IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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March 7, 2014

William Evans, Administrator
Emerald Surgical Center
811 North Liberty
Boise, ID 83704

RE: Emerald Surgical Center, Provider #13C0001017

Dear Mr. Evans:

On March 4, 2014, a follow-up visit of your facility, Emerald Surgical Center, was conducted to verify corrections of deficiencies noted during the survey of January 23, 2014

We were able to determine that the Conditions of Participation of **Governing Body and Management (42 CFR 416.41), Surgical Services (42 CFR 416.42) and Quality Assessment and Performance (42 CFR 416.43)** are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Also 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.

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 **March 19, 2014**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us 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
ec: Kate Mitchell, CMS Region X Office

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

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13C0001017	A. BUILDING _____ B. WING _____	R 03/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD SURGICAL CENTER	811 NORTH LIBERTY BOISE, ID 83704

(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 A follow up survey was performed at your ambulatory surgery center on 3/04/14. Surveyors conducting the follow up were: Gary Guiles, RN, HFS, Team Leader Donald Sylvester, RN, HFS Acronyms used in this report include: ASC - Ambulatory Surgery Center PIP - Performance Improvement Project pt - patient QAPI - Quality Assessment Performance Improvement	{Q 000}		
{Q 083}	416.43(d) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations. (2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results This STANDARD is not met as evidenced by: Based on staff interview and review of plans of correction, policies, and QAPI documents, it was determined the ASC failed to ensure distinct performance improvement projects were developed and implemented. The lack of performance improvement projects impeded the ability of the ASC to conduct in depth evaluations	{Q 083}	Q083 Corrective action QI committee met February 13, 2014. Performance Improvement Projects planned for 2014 are: Normothermic temperature regulation and improving discharge education for appropriate patient self- management. Studies have begun. * See enclosed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Camille Mills	Nurse Director	3-19-2014

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 083}	Continued From page 1 of specific aspects of patient care. Findings include: The "STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION" for Emerald Surgical Center, dated 1/23/14, included a deficiency at 42 CFR Part 416.43(d) for the failure to develop and implement PIPs. A Plan of Correction by the ASC, dated 2/18/14, stated PIPs to examine "Normothermic temperature regulation and improving discharge education" were being developed. However, no evidence was available to demonstrate PIPs had been developed. A letter from the Clinical Manager, dated 2/19/19, stated the facility would be in compliance with Q83 by 2/19/14. This had not occurred. The Nurse Director was interviewed on 3/04/14 beginning at 1:30 PM. She stated the ASC planned to implement PIPs but said they had not been developed yet.	{Q 083}	QO83 Met standard as of 3-6-2014.	
{Q 244}	The ASC had not conducted PIPs. 416.51(b)(2) INFECTION CONTROL PROGRAM - QAPI [The program is -] An integral part of the ASC's quality assessment and performance improvement program This STANDARD is not met as evidenced by: Based on staff interview, and review of plans of correction and QAPI documents, it was determined the facility failed to integrate infection control into its QAPI program. This resulted in	{Q 244}		

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{Q 244}	Continued From page 2 the potential for infections to occur. Findings include: The "STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION" for Emerald Surgical, dated 1/23/14, included a deficiency at 42 CFR Part 416.51(a) for the failure of staff to perform appropriate hand hygiene. "Quality Improvement Committee Meeting" minutes, dated 2/13/14, stated "Hand hygiene audits" would be conducted and monitored as part of the facility's quality indicators. The minutes did not include suggestions to increase hand hygiene compliance. One "Infection Control Audit Tool," dated 2/14/14, had been completed. The tool documented the staff member being observed had not performed hand hygiene including "a. After removing gloves b. After direct pt care c. Before invasive procedures d. After contact with blood, body fluids, or contaminated surfaces." No other "Infection Control Audit Tools" were completed. No documentation was present stating the Qua Improvement Committee was informed of the 2/14/14 audit. No documentation was present stating any further action was taken through th QAPI program to correct the deficient practice. The Nurse Director was interviewed on 3/04/14 beginning at 1:30 PM. She stated the above "Infection Control Audit Tool" documented the only hand hygiene observation that had been conducted. She stated further observations w planned but had not been conducted yet. She stated the facility's QAPI program had not addressed the lack of hand hygiene by staff.	{Q 244}	Q 244 Corrective Action: Hand Hygiene audits were resumed February 14, 2014, and will be continued on a monthly basis. March 12, 2014, the Governing Body discussed hand hygiene audits. Four audits will be conducted monthly, one from each group (physicians, CRNA, RN and CST) Recommendations to increase compliance were adding additional hand sanitizers at point of care locations, offering pocket sized sanitizers, and direct feedback following audit The Nurse Director will perform these or assign silent shopper observations to another staff member. Staff members who continue with non-compliance with our policies will be brought to the attention of the Governing Body. Hand hygiene education includes all staff, including individual feed-back on hand hygiene observations.	

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{Q 244}	Continued From page 3 The ASC's QAPI program had not taken action to ensure staff performed appropriate hand hygiene.	{Q 244}	Q 244 Met standard as of 3-12-2014	