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
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 27, 2016

Mark Hollingshead, Administrator
Surgicare Center Of Idaho
360 East Mallard Drive, Suite 125
Boise, ID 83706

RE: Surgicare Center Of Idaho, Provider #13C0001014

Dear Dr. Hollingshead:

This is to advise you of the findings of the Medicare survey of Surgicare Center Of Idaho, which was conducted on January 21, 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:

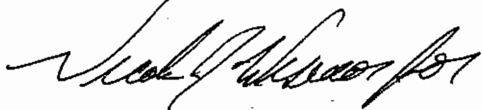
An acceptable plan of correction (PoC) contains the following elements:

- 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 **February 8, 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, option #4.

Sincerely,



GARY GUILES
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

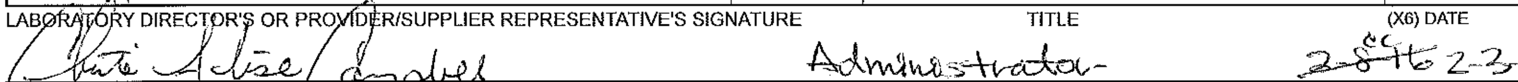
GG/pmt
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 1/19/16 through 1/21/16. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS Acronyms used in this report include: ASC - Ambulatory Surgery Center BG - Blood Glucose CRNA - Certified Registered Nurse Anesthetist H&P - History and Physical Examination IV - Intravenous NPO - nothing to eat or drink OR - Operating Room RN - Registered Nurse	Q 000	RECEIVED FEB - 8 2016 FACILITY STANDARDS	
Q 121	416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of credentials files and policies, it was determined the ASC failed to ensure a consistent process was implemented to grant surgical privileges in accordance with the ASC's policies. This affected the care of 1 of 1 patient (#13) whose surgery was observed and of all other patients who had surgery performed at the ASC after the surgeon's	Q 121	Action for correction: Review of current policy & procedure. All medical staff records will be reviewed & updated immediately. To ensure all staff records for privileges are current the following will occur: 1) After current review & update all ~~st~~ medical staff privilege dates will be placed in Administrator's & Administrator's assistant calenders with reminder notification when renewals will be needed.	2-8-16



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-8-16 2-2-16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 121	Continued From page 1 privileges expired. This prevented the ASC from ensuring the surgeon was qualified and competent to perform the surgeries. Findings include: One surgeon practiced at the ASC. The surgeon was observed to perform a cataract extraction with lens implant on Patient #13 on 1/19/16 beginning at 12:44 PM. The policy "POLICIES AND PROCEDURES FOR OPERATING ROOM PRIVILEGES FOR PHYSICIANS," revised 1/08/15, stated physician appointments to the Medical Staff were valid for 2 years. A letter from the Administrator, dated 11/01/12, stated the surgeon was appointed to the Medical Staff on that date. The letter stated the appointment ran from 11/01/12 through 11/01/15. No other document stated the surgeon had been reappointed to the Medical Staff since 11/01/12 which was 3 years, 2 months, and 20 days after the appointment date. The appointment of the surgeon expired 2 months, and 20 days prior to the survey date. The Acting Administrator was interviewed on 1/21/16 beginning at 10:10 AM. She agreed the surgeon's appointment to the Medical Staff had expired. She also agreed the appointment letter did not match the ASC's policy. The ASC failed to reappoint the surgeon to the Medical Staff and failed to grant him current privileges to perform procedures at the ASC. The ASC failed to develop a consistent reappointment process.	Q 121	cont, Action 2) Renewals will reflect policy of appointments validation of 2 yrs. 3) The appointments & reappointments & privileges will be reflected in the governing body minutes. How Action will improve Process 1) this Action will assist both administrator & assistant administrator by having renewals on calendar with prior notification of action required (alerts). 2) Having both administrator & assistant administrator involved will ensure privileges will remain current. Monitoring & Tracking 1) After Reviewing all medical staff's privileges the date for renewal will be entered in the computer calendar. An Alert one month prior to renewal will also be entered into this calendar. 2) On the first work day of each month the Administrator will review the month for any alerts coming due that month. Person Responsible: Christi Campbell, Administrator 2-8-16	2-8-16 2-8-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 141	Continued From page 2	Q 141	Action for Tag 141	
Q 141	416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the ASC failed to ensure nursing services were provided in accordance with nursing standards of care, ASC protocol and orders for 2 of 2 patients (#9 and #13) whose care was observed. This had the potential to result in inadequate care and negative patient outcomes. Findings include: 1. Patient #9 was a 69 year old male who was admitted to the ASC on 1/19/16, for removal of a cataract in his left eye. Patient #9's record documented additional diagnoses of hypertension, heart valve replacement, diabetes, and unsteady gait. The PreOp Report, completed by the admitting RN, included vital signs and blood sugar readings. Patient #9 had low blood sugar results, his record did not include documentation the CRNA or the physician was alerted of the multiple low blood sugar results and interventions that were initiated. a. The PreOp Report included documentation of Patient #9's blood sugar and interventions by the RN as follows:	Q 141	1) Retraining will be required of all nurses on the Protocol of a hypoglycemic patient. 2) This will be done by an inservice given by administrator & administrator's assistant. 3) The Policy & Procedure will be ~~revised to include~~ reviewed by Governing Body at their 2-10-16 meeting. 4) The nurse involved in this case will be taken out of the pre-op area until retraining is completed. 5) This nurse will also be disciplined for not following policy.	2-9-16 2-9-16 2-10-16 2-9-16 2-9-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 141	Continued From page 3 - 12:48 PM, the RN documented she administered 24 grams of glucose gel orally to Patient #9, however, there was no documentation of a BG result to indicate the need for the glucose gel. - 12:59 PM, BG 51. - 1:02 PM, BG 68. - 1:03 PM, an additional 12 grams of glucose gel was administered orally to Patient #9. - 1:07 PM, an IV was started in his left arm. - 1:17 PM, BG 68. - 1:20 PM, an IV of 5% Dextrose/Normal Saline infusion was started. - 1:34 PM, BG 105. No further blood sugars were documented in PreOp. Patient #9 was taken to the OR at 1:53 PM. His record did not include documentation of reporting the low BG to the RN who received him in the OR, the CRNA, or the physician. Additionally, Patient #9 was no longer NPO status once he received the oral glucose solution. His record did not include documentation the CRNA and physician were notified. Patient #9's procedure was completed at 2:24 PM, and he was transferred to post operative recovery at 2:26 PM. During observation of a BG sample procedure, Patient #9's record documented a BG result of 202, taken at 2:32 PM. His record documented his IV was removed after the BG was completed.	Q 141	How Action will Improve Process 1) Retraining Nurses on Policy & Procedure on hypoglycemic patients will ensure all nurses are knowledgeable on Policy. 2) Retraining will ensure that all nurses follow the same protocol & ensure patient saftey & positive outcomes. 3) Removing the nurse involved in deficiency until retrained will ensure patient safety. 4) Discipline of nurse involved will stress the seriousness of not following policy & ensure she will follow it in the future.	2-9-16 2-9-16 2-9-16 2-9-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 141	Continued From page 4 The RN noted he received a total of 500 ml IV fluid. Patient #9 was discharged at 3:21 PM. An ASC policy titled "HYPOGLYCEMIC PROTOCOL," dated 1/12/15, for "Hypoglycemic Treatment of Diabetic Patients with BG less than or equal to 70 mg/dl, and/or Symptomatic." The protocol included treatment of Responsive NPO patient or Unresponsive patient, and Responsive patient who was not NPO. b. Patient #9's record indicated he was responsive, and NPO. His record was reviewed alongside the protocol, and it was unclear which portion of the protocol was followed by the RN: The protocol for Responsive Patient that was NPO specified: - "Administer 500 ml of Dextrose 5% via IV at 100 ml/hour." However, the RN documented she provided Patient #9 24 grams of an oral glucose gel solution at 12:48 PM. An IV was not started at that time. - "Recheck BG in 15 minutes," however his BG was rechecked at 1:02 PM, (3 minutes after the first BG was documented, and 14 minutes after the glucose gel was given.) An additional 12 grams of glucose gel was administered orally at 1:03 PM. - "If BG less than 70 mg/dl, administer the remainder of the D5W,[Dextrose 5% solution]" however, an IV was started at 1:07 PM. Patient #9's BG at 1:17 PM was 68, and the IV fluid of Dextrose 5% with Normal Saline was started at 1:20 PM.	Q 141	Monitoring & Tracking Procedures 1) Documentation of training will be filed in nurse's employee files & in meeting book. 2) The month after training a test will be given to each nurse to evaluate knowledge of policy. 3) The results will be kept in nurses employee file. Any nurse scoring below 85% will be held back from patient care until additional training & evaluation is done. 4) All nurses will review any ~~test~~ questions missed & correct answers discussed until understood.	2-9-16 3-9-16 3-9-16 3-9-16

5) Nurses that didn't pass first policy test will then retake test. If they do not pass with an 85% or better the nurse will be dismissed. 4-1-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 141	Continued From page 5 - "Recheck BG in 15 minutes," the RN documented at 1:34PM, Patient #9's BG was 105. No further testing of his BG was performed in the PreOp area. The Hypoglycemia Protocol also included directions that the Nurse Administrator, the Physician, and the CRNA on duty be notified. Patient #9's record did not include documentation that the individuals were notified. c. Patient #9's record did not include orders to implement Hypoglycemia Protocol, orders for the IV fluid of 5% Dextrose/Normal Saline, or Glucose gel of 24 grams and 12 grams. During an interview on 1/20/16 at 10:30 AM, the Acting Administrator reviewed Patient #9's record and confirmed documentation of the BG results and nursing interventions. She reviewed the Hypoglycemic Protocol, and confirmed it was not followed by the RN who provided his care in PreOp. The Acting Administrator was documented in Patient #9's record as the circulator RN during his surgical procedure. She confirmed she was not notified of his hypoglycemia and BG results. Patient #9's RN did not follow the ASC's protocol for hypoglycemia management. 2. Patient #13 was a 72 year old female who was admitted on 1/19/16, for a cataract extraction and lens implant on her left eye. Patient #13's care was observed from her admission at 11:52 AM until her discharge at 1:18 PM. Patient #13's record included documentation she had medication allergies to sulfa, codeine and	Q 141	Person Responsible for Implementing POC Christi Campbell, Administrator Plan of Action for tag 141 on Patient #4 13 1) Retrain surgery personnel that patient allergies will be taken from their history & physical. This will be used for surgery time outs & communication with other team members. 2) The retraining will be performed in an inservice. The inservice will review the components of an history & physical & a surgical time out How Action Will Improve Process 1) Retraining Personnel on patient allergy documentation & time outs will ensure everyone is following correct protocol & ensure patient safety.	 2-9-16 2-9-16 2-9-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 141	Continued From page 6 morphine. Her record was in the operating room and the form titled "Medication Reconciliation/Allergy Form" was on a table where the circulating RN was working. Just before the procedure started, the Circulator RN announced a "Time Out." During the "Time Out" the entire team in the operating room paused to identify the patient, procedure, allergies, and any pertinent details. The Circulator RN read the information from her worksheet, and stated "No Known Allergies." When the procedure was over, and Patient #13 was taken to the recovery area, the Circulator RN was asked about the "Time Out" process that was observed. She confirmed she stated "No Known Allergies," however, when she reviewed the Medication Reconciliation/Allergy Form, she saw that Patient #13 did have allergies. The RN stated she used her worksheet, and should have read the information from Patient #13's record. The Circulator RN did not perform an accurate time out.	Q 141	Monitoring & Tracking Procedure 1) Training of surgery personnel will be in meeting minutes regarding documenting allergies & using them for communication to team members. 2) A review of this training will be performed the following month & reflected in the department meeting minutes. Person Responsible Christi Campbell, Administrator	2-9-16
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, 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,	Q 225	Plan of Action Tag Q225 1) The patients rights & responsibilities will be revised to include a section on the grievance process. 2) the grievance policy will be revised to state how patients would be informed of their right to file grievances & who to contact to file a grievance.	2-11-16 2-11-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 7 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 staff interview, and review of policies and forms, it was determined the ASC failed to ensure a grievance procedure, including informing patients of their right to file grievances, had been implemented for all patients receiving care at the facility. This increased the difficulty for patients to exercise their right to file grievances. Findings include: A notice of rights, not dated, was provided to patients prior to surgery. The notice did not mention grievances nor did it include a process that explained how patients could file a grievance. The policy "Patient Grievance Procedure," dated 1/12/15, stated patients would be given a patient satisfaction questionnaire. The policy stated if the forms were signed and if grievances were noted on the forms then an investigation would be conducted. The policy did not state how patients would be informed of their right to file grievances or who they could contact to file a grievance. The ASC performed approximately 3200 surgeries in 2015. The Acting Administrator,	Q 225	How will the Actions Improve the Process 1) By revising the patients rights & responsibilities form, the patient will be knowledgeable of the grievance process. 2) By revising the grievance policy the policy will reflect how patients are informed of their right to file a grievance. This will help staff understand & follow the process. Monitoring & Tracking Procedures 1) The revised policy & Patient's rights & responsibilities will be presented to the governing body on 2-10-16. This will be reflected in the governing body minutes. 2) When the revisions are approved by the Governing Body they will be presented to the surgery department in the monthly department meeting. This will be reflected in the meeting minutes. 3) Revisions will be implemented.	2-11-16 2-11-16 2-10-16 2-24-16 2-11-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ____ B. WING ____	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 8 interviewed on 1/20/16 beginning at 1:45 PM, stated the ASC had not received any grievances in 2015 or January of 2016. She confirmed the policy and the rights form given to patients did not include notification of the grievance process or directions how to file a grievance. The ASC failed to adopt a grievance procedure that included informing patients how to file a grievance.	Q 225	Person Responsible Christi Campbell, Administrator	
Q 242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: Based on observation, staff interview, and policy review, the ASC failed to ensure hand hygiene and infection control practice was performed in accordance with policy or standards of practice for 1 of 1 ASC patients (#13), whose surgery was observed. This had the potential to increase risk of patient infection. Findings include: 1. The ASC handwashing policy, "Hand Hygiene," dated 1/08/15, included, but was not limited to, the following information: - "Decontaminate hands before having direct contact with patients."	Q 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 242	Continued From page 9 - "Decontaminate hands before donning gloves." - "Decontaminate hands after removing gloves." - "Decontaminate hands after contact with a patient's intact skin." - "Decontaminate hands after contact with inanimate objects, including medical equipment, charts, etc..." Breaches in hand hygiene and infection control were observed as follows: Patient #13 was a 72 year old female who was admitted to the ASC on 1/19/16, for cataract removal and lens implant in her right eye. She was observed from entrance to the waiting area at 11:52 AM until discharge from the ASC at 1:18 PM. The following observations were noted by 2 surveyors during the surgical procedure for Patient #13: 1. At 12:35 PM, Patient #13 entered the OR and was placed on the operating table. A scrub tech entered the room. She was not observed to perform hand hygiene when she entered the room. The scrub tech opened the drawer of a cabinet, removed a bottle of eye drops, then placed a drop of medication into Patient #13's right eye. She placed the drops back into the drawer. She did not put gloves on or perform hand hygiene before the eye drops were administered. The scrub tech was observed to stabilize Patient #13's head with tape, then proceed to don sterile gloves to perform a prep scrub of Patient #13's eye and face area. The	Q 242	Plan of Action 1) Retraining of surgery staff on hand hygiene. This will be accomplished through hands on demonstration, in-service, handouts, & observation. 2) The surgery staff will also be required to reread the policy & procedure on hand hygiene. Each staff member will be required to sign & date printed policy to document it was reviewed. Monitoring & Tracking Process 1) The effectiveness of the hand hygiene training will be monitored by anymonous observers with documentation. The documentation will be given to the administrator who will evaluate the results. 2) The results will be shared with staff at monthly department meetings. Results will also be used to evaluate staff performance & may warrant discipline actions.	2-9-16 2-9-16 Beginning 2-16-16 & then ongoing 2-24-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	**360 EAST MALLARD DRIVE, SUITE 125** **BOISE, ID 83706**

(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 242	Continued From page 10 scrub tech was not observed to perform hand hygiene during this time. After the prep was completed, the scrub tech removed her gloves, went back into the drawer for eye drops, then applied another drop to Patient #13's right eye. The bottle of eye drops was placed back in the drawer, then she gathered up her prep supplies, threw them away, and used hand sanitizer on her way out of the OR. 2. The CRNA entered the OR at 12:37 PM. He put on a pair of gloves without performing hand hygiene at 12:42 PM. The CRNA administered sedation, then removed his gloves, and sat down at the computer to document his activities. He was not observed to perform hand hygiene before or after the glove use. During an interview on 1/20/16 beginning at 10:20 AM, the Acting Administrator confirmed she was present during the surgical procedure for Patient #13. She confirmed the scrub tech should have worn gloves and performed hand hygiene. She confirmed the CRNA should have performed hand hygiene before and after glove use. The Acting Administrator stated she would ensure that the CRNA and scrub staff would participate with education and surveillance of hand hygiene activities. The ASC did not follow infection control guidelines as they related to hand hygiene.	Q 242	Person Responsible Christi Campbell, Administrator	
Q 262	416.52(a)(2) PRE-SURGICAL ASSESSMENT Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and	Q 262		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 262	Continued From page 11 safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the ASC failed to ensure assessments were completed prior to surgical procedures for 1 out of 2 patients (#9) whose care was observed and whose records were reviewed. This resulted in the potential for patients to receive inadequate care during their procedures. Findings include: Patient #9 was a 69 year old male who was admitted to the ASC on 1/19/16, for removal of a cataract in his left eye. Patient #9's record documented additional diagnoses of hypertension, heart valve replacement, diabetes, and unsteady gait. An H&P, dated 1/19/16 and signed by the physician at 12:55 PM, included an attestation that he reviewed the H&P, no changes were noted, and Patient #9 could proceed with surgery at that time. However, the physician signed the H&P before the PreOp RN documented vital signs. The PreOp Report completed by the admitting RN, included vital signs and blood sugar readings. The first set of vital signs was obtained at 12:59 PM, 4 minutes after the physician	Q 262	Plan of Action 1) Review with physician the auditors findings on patient #9. Inform physician that H&Ps are not to be signed off for surgery until preop vitals have been taken, documented, & he has reviewed them. 2) Retraining of nurses on hypoglycemic patients will be performed as mentioned in Tag 141. 3) The nurse involved in the pre op care of this patient will be taken out of patient pre op area until retraining is performed. 4) This nurse will also be disciplined for not following policy. Monitoring & Tracking Procedures 1)	2-8-16 2-9-16 2-9-16 2-9-16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 262	Continued From page 12 examined Patient #9. Patient #9 had low blood sugar results, his record did not include documentation the CRNA or the physician was alerted of the multiple low blood sugar results and interventions that were initiated. The PreOp Report included documentation of Patient #9's blood sugar and interventions by the RN as follows: - 12:48 PM, the RN documented she administered 24 grams of glucose gel orally to Patient #9. - 12:59 PM, BG 51. - 1:02 PM, BG 68. - 1:03 PM, 12 grams of glucose gel was administered orally. - 1:07 PM, IV was started in his left arm. - 1:17 PM, BG 68. - 1:20 PM, an IV of 5% Dextrose/Normal Saline infusion was started. - 1:34 PM, BG 105. No further blood sugars were documented in PreOp. Patient #9 was taken to the OR at 1:53 PM. His record did not include documentation of reporting the low BG to the RN who received him in the OR, the CRNA, or the physician. Patient #9's procedure was completed at 2:24 PM, and he was transferred to post operative recovery at 2:26 PM.	Q 262	How Action Will Improve Process 1) Reminding Physician on Pre OP H+P review will ensure he understands process. 2) As discussed in Tag 141 retraining nurses on Policy & Procedure on hypoglycemic patients will ensure they are knowledgeable on the policy. Monitoring & Tracking Process 1) As mentioned in Tag 141 documentation will be filed in nurses employee files & meeting book. 2) Post Tests will be taken one month after retraining. 3) Results will be filed in nurse's file. 4) & 5) of Tag 141 will also be followed.	 2-9-16 2-9-16 2-9-16 3-9-16 3-9-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001014	A. BUILDING ______ B. WING ______	01/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICARE CENTER OF IDAHO	360 EAST MALLARD DRIVE, SUITE 125 BOISE, ID 83706

(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 262	Continued From page 13 The Acting Administrator provided an ASC policy titled "HYPOGLYCEMIC PROTOCOL," dated 1/12/15, for "Hypoglycemic Treatment of Diabetic Patients with BG less than or equal to 70 mg/dl, and/or Symptomatic." The Hypoglycemia Protocol included directions that the Nurse Administrator, the Physician, and the CRNA on duty be notified. Patient #9's record did not include documentation that the individuals were notified. During an interview on 1/20/16 at 10:30 AM, the Acting Administrator reviewed Patient #9's record and confirmed there was no documentation the CRNA or physician was notified and performed a reassessment of his status prior to the surgical procedure. Additionally, the Acting Administrator was noted in Patient #9's record as the Circulator RN during his surgical procedure. She confirmed she was not notified of his hypoglycemia and BG results. Patient #9's hypoglycemia was not re-evaluated by the physician or CRNA prior to his surgical procedure.	Q 262	person responsible Christi Campbell, Administrator	