10/21/15 for a lumbar sympathetic block.<br><br>Patient #10 was admitted to the ASC on 10/28/15 for a caudal epidural steroid injection.<br><br>Patient #11 was admitted to the ASC on 11/12/15 for a thoracic epidural steroid injection.<br><br>Patient #12 was admitted to the ASC on 11/16/15 for a radio frequency ablation of C2-3.<br><br>Patient #13 was admitted to the ASC on 11/18/15 for cervical facet injections.<br><br>Patient #14 was admitted to the ASC on 11/02/15 for a steroid injection. | Q 266 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| Q 266 | Continued From page 24<br>Patient #15 was admitted to the ASC on 11/18/15 for a steroid injection.<br><br>Patient #16 was admitted to the ASC on 12/07/15 for a nerve root injection.<br><br>Patient #17 was admitted to the ASC on 12/14/15 for a caudal epidural steroid injection.<br><br>ASC policies did not address the requirement to time and date discharge orders.<br><br>According to AHIMA (website: ahima.org, accessed 12/17/15) "Every entry in the health record must include a complete date (including month, day, and year) and a time."<br><br>During an interview on 12/14/15 beginning at 8:45 AM, The Administrator confirmed the physician signature was not accompanied by a date or time to indicate when it was written.<br><br>ASC patients were discharged without valid and complete discharge orders. | Q 266 | | |

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# Plan of Correction

## 416.47(b) Standard level tag under FORM AND CONTENT OF RECORD

**Deficiencies – Q-0162**

*The ASC failed to ensure complete, accurate medical records were maintained. An incident report had been filled out, but patient record lacked appropriate documentation.*

- **Action that was taken to correct the deficiency:** The nurse involved was informed of the lack of documentation in the patient's EMR and added an addendum based on her notes from the incident report from the date of service. The Incident Report and Adverse Event Report forms were updated to include a checkbox for "Proper documentation in patient record (if applicable)." All staff were in-serviced on the need to always include incident/adverse event charting in the EMR as well as the separate incident report.
- **Description of how the actions will improve the processes that led to the deficiency being cited:** Having the note on the incident report will ensure that staff members filling out the report will also properly document in the medical record.
- **Plan for Monitoring/Tracking:** SEE BELOW
- **Compliance Date: 12/28/15**

*Procedural consents were not timed.*

- **Action that was taken to correct the deficiency:** A "time" line was added behind the date on all consent forms. Staff instructed at in-service on 12/28/2015 to always check that this is completed. The new policy titled: "Documentation of Patient Treatment, Verbal Orders and Chart Requirements" reflects this change.
- **Description of how the actions will improve the processes that led to the deficiency being cited:** Patient and witnesses will fill in the blank with the time that the consent form was signed. Having the new line will alert them to fill it in. Nursing staff in the treatment room will continue to ensure that the consent form is filled out in its entirety prior to the start of the procedure.
- **Plan for Monitoring/Tracking:** SEE BELOW
- **Compliance Date: 12/28/15**

*Additionally, procedure start and end times were not included in the patient records.*

- **Action that was taken to correct the deficiency:** The procedure report was updated to include a line for the grand pause and the procedure start time. Staff was in-serviced at staff meeting/in-service on 01/07/2016 on the importance of

accurate charting and the need to record the procedure start and end times as well as the time the patient is moved to the recovery room.

- **Description of how the action will improve the processes that led to the deficiency being cited:** The new line will ensure that the procedure start time is documented and thereby the staff will also identify the need to document the end time.
- **Plan for Monitoring/Tracking:** SEE BELOW
- **Compliance Date: 01/07/16**

*Medical Records were incomplete/inaccurate.*

- **Action that was taken to correct the deficiency:** All records that were found to have inaccurate, incomplete or missing information were reviewed by the Governing Body and follow up with appropriate staff members was done by both the Medical Director and the Nurse Administrator.
  We added/changed the following items to our bi-annual Chart Review/Audit Checklist: #15.) History and Physical complete and accurate with attention to details re: specific diagnosis. #21.) Does the Review of Systems contain any "unspecified" or "no information provided" statements? If so, review chart for discrepancies and document on page 2. All findings will be shared with staff at monthly meetings to increase staff awareness and to correct documentation errors. All staff members were in-serviced on 01/07/2016.
- **Description of how the action will improve the processes that led to the deficiency being cited:** Alerting our personnel about areas that were found to have discrepancies will allow them to be better aware of areas in the EMR where discrepancies can be located, identified and corrected appropriately.
- **Plan for Monitoring/Tracking:** SEE BELOW
- **Compliance Date: 01/07/16**

- **Plan for Monitoring/Tracking:** The Nurse Administrator and/or nursing staff will continue to monitor proper documentation in all areas of the patient record each day during chart review or "encounters" (our process of reviewing chart and preparing charges). Any failure to complete proper documentation or sign off properly will be referred to the Nurse Administrator and she will follow up with staff members individually.
  Additionally, the Nurse Administrator will double check for incident/adverse event documentation in the medical record when she receives any Adverse Event or Incident Reports (prior to placing in the Governing Body meeting file and/or minutes).
  The Governing Body will continue to review and follow up on the bi-annual chart reviews at monthly meetings.

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# Plan of Correction

## 416.48(a) Standard level tags under PHARMACEUTICAL SERVICES

**Deficiency – Q-0181 Administration of Drugs**
*The facility did not ensure that treatments that were performed for patients who received conscious sedation were accompanied by valid physician orders.*

- **Action that was or will be taken to correct deficiency:** All patients receiving sedation will have a copy of the standing orders "Preparing for Sedation" scanned into their medical record. This action will be performed the day prior to the procedure during chart prep (at which time forms are created).
  The Procedure Report title was also updated to include Physician Orders. This report was also updated to include an initial line for "Conscious Sedation Standing Orders" where the RN caring for the patient will initial after she has confirmed that a scanned copy of the standing orders are in the patient's medical record.
  The nursing staff was updated of this change on 01/04/16 and it was reviewed again with all staff members on 01/07/2016 during staff meeting.
- **Description of how the actions will improve the processes that led to the deficiency being cited:** These items will ensure that we have valid physician orders for starting the IV, administering IV fluid, administering O2 per nasal cannula and discontinuing the IV.
- **Plan for Monitoring/Tracking:** The Nurse Administrator and/or nursing staff will continue to monitor proper documentation in all areas of the patient record each day during chart review or "Encounters." Any failure to complete proper documentation or sign off properly will be referred to the Nurse Administrator and she will follow up with staff members individually.
- **Compliance Date: 1/4/2016**

**Deficiency – Q-0184 Administration of Drugs**
*The facility failed to ensure verbal orders were written and signed by the recipient of the order and by the physician.*

- **Action that was or will be taken to correct deficiency:** The policies "Complete and Accurate Documentation of Patient Treatment," "Chart Requirements," "Medical Records Entries," "Order Authentication" and "Verbal Orders" were consolidated into one policy titled "Documentation of Patient Treatment, Verbal Orders, and Chart Requirements"(updated and approved by the Governing Body on 01/04/2016).

All nursing staff were in-serviced on the proper documentation of verbal orders at the staff meeting/charting requirements in-service on 01/07/2016.
All verbal orders for medications given in the ASC and/or recovery area will be authenticated by the physician by his signature on the Procedure Report.

- **Description of how the actions will improve the processes that led to the deficiency being cited:** Having one clear concise policy on proper documentation will allow for better education of all staff and will provide a reference if they have any questions re: verbal orders/authentication.
  Having the physician sign off on the procedure report for all verbal and standing orders will ensure that the orders are authenticated.
- **Plan for Monitoring/Tracking:** The Nurse Administrator and/or nursing staff will continue to monitor proper documentation in all areas of the patient record each day during chart review or "Encounters." Any failure to complete proper documentation or sign off properly will be referred to the Nurse Administrator and she will follow up with staff members individually.
- **Compliance Date: 01/07/2016**

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# Plan of Correction

## 416.50 Standard level tags under PATIENT RIGHTS

**Deficiency – Q-0221**

*The ASC failed to ensure patients were provided verbal and written notice of their rights as patients prior to their procedures.*

- **Action that was or will be taken to correct the deficiency:** Front office staff will now give all new visitors to the surgery center a welcome packet that contains their notice of rights. This packet is used in place of the clipboards for any ASC visit that contains a registration form. Additionally, copies of the patient rights will be provided (on the clipboard behind the consent form) for existing patients so that they will have them in hand upon check-in.
- **Description of how the actions will improve the processes that led to the deficiency being cited:** This will ensure that patients who sign that they have received their notice of rights (as well as returning/existing patients) will actually have a copy in hand.
- **Plan for Monitoring/Tracking:** Nurse Administrator will ensure that the packets are in place and being used appropriately by performing random checks of ASC registration forms, and confirming that they are attached to welcome packets in place of the clipboard as well as confirming that notices of patient rights are being placed on the clipboards behind ASC consent forms.
- **Compliance Date: 12/28/15**

**Deficiency – Q-0224**

*The ASC failed to provide written information concerning its policies on advanced directives.*

- **Action that was or will be taken to correct the deficiency:** Our policy has been updated and approved by the Governing Body to include the statement that our patients will be informed in writing of its policy related to advanced directives. Our policy statement regarding advanced directives has been added to the bottom of our Notice of Patient Rights that is given to all patients in the welcome packet upon their first visit to the ASC, as well as provided at subsequent visits.
- **Description of how the actions will improve the processes that led to the deficiency being cited:** Placing the welcome packet in all ASC patients' hands upon check-in will ensure that patients are receiving written notice in addition to our verbal explanation of our policy.
- **Plan for Monitoring/Tracking:** Nurse Administrator will ensure that the packets are in place and being used appropriately by performing random checks of ASC registration forms, and confirming that they are attached to welcome packets in place of the clipboard as well as confirming that notices of patient rights are being placed on the clipboards behind ASC consent forms.
- **Compliance Date: 12/28/15**

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**416.52(b) Standard level tags under PATIENT ADMISSION, ASSESSMENT AND DISCHARGE**

**Deficiency – Q-0265**

*The ASC failed to ensure written discharge instructions were provided.*

- **Action that was or will be taken to correct the deficiency:** The Procedure Report checklist was changed from "Paper copy of DC instructions offered" to "Paper copy of DC instructions *provided*." Staff informed individually on 12/28/15 and as a group again on 01/07/16 of importance of always giving patients a written copy to take home. Additionally, all first time visitors to the ASC will receive a paper copy of DC instructions in the new welcome packet upon registration.
- **Description of how the actions will improve the processes that led to the deficiency being cited:** Patients are now ensured that they are receiving paper copies of DC instructions each visit to the ASC.
- **Plan for Monitoring/Tracking:** Nurse Administrator will perform random checks when checking out patients at the front desk by inquiring if they have received their copy of the discharge instructions.
- **Compliance Date: 12/28/2016**

**Deficiency – Q-0266**

*The ASC failed to ensure patients were discharged based on a complete physician's order.*

- **Action that was or will be taken to correct the deficiency:** The time when the physician signs off on standing discharge orders will now be noted on the procedure report. Additionally all patients having procedures done in the ASC will have a copy of the standing orders for discharge scanned into their medical records. Nursing staff will perform this during chart prep for all ASC patients.
- **Description of how the actions will improve the processes that led to the deficiency being cited:** Having a copy of the standing orders for discharge and noting the time of the signature for the orders to discharge will ensure that patients have valid and complete discharge orders in the medical records.
- **Plan for Monitoring/Tracking:** The Nurse Administrator and/or nursing staff will continue to monitor proper documentation on the procedure report, as well as confirming that all scanned documents are accounted for every day during chart review or "encounters". Any failure to complete proper documentation or sign off properly will be referred to the Nurse Administrator and she will follow up with staff members and/or the physician individually.
- **Compliance Date: 1/7/2016**