IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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January 14, 2016

Teresa Wellard, Administrator
Grand Teton Surgical Center
2290 Coronado Street
Idaho Falls, ID 83404

RE: Grand Teton Surgical Center, Provider #13C0001026

Dear Ms. Wellard:

This is to advise you of the findings of the Medicare survey of Grand Teton Surgical Center, which was conducted on January 7, 2016.

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 26, 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,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures

GRAND TETON surgical center

2290 CORONADO STREET • IDAHO FALLS, ID 83404
PH (208) 524-3800 • FAX (208) 524-3805

January 22, 2016

Mr. Gary Guiles
Health Facility Surveyor
Non-Long Term Care

Nicole Wisenor
Co-Supervisor
Non-Long Term Care

RE: Grand Teton Surgical Center Provider #13C0001026

Dear Gary and Nicole,

Please find enclosed the Plan of Correction for our surgical center. I hope all is up to par.

I appreciate your visit and always am interested in doing a better job for our patients.

Thank you for your visit. Please feel free to contact me with any questions.

Sincerely,

Teresa Willard RN

Teresa A Wellard, RN
Director of Nursing
Grand Teton Surgical Center

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001026	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND TETON SURGICAL CENTER	2290 CORONADO STREET 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
Q 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your surgery center from 1/04/16 through 1/07/16. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Lead Teresa Hamblin, RN, MS, HFS Acronyms used in this report include: ASC - Ambulatory Surgery Center cc - copy EGD - Upper Endoscopy, a procedure to view the esophagus, stomach, and duodenum with a scope DON - Director of Nursing g - gram IV - Intravenous mcg - microgram mg - milligram OR - Operating Room	Q 000	RECEIVED JAN 27 2016 FACILITY STANDARDS	
Q 082	416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care. (c)(2) Performance improvement activities must track adverse patient events, examine their	Q 082	To address the defect in the QAPI program the following steps have been taken and approved the GTSC Governing Board. The meeting minutes are attached. 1. The Quality Assessment Performance Improvement program was evaluated by the Governing Board on January 19, 2016. The program is found to be in need of improvement. A re-vamp of the program will begin Jan 19, 2016. 2. The DON will delegate most of the responsibilities for QAPI Program to another licensed nurse (LJ, LPN). This nurse will immediately begin to facilitate the QAPI program within the facility.	1-19-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Willard RN — TITLE: Director of Nursing — (X6) DATE: 1-22-16

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 082	Continued From page 1 causes, implement improvements, and ensure that improvements are sustained over time. (c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, incident reports, and meeting minutes, it was determined the ASC failed to ensure the causes of adverse patient events were examined and documented and improvements were implemented in order to prevent future events. This affected the care of 1 of 6 patients (#16) who had cataract surgery with lens implants whose records were reviewed. It had the potential to affect all patients who had surgery with lens implants. The failure to examine the causes of the event and implement improvements increased the likelihood that other patients receiving lens implants could suffer an adverse event. Findings include: Patient #16 was an 81 year old male who had cataract extraction with lens implant of his right eye on 6/10/15. The medical record did not indicate any problems or complications during the procedure. An incident report, dated 6/11/15 at 11:50 AM, stated the surgeon called on that date and reported the incorrect lens was implanted into Patient #16's right eye. The incident report stated "lens calculation 23.0 inserted was 20.0." The report stated "immediate staff meeting held to discuss this incident, OR Procedure reviewed.	Q 082	3. DON will provide assistant and supervision with corresponding resources to complete QAPI requirements. This assistant member will be allotted all time she feels necessary to keep QAPI requirements current. 4. **All** sentinel events shall be investigated utilizing the Root Cause Analysis Form. (attached) 5. The GTSC Governing Board shall be informed of a sentinel event at the next closet Governing Board meeting, regardless if QAPI Committee has met or not. 6. In the event of a sentinel event, policy and procedures review will ensue with policy revisions will be initiated as per Root Cause Analysis findings. 7. Performance study analysis will be completed with a re-study completed 90-120 days after policy change is made to ensure further changes to policy and procedures is not necessary. 8. Staff re-education is completed and documented as policy and procedures are updated. 9. New policies developed and discussed at staff meeting January 22, 2016. (attached)	1-19-16

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Q 082	Continued From page 2 Emphasis on importance of time out." An investigation of the incident, including an analysis of the incident's causes and a review of systems that led to the error were not documented. A causal analysis of the incident was not documented. The incident report did not state whether the incorrect lens was an ordering error or a failure to provide the lens that was ordered. Recommendations to prevent future incidents were not documented. A summary of incident reports for 2015, not dated, stated the incorrect lens incident occurred and stated "DON inquired about proper time-out being done in the OR. Surgeon stated time-outs are being done before each surgical case." The summary stated an emergency meeting of "OR personnel" was held. The summary stated "Discussion included how the incident may have happened and what processes need to change to ensure this does not happen ever again. Step by step process/policy was evaluated." The summary did not state what conclusions were reached or what actions were taken. "REGULAR STAFF MEETING" minutes, dated 7/27/15, were documented after the incident. The meeting included OR nursing staff. No physicians or Governing Body members were documented in attendance. The minutes stated "Discussion was held regarding the practice of ensuring right lens for right patient." The minutes outlined a protocol for nursing staff to select lens implants and to verify the correct lens was provided to patients. One set of "Quality Management Meeting" minutes was documented after the incident. It	Q 082	All staff members agreed with policy and all questions addressed with staff for absolute understanding of policy 8. QAPI meeting scheduled for February allowing time for LJ to prepare and become more familiar with QAPI program. Patient # 16, Prompted the following Policy and Procedure **development or revision** implementation: January 11,2016 1. Policy created stating Ophthalmologists orders for IOL will be presented to the surgical center in the form of 1 patient per page per lens requested. The surgical center will not accept a "lens list" with all patients for a given day with the entire IOLs list on 1 page. (Staff education Jan 22, 2016) 2. Policy created to list step by step procedure for correct lens selection for pt undergoing cataract surgery. (Staff education Jan 22, 2016) 3. Surgical checklist policy reviewed with medical staff and operating room staff. (Staff education Jan 22, 2016) 4. Any sentinel event shall be investigated utilizing the Root Cause Analysis form. (Staff education Jan 22, 2016) 5. Staff education regarding newly developed or revised policy and procedure will be documented in the	Staff Training 1-11-16 1-22-16 GB 1-19-16

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Q 082	Continued From page 3 was dated 12/30/15. It did not reference the incident or actions taken. Governing Board Meeting Minutes were documented on 9/22/15 and 11/17/15 following the incident. Neither set of minutes referenced the incident or mentioned policy changes. The minutes did not mention the protocol noted in the "REGULAR STAFF MEETING" minutes or approve its use. Two eye surgeons practiced at the ASC. At the time of the incident, each surgeon had a separate system to notify the ASC of the lenses to be implanted. ASC staff pulled the lenses and made them available for the surgery. The surgeon involved in the incident provided the ASC with a list of several patients having surgery the following day and a list of lens implants for those patients. Patient #16 was 1 of 9 patients having lens implants on 6/10/15. The other surgeon provided the ASC with 1 document for each patient which included their personal information and lens implant information. These systems were both still practiced as of 1/05/16. A single consistent system to provide lens implant information had not been developed. Patient #16's physician was interviewed on 1/06/16 beginning at 11:00 AM. He stated at the time of the incident staff pulled all of the lenses for the cases that day and stacked them on the counter. He stated now staff only placed the lens to be implanted for the next case on the counter prior to the procedure. He stated he did his own investigation following the incident. He stated he did not know if the surgery center had conducted an investigation or not. He stated a time out procedure was performed but said he did not	Q 082	form of a staff educational log. (Staff education Jan 22, 2016) 6. Staff compliance with policy and procedures will be assessed on an ongoing basis by the management of the surgical center including completion of skills lists and direct observation. (Staff education Jan 22, 2016) 7. As not to put any patient in an unsafe situation, disciplinary and/or educational measures will be immediately taken for employees that fall short of operating room skills competency. (Staff education Jan 22, 2016)	

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Q 082	Continued From page 4 know why the time out did not identify the error. He stated he did not know if the time out procedure was different at the time of the error than it was now. The Circulating RN for Patient #16's surgery was also the Circulating RN for lens implant cases on 1/06/16. He was interviewed on 1/06/16 beginning at 11:20 AM. He stated he did not know the cause of the wrong lens implant. He stated a time-out was conducted before the 6/10/15 surgery. He stated he did not know if the incorrect lens had been ordered or if staff had pulled the incorrect lens. He stated a staff meeting had been held following the incident but said he did not know if policies were changed as a result of the incident. He stated he was not aware if a formal investigation of the incident was conducted. The DON/Quality Coordinator was interviewed on 1/06/16 beginning at 10:10 AM. She stated a nursing staff meeting was held following the incident. She stated the way lens implants were pulled had changed but said a written procedure had not been developed. She stated the ASC had a procedure for root cause analysis but she said a root cause analysis or other formal investigation of the incorrect lens incident had not been conducted. She stated she did not know if the incident was a prescription error or if nursing staff pulled the wrong lens. She stated the ASC did not have documentation the Governing Body had reviewed the incident The ASC failed to thoroughly examine the causes of this adverse event and implement comprehensive corrective actions.	Q 082	Patient # 16, Prompted the following Policy and Procedure **development or revision** implementation: January 11,2016 1. Policy created stating Ophthalmologists orders for IOL will be presented to the surgical center in the form of 1 patient per page per lens requested. The surgical center will not accept a "lens list" with all patients for a given day with the entire IOLs list on 1 page. (Staff education Jan 22, 2016) 2. Policy created to list step by step procedure for correct lens selection for pt undergoing cataract surgery. (Staff education Jan 22, 2016) 3. Surgical checklist policy reviewed with medical staff and operating room staff. (Staff education Jan 22, 2016) 4. Any sentinel event shall be investigated utilizing the Root Cause Analysis form. (Staff education Jan 22, 2016) 5. Staff education regarding newly developed or revised policy and procedure will be documented in the	Stabb 1-11-16 1-22-16 GB 1-19-16 TW

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Q 162	Continued From page 5	Q 162		
Q 162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the ASC failed to ensure complete and accurate documentation was completed for 11 of 21 patient records (#1, #5, #7, #8, #10, #12, #14, #15, #17, #18, and #20) reviewed. This resulted in incomplete or inaccurate medication administration documentation and incomplete consent forms. Findings include: An undated ASC policy "Medication Administration," was reviewed. The section "Documentation" included, but was not limited to, the following information:	Q 162	Policy created stating that under no circumstances is writing "titrated" acceptable nursing practice under medication administered on the endoscopy procedure report. Memo circulated on January 6th stating that the practice of writing "titrated" would no longer be acceptable in this facility. Signatures of nurses within the facility that administer sedation medication obtained. All of these nurses verbally expressed understanding of the new charting policy. To date, after 2 weeks of chart review, post policy change, all nurses are in	Staff 1-11-16 1-21-16 GB 1-19-16

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Q 162	Continued From page 6 - "Perioperative team members who administer medications will document in a manner that identifies the concentrations of the medication and solutions administered and the route of administration." - "The RN circulator will document all medications administered intraoperatively, with the exception of those administered by anesthesia providers." An undated "Medication Policy," was reviewed. It included, but was not limited to, the following information: "All entries noting administration of medication must be properly entered in the medical record. All entries include the following: a. name of medication b. route of administration and site of administration for intramuscular medication only c. time of administration (endoscopy and surgery medications are generally titrated over the time of the procedure, the time of the first dose is recorded)..." A standard of practice was requested on 1/05/16 from the DON to support the policy and practice to enter only the time of the first dose. None was provided. A "Medicare Standards and Checklist for Accreditation of Ambulatory Surgery," PDF, approved by CMS September 8, 2014 (AAAASF MEDICARE <http://www.aaaasf.org/Surveyor/cms_web/PDF%20FILES/ASC%20PDFS/ASC%20Standards.pd	Q 162	compliance with this charting practice. No charts were found to have improper charting. Continued chart monitoring will continue by the DON. The **Procedure Report** has been updated to include milligram (mg) and microgram (mcg) to alleviate confusion on the amount of medication administered to a patient. Please see attachment. One nurse per day will be assigned to do chart review on a daily basis. Monday for Friday to ensure proper charting is being completed. This shall include proper consent, H&P, and making sure medications on the Procedure Report match the medications recorded by the physician on the Procedure Report. Any trends or other consistent variations will be reported to the DON. The DON will address the problem with the staff and/or physician. Chart review will continue to be part of QAPI program.	1-14-16

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Q 162	Continued From page 7 f> accessed on 01/12/16) was reviewed. It included the following standard: 600.040.012 All medications given to a patient are recorded by date, time and dosage. A third policy, "Informed Consent," dated 6/1999, was reviewed. It stated "Proper consent must be obtained before administering medical treatment or special procedures." Medical record documentation was incomplete or inaccurate as follows: 1. Patient #15 was a 38 year old female who was admitted to the ASC on 5/28/15 for a colonoscopy and endoscopy. a. The hand written procedure report documented administration of IV Midazolam "2"on 5/28/15 at 3:11 PM. The units of measurement was not documented. b. The hand written procedure report included documentation that IV Propofol "130" and IV Propofol "100" were "titrated." There were no times or amounts of the initial or subsequent doses. c. The consent form for the "gastroscopy" was signed by Patient #15 on 5/28/15, the date of the procedure. The time the consent form was signed was not included on the form. It could not be verified, based on documentation, the consent was obtained before administering medical treatment or special procedures, in accordance with ASC policy. Medication administration documentation and the	Q 162	The **Procedure Report** has been updated to include milligram (mg) and microgram (mcg) to alleviate confusion on the amount of medication administered to a patient. Please see attachment. One nurse per day will be assigned to do chart review on a daily basis. Monday for Friday to ensure proper charting is being completed. This shall include proper consent, H&P, and making sure medications on the Procedure Report match the medications recorded by the physician on the Procedure Report. Any trends or other consistent variations will be reported to the DON. The DON will address the problem with the staff and/or physician. Chart review will continue to be part of QAPI program.	1-19-16

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Q 162	Continued From page 8 procedural consent form for Patient #15 were incomplete. This was confirmed by the Director of Nursing during interview on 1/06/16 at 10:54 AM. 2. Patient #1 was a 22 year old female who was admitted to the ASC on 12/15/15 for a colonoscopy and endoscopy. a. The hand written procedure report documented administration of IV Fentanyl "50" and IV Midazolam "2" on 12/15/15 at 10:06 AM. The units of measurement, such as mg or mcg, were not documented. b. The hand written procedure report included documentation that IV Propofol "30 mg" was administered at 10:00 AM, followed by "titrated to 150." The times and amounts of specific doses administered were not documented. Medication administration documentation for Patient #1 was incomplete. This was confirmed by the DON during interview on 1/06/16 at 10:32 AM 3. Patient #5 was an 85 year old male who was admitted to the ASC on 12/30/15 for an endoscopy. a. The hand written procedure report documented administration of IV Fentanyl "25" and IV Midazolam "1" on 12/30/15 at 10:06 AM. The units of measurements, such as mg or mcg, were not documented. b. The hand written procedure report included documentation that IV Propofol "10 mg" was administered at 1:14 PM, followed by "titrated to	Q 162	The **Procedure Report** has been updated to include milligram (mg) and microgram (mcg) to alleviate confusion on the amount of medication administered to a patient. Please see attachment. One nurse per day will be assigned to do chart review on a daily basis. Monday for Friday to ensure proper charting is being completed. This shall include proper consent, H&P, and making sure medications on the Procedure Report match the medications recorded by the physician on the Procedure Report. Any trends or other consistent variations will be reported to the DON. The DON will address the problem with the staff and/or physician. Chart review will continue to be part of QAPI program. Policy created stating that under no circumstances is writing "titrated" acceptable nursing practice under medication administered on the endoscopy procedure report.	1-19-16 1-6-16

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Q 162	Continued From page 9 70." The times and amounts of specific doses administered were not documented. Medication administration documentation for Patient #5 was incomplete. This was confirmed by the DON during interview on 1/06/15 at 10:37 AM. 4. Patient #14 was a 90 year old male who was admitted to the ASC on 1/05/16 for a colonoscopy. a. The hand written procedure report documented administration of IV Fentanyl "25" and IV Midazolam "1" on 1/05/16 at 12:13 PM. The units of measurements, such as mg or mcg, were not documented. b. The hand written procedure report included documentation that IV Propofol "10 mg" was administered at 11:49 PM, followed by "titrated per MD order to 50." The times and amounts of specific doses administered were not documented. c. The consent form for the colonoscopy was signed by Patient #14 and dated on 1/05/16, the date of the procedure. The time the consent form was signed was not included on the form. It could not be verified, based on documentation, the consent was obtained before administering medical treatment or special procedures, in accordance with ASC policy. Medication administration documentation and the procedural consent form for Patient #14 were incomplete. This was confirmed by the DON during interview on 1/06/16 at 1:35 PM.	Q 162	The **Procedure Report** has been updated to include milligram (mg) and microgram (mcg) to alleviate confusion on the amount of medication administered to a patient. Please see attachment. One nurse per day will be assigned to do chart review on a daily basis. Monday for Friday to ensure proper charting is being completed. This shall include proper consent, H&P, and making sure medications on the Procedure Report match the medications recorded by the physician on the Procedure Report. Any trends or other consistent variations will be reported to the DON. The DON will address the problem with the staff and/or physician. Chart review will continue to be part of QAPI program. Policy created stating that under no circumstances is writing "titrated" acceptable nursing practice under medication administered on the endoscopy procedure report.	1-19-16 1-6-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001026	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Q 162	Continued From page 10 5. Patient #10 was a 51 year old male who was admitted to the ASC on 12/21/15 for a colonoscopy and endoscopy. a. The hand written procedure report included documentation that IV Propofol "20 mg" was administered at 8:12 AM, followed by "titrated to 100 mg." The times and amounts of specific doses administered were not documented. b. The consent form for the colonoscopy was signed by Patient #10 and dated on 12/21/15, the date of the procedure. The time the consent form was signed was not included on the form. It could not be verified, based on documentation, the consent was obtained before administering medical treatment or special procedures, in accordance with ASC policy. Medication administration documentation and the procedural consent form for Patient #10 were incomplete. This was confirmed by the DON during interview on 1/06/16 at 10:48 AM. 6. Patient #12 was a 50 year old female who was admitted to the ASC on 12/08/15 for a colonoscopy. a. The hand written procedure report included documentation of "IV Midazolam 2 g." The unit of measurement was not accurate and should have been documented as "mg." b. The hand written procedure report included documentation that IV Propofol "20 mg" was administered at 11:18 AM, followed by "titrated to 100 mg." The times and amounts of specific doses administered were not documented.	Q 162	Nursing staff and physicians notified of the deficiency to time the patient consents. Form to printers with new area for witness to write time of consent timing. It was it was reiterated to staff and physicians that the consent must indicate, by a time written on the consent, that the consent was obtained prior to the procedure. No time on the consent could not confirm when the consent was signed. The **Procedure Report** has been updated to include milligram (mg) and microgram (mcg) to alleviate confusion on the amount of medication administered to a patient. Please see attachment. One nurse per day will be assigned to do chart review on a daily basis. Monday for Friday to ensure proper charting is being completed.	1-11-16 TW 1-11-16

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Q 162	Continued From page 11 b. The consent form for the colonoscopy was signed by Patient #12 and dated on 12/08/15, the date of the procedure. The time the consent form was signed was not included on the form. It could not be verified, based on documentation, the consent was obtained before administering medical treatment or special procedures, in accordance with ASC policy. Medication administration documentation was incomplete or inaccurate and the procedural consent form for Patient #12 was incomplete. This was confirmed by the DON during interview on 1/06/16 at 10:51 AM. 7. Patient #17 was a 74 year old female who was admitted to the ASC on 6/16/15 for a colonoscopy and endoscopy. The hand written procedure report included documentation that IV Propofol "20 mg" was administered at 8:35 AM, followed by "titrated to 90 mg." The times and amounts of specific doses administered were not documented. Medication administration documentation for Patient #17 was incomplete. This was confirmed by the DON during interview on 1/06/16 at 10:58 AM. 8. Patient #8 was a 51 year old male who was admitted to the ASC on 12/10/15 for a colonoscopy and endoscopy. a. The hand written procedure report included documentation of "IV Midazolam 1 g." The unit of measurement was not accurate and should have been documented as "mg."	Q 162	Nursing staff and physicians notified of the deficiency to time the patient consents. Form to printers with new area for witness to write time of consent timing. It was it was reiterated to staff and physicians that the consent must indicate, by a time written on the consent, that the consent was obtained prior to the procedure. No time on the consent could not confirm when the consent was signed. Policy created stating that under no circumstances is writing "titrated" acceptable nursing practice under medication administered on the endoscopy procedure report. Memo circulated on January 6th stating that the practice of writing "titrated" would no longer be acceptable in this facility. Signatures of nurses within the facility that administer sedation medication obtained. All of these nurses verbally expressed understanding of the new charting policy. To date, after 2 weeks of chart review, post policy change, all nurses are in compliance with this charting practice. No charts were found to have improper charting. Continued chart monitoring will continue by the DON.	1-11-16 1-11-16

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Q 162	Continued From page 12 b. The hand written procedure report included documentation that IV Propofol "20 mg" was administered at 10:33 AM during the endoscopy procedure, followed by "titrated to 140 mg." The hand written procedure report included documentation that IV Propofol "20 mg" was administered at 10:49 PM during the colonoscopy procedure, followed by "titrated to 110 mg." The times and amounts of specific doses administered were not documented. c. The consent form for the colonoscopy and endoscopy was signed by Patient #8 and dated on 11/23/15, the date of the procedure. The time the consent form was signed was not included on the form. It could not be verified, based on documentation, the consent was obtained before administering medical treatment or special procedures, in accordance with ASC policy. Medication administration documentation for Patient #8 was incomplete or not accurate. This was confirmed by the DON during interview on 1/06/16 at approximately 11:00 AM. 9. Patient #7 was a 71 year old female who had colonoscopy performed at the ASC on 10/12/15. a. The consent form for the "Colonoscopy" was signed by Patient #7 on 10/12/15, the date of the procedure. The time the consent form was signed was not included on the form. It could not be verified, based on documentation, the consent was obtained before the colonoscopy was performed. b. The procedure report, dated 10/12/15, documented administration of IV Midazolam "2" by the RN on 10/12/15. The time it was	Q 162	Policy created stating that under no circumstances is writing "titrated" acceptable nursing practice under medication administered on the endoscopy procedure report. Memo circulated on January 6th stating that the practice of writing "titrated" would no longer be acceptable in this facility. Signatures of nurses within the facility that administer sedation medication obtained. All of these nurses verbally expressed understanding of the new charting policy. To date, after 2 weeks of chart review, post policy change, all nurses are in compliance with this charting practice. No charts were found to have improper charting. Continued chart monitoring will continue by the DON. Nursing staff and physicians notified of the deficiency to time the patient consents. Form to printers with new area for witness to write time of consent timing. It was it was reiterated to staff and physicians that the consent must indicate, by a time written on the consent, that the consent was obtained prior to the procedure. No time on the consent could not confirm when the consent was signed.	1-11-16 Staff 1-11-16 1-22-16 GB 1-19-16

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Q 162	Continued From page 13 administered was not documented. The units of measurement were not documented. c. The procedure report included documentation that IV Propofol 20 mg was given at 7:24 AM and 50 mg was titrated. The times or amounts of subsequent doses were not documented. d. The procedure report, stated "2" of Midazolam was given. The "Colonoscopy Report" by the physician, dated 10/12/15, stated 1 mg of Midazolam was administered. The nursing documentation and physician documentation was not consistent. The above documentation issues were confirmed by the DON during interview on 1/06/16 at 2:45 PM. 10. Patient #18 was a 37 year old male who had EGD and sigmoidoscopy performed at the ASC on 12/11/15. a. The procedure report, dated 12/11/15, documented "IV fentanyl 50" was administered by the RN at 2:52 PM on 12/11/15. The units of measurement were not documented. The "EGD Report," dated 12/11/15 at 3:35 PM, stated 50 mcg of Fentanyl was administered. The "Sigmoidoscopy Report," dated 12/11/15 at 3:32 PM, stated another 50 mcg of Fentanyl was administered. This was not consistent with the procedure report which stated only 1 dose of Fentanyl was administered. b. The procedure report included documentation that IV Propofol 10 mg was given at 3:05 PM and 140 mg was titrated. The next line of the form documented 110 of Propofol was titrated. The	Q 162	Policy created stating that under no circumstances is writing "titrated" acceptable nursing practice under medication administered on the endoscopy procedure report. Memo circulated on January 6th stating that the practice of writing "titrated" would no longer be acceptable in this facility. Signatures of nurses within the facility that administer sedation medication obtained. All of these nurses verbally expressed understanding of the new charting policy. To date, after 2 weeks of chart review, post policy change, all nurses are in compliance with this charting practice. No charts were found to have improper charting. Continued chart monitoring will continue by the DON. The **Procedure Report** has been updated to include milligram (mg) and microgram (mcg) to alleviate confusion on the amount of medication administered to a patient. Please see attachment. One nurse per day will be assigned to do chart review on a daily basis. Monday for Friday to ensure proper charting is being completed.	1-11-16 1-22-16 GB 1-19-16 1-11-16

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Q 162	Continued From page 14 times or amounts of individual doses of Propofol were not documented. The above documentation issues were confirmed by the DON during interview on 1/06/16 at 3:00 PM. 11. Patient #20 was a 39 year old female who had EGD and colonoscopy performed at the ASC on 1/04/16. a. The consent forms for the EGD and the colonoscopy were both signed by Patient #20 on 1/04/16, the date of the procedure. The time the consent forms were signed was not included on the forms. It could not be verified, based on documentation, the consents were obtained before the procedures were performed. b. The nursing procedure report for Patient #20 included documentation that IV Propofol 150 mg was administered for the EGD and the physician's "EGD Report," dated 1/04/16 at 9:07 AM, stated 50 mg of Propofol was administered. The Propofol amounts administered were not consistent. In addition, the nursing procedure report for Patient #20 stated IV Propofol 150 mg was administered during the EGD and 80 mg was administered during the colonoscopy. The procedure report stated 20 mg of Propofol was administered at 8:41 AM and another 20 mg of Propofol was administered at 9:08 AM for the second procedure. The times the remaining doses of Propofol were administered were not documented. The above documentation issues were confirmed by the DON during interview on 1/06/16 at 3:05 PM.	Q 162	Nursing staff and physicians notified of the deficiency to time the patient consents. Form to printers with new area for witness to write time of consent timing. It was it was reiterated to staff and physicians that the consent must indicate, by a time written on the consent, that the consent was obtained prior to the procedure. No time on the consent could not confirm when the consent was signed. Policy created stating that under no circumstances is writing "titrated" acceptable nursing practice under medication administered on the endoscopy procedure report. Memo circulated on January 6th stating that the practice of writing "titrated" would no longer be acceptable in this facility. Signatures of nurses within the facility that administer sedation medication obtained. All of these nurses verbally expressed understanding of the new charting policy. To date, after 2 weeks of chart review, post policy change, all nurses are in compliance with this charting practice. No charts were found to have improper charting. Continued chart monitoring will continue by the DON.	1-6-16 1-11-16

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Q 162	Continued From page 15 On 1/06/16, the DON distributed a memo to "all nurses involved in sedation of patients," dated 1/06/16. The memo was cc'd to "the medical director." It stated the following: "Please be aware that from this date forward, writing "titrated" on the medication section of any procedure report will no longer be acceptable practice in this facility. Henceforth, please record each dose of medication given with the time given on the procedure record. This applies to all medications given, particularly propofol/diprivan. Thank you for your cooperation as we continue to make your surgical center unsurpassed in patient safety and patient care. Please sign below that you understand the above change in procedure charting practice." The ASC failed to ensure documentation was complete and accurate.	Q 162	Policy created stating that under no circumstances is writing "titrated" acceptable nursing practice under medication administered on the endoscopy procedure report. Memo circulated on January 6th stating that the practice of writing "titrated" would no longer be acceptable in this facility. Signatures of nurses within the facility that administer sedation medication obtained. All of these nurses verbally expressed understanding of the new charting policy. To date, after 2 weeks of chart review, post policy change, all nurses are in compliance with this charting practice. No charts were found to have improper charting. Continued chart monitoring will continue by the DON.	1-6-16 1-11-16 1-22-16 6B 1-19-16
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on review of narcotic disposal logs, facility policy, and staff interview, it was determined the ASC failed to ensure 1 of 2 medication	Q 181		

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Q 181	Continued From page 16 destruction records (Fentanyl) was completed in accordance with ASC policy. This resulted in narcotics being wasted without a second nurse as a witness to the disposal. This had the potential to result in drug diversion or unauthorized access of narcotics. Findings include: An undated ASC policy "Medication Administration," was reviewed. It stated "Perioperative team members who administer medications will document Schedule II through V medications that were not administered to the patient were disposed of in accordance with local, state, and federal law, as well as with the surgical center's policies." An undated ASC "Medication Policy," stated "In the event a controlled substance is not completely used in any given situation and the drug is to be discarded, the registered nurse will have another registered nurse witness the drug being discarded. Both nurses will sign/verify that the drug was wasted." These policies were not followed: Logs for "fentanyl," a synthetic opiate analgesic, were reviewed between 12/16/15 and 1/04/16. Logs included 57 entries of wasting or discarding portions of the dose after administration. Six of the 57 entries were initialed as witnessed. Fifty-one entries did not include evidence of witness of wastage. Three nurses were represented in the 57 entries. The Director of Nursing confirmed, during interview on 1/06/16 at 3:08 PM, that initials were missing to indicate the discarded narcotics had been witnessed. She stated they should have	Q 181	Previous to January 11, 2016 it was the policy of Grand Teton Surgical Center to have 2 "licensed" individuals sign the wasting of medications. This proved to be problematic as there were not always 2 licensed individuals at the location of the wasting of medication. This led to a deficiency as some of medication logs reviewed were lacking the second signature to confirm wastage of the medication. The Idaho State Board of Pharmacy was contacted to see who may witness the destruction or wasting of narcotic/ medication? Copy attached. As per the information gained from the Idaho State Board of Pharmacy, the surgical center's policy has been changed to state that 2 employees, regardless if licensed or not, may witness the wasting of medications. (attached) Non-licensed and licensed clinical staff members have been educated on the policy change which went in effect on January 11, 2016	staff 1-11-16 1-22-16 GB 1-19-16

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Q 181	Continued From page 17 been witnessed. Narcotics were not disposed of in accordance with ASC policy and standards of practice.	Q 181	Policy created and staff/physicians educated that any verbal orders given by the physicians to the nursing staff administering sedation medications must be a clear, concise, and audible order for the medication. No abbreviations or slang is to be used. Then the verbal order should be repeated back to the physician for clarity. Policy ***Sedation Nurse Responsibilities*** has been revised as above. The Director of Nursing will use direct observation to ensure this practice is being followed on a weekly basis. Sedation nurses are to report to the DON if there is push-back from the physicians.	1-6-16 1-11-16 1-22-16 GB 1-19-16 Physicians 1-6-16
Q 184	416.48(a)(3) VERBAL ORDERS Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure verbal orders were delivered and read-back clearly for 1 of 1 sedation RN (RN A) who was observed to receive verbal orders. The lack of clear orders directly impacted 1 of of 1 patient observed (#14) where an RN accepted verbal medication orders. It had the potential to impact all patients for whom verbal orders were given. This resulted in the potential for medication errors to occur and compromise patient safety. Findings include: The policy "Physician Verbal Orders," dated 06/1999, was reviewed. The policy included the following information: "Physician verbal orders for medications or any other patient care must be followed up by a written and signed order from that physician as soon as possible after the verbal order and no more than 7 days after the verbal order. The registered nurse taking the verbal order will repeat the order back to the physician to assure	Q 184		

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Q 184	Continued From page 18 accuracy. The nursing staff will write the order and flag the chart as needing a physician signature. The patient chart will be considered incomplete and not filed until all signatures are completed." The policy did not address the need for the verbal orders to be complete, including the name, dose, and route of the medication. It did not include the requirement for the read back to include clarification if not all of those elements were present. A second undated "Medication Policy," was reviewed. The policy included, but was not limited to, the following information: - "Verbally transmitted orders will have the name, spelling, and dosage of the drug written down and then repeated back to the prescriber." - "Information staff must have in place prior to the administration of medication include knowledge of: a. the patient b. the medication c. the method of administration d. any device used to administering the drug..." Patient #14 was a 90 year old male who was admitted to the ASC on 1/05/16 for a colonoscopy.	Q 184	Policy created and staff/physicians educated that any verbal orders given by the physicians to the nursing staff administering sedation medications must be a clear, concise, and audible order for the medication. No abbreviations or slang is to be used. Then the verbal order should be repeated back to the physician for clarity. Policy ***Sedation Nurse Responsibilities*** has been revised as above. The Director of Nursing will use direct observation to ensure this practice is being followed on a weekly basis. Sedation nurses are to report to the DON if there is push-back from the physicians. One nurse per day will be assigned to do chart review on a daily basis. Monday for Friday to ensure proper charting is being completed. This shall include proper consent, H&P, and making sure medications on the Procedure Report match the medications recorded by the physician on the Procedure Report. Any trends or other consistent variations will be reported to the DON. The DON will address the problem with the staff and/or physician. Chart review will continue to be part of QAPI program.	1-19-16 tw

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Q 184	Continued From page 19 The procedure was observed by two surveyors. A surveyor heard a verbal order at approximately 11:47 AM for "Versed 125" followed by a read-back verification. Documentation in Patient #14 record indicated Patient #14 was given "IV Fentanyl 25" and "IV Midazolam 1." There was no reference to Fentanyl in the verbal order or read back verification. Patient #14's medical record included documentation of administration of "IV propofol 10 mg" at 11:49 AM, "titrated per MD order" and a total of 50 mg administered. During observation, surveyors did not hear any verbal orders for "propofol" or read-back verification. The RN who administered the medications for Patient #14 was interviewed by both surveyors on 1/05/15 at 3:39 PM. He stated he understood what the physician wanted even if the specific medications were not referenced because they were the only medications they gave. A second RN was interviewed on 1/06/15 at 9:45 AM. She stated it was generally understood what medications the physicians were referring to when they were ordered, whether Fentanyl or Versed or Propofol. She stated she repeated back the dosage but did not necessarily repeat back the medications. Verbal orders and read-back verification for Patient #14 were incomplete.	Q 184	The **Procedure Report** has been updated to include milligram (mg) and microgram (mcg) to alleviate confusion on the amount of medication administered to a patient. Please see attachment. One nurse per day will be assigned to do chart review on a daily basis. Monday for Friday to ensure proper charting is being completed. This shall include proper consent, H&P, and making sure medications on the Procedure Report match the medications recorded by the physician on the Procedure Report. Any trends or other consistent variations will be reported to the DON. The DON will address the problem with the staff and/or physician. Chart review will continue to be part of QAPI program.	1-22-16
Q 225	416.50(d)(4),(5), & (6) SUBMISSION AND INVESTIGATION OF GRIEVANCES The ASC must establish a grievance procedure for documenting the existence, submission,	Q 225	Policy created and staff/physicians educated that any verbal orders given by the physicians to the nursing staff administering sedation medications must be a clear, concise, and audible order for the medication. No abbreviations or slang is to be used. Then the verbal order should be repeated back to the physician for clarity.	1-22-16

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	13C0001026	A. BUILDING _____ B. WING _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND TETON SURGICAL CENTER	2290 CORONADO STREET 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
Q 225	Continued From page 20 investigation, and disposition of a patient's written or verbal grievance to the ASC. The following criteria must be met: (1) The grievance process must specify timeframes for review of the grievance and the provisions of a response. (2) The ASC, in responding to the grievance, must investigate all grievances made by a patient, the patient's representative, or the patient's surrogate regarding treatment or care that is (or fails to be) furnished. (3) The ASC must document how the grievance was addressed, as well as provide the patient, the patient's representative, or the patient's surrogate with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the result of the grievance process and the date the grievance process was completed. This STANDARD is not met as evidenced by: Based on review of the ASC grievance policy, patient rights information, and staff interview, it was determined the facility failed to ensure grievance procedures were fully defined and developed for all patients receiving care at the ASC. This resulted in non-specific timeframes for the review of grievances and the provisions of a response. It also resulted in a procedure that did not include the expectation a written response would be provided to any grievance. It had the potential to interfere with the successful filing, investigation, and resolution of grievances. Findings include: The grievance log for the prior year was requested. A list of incidents was provided. No	Q 225	Policy stating **Patient Complaint/Grievance** revised on staff educated on protocol as well as importance of the subject matter. See Attached. Physician education at GB meeting 1-19-16. Staff education 1-22-16. Response letter within 7 days	GB 1-19-16 Staff 1-22-16

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Q 225	Continued From page 21 grievances were documented. The Director of Nursing explained, during interview on 1/06/16 at approximately 3:30 PM, that grievances were documented on incident reports and they had "not had a grievance in 16 years." An undated patient handout "Patient Rights and Responsibilities," was reviewed. It included a section, titled "Complaints and Grievances," that included, but was not limited to, the following information: "The patient or family member may contact the Director of Nursing at any time with complaints or grievances and can expect a resolution to the grievance in a reasonable time including external appeals as required by state and federal regulations." The handout did not provide a telephone number or address to contact the Director of Nursing. It did not specify a time frame for review and response to the complaint or communicate that written notice would be provided. The policy "Patient or Visitor Complaint/Grievance," dated 06/1999, was reviewed. It described the following protocol: "1. Patient or visitor describes a problem or complaint to an employee of the surgical center. 2. The employee taking the complaint or dissatisfying issue, immediately defines the problem, and takes instantaneous action to fix the problem or rectify the issue. 3. Every effort will be made by the employee to remedy the problem on the spot.	Q 225	In as much as it was discovered that the phone number for the Idaho Bureau of Statistics was incorrect on the surgical center's Patient Rights and Responsibilities, the phone number has been changed on the Patient Rights and Responsibilities. In addition, the telephone number for the Director of Nursing has been included on the Patient Rights and Responsibilities as well as the address for the Director of Nursing. This information was added and 100s of new copies printed. Old copies of the Patient Rights and Responsibilities have been destroyed and a new version of the Patient Rights and Responsibilities, with updated information, has been posted in the lobby and each patient admit room. 1-19-16 TW	

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Q 225	Continued From page 22 4. In no instance will the patient be made to feel as though they do not have a legitimate complaint, no matter how trivial the complaint is to the employee. 5. Efforts will continue until the patient or visitor's complaint or dissatisfaction is resolved. 6. The Director of Nursing or other charge person will be notified of the complaint. 7. The patient's physician will be notified of the problem, if appropriate. 8. Patients have the option of filling out a complaint/grievance (incident) form if they wish and will be provided the form upon request. 9. Completed forms will be given to the Director of Nursing as soon as possible. 10. The Director of Nursing will review the complaint/grievance and contact the Medical Director. 11. The complaint/grievance will be reviewed in the next scheduled QM meeting and on to the Governing Board as scheduled [sic]. 12. All patient complaints/grievances will be followed through on and filed in the grievance file located under lock and key in the Director of Nursing's office." The policy and procedure was incomplete and did not address the following information: - It did not address the differences between	Q 225	In as much as it was discovered that the phone number for the Idaho Bureau of Statistics was incorrect on the surgical center's Patient Rights and Responsibilities, the phone number has been changed on the Patient Rights and Responsibilities. In addition, the telephone number for the Director of Nursing has been included on the Patient Rights and Responsibilities as well as the address for the Director of Nursing. This information was added and 100s of new copies printed. Old copies of the Patient Rights and Responsibilities have been destroyed and a new version of the Patient Rights and Responsibilities, with updated information, has been posted in the lobby and each patient admit room.	1-19-16

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Q 225	Continued From page 23 complaints and grievances. - It did not state how the facility would communicate to the patient and/or the patient's representative or surrogate of the ASC's grievance process, including how to file a grievance. - It did not address the necessity to investigate all grievances. - It did not address a specific timeframe for the completion of the ASC's review of the grievance allegations or the provision of a response to the person filing the grievance. - It did not address the requirement to notify the patient or the patient's representative or surrogate, in writing, of the ASC's decision regarding each grievance. The written notice must include the name of an ASC contact person, the steps the ASC took to investigate the grievance, the results of the grievance process, and the date the process was completed. The Director of Nursing was interviewed on 1/06/15 at 10:23 AM. She confirmed the grievance process and patient handout information were incomplete.	Q 225	In as much as it was discovered that the phone number for the Idaho Bureau of Statistics was incorrect on the surgical center's Patient Rights and Responsibilities, the phone number has been changed on the Patient Rights and Responsibilities. In addition, the telephone number for the Director of Nursing has been included on the Patient Rights and Responsibilities as well as the address for the Director of Nursing. This information was added and 100s of new copies printed. Old copies of the Patient Rights and Responsibilities have been destroyed and a new version of the Patient Rights and Responsibilities, with updated information, has been posted in the lobby and each patient admit room. Policy stating **Patient Complaint/Grievance** revised on staff educated on protocol as well as importance of the subject matter. See Attached. Physician education at GB meeting 1-19-16. Staff education 1-22-16.	1-19-16