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
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July 18, 2014

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 July 10, 2014.

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 **July 30, 2014,** 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

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 _____	07/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND TETON SURGICAL CENTER	2290 CORONADO STREET IDAHO FALLS, ID 83404

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Q 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your surgical center from 7/08/14 to 7/10/14. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Donald Sylvester, RN, HFS Acronyms used in this report include: ASC - Ambulatory Surgery Center DON - Director of Nursing EGD - Esophagogastroduodenoscopy, viewing a patient's upper gastrointestinal system through a scope IV - Intravenous mcg - microgram mg - milligram RN - Registered Nurse	Q 000		
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.	Q 162	RECEIVED AUG 11 2014 FACILITY STANDARDS (Please see next page)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa A Wellard RN — TITLE: Director of Nursing — (X6) DATE: 8-6-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 162	Continued From page 1 (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 review of medical records and staff interview, it was determined the ASC failed to ensure medical records were complete and accurate for 7 of 20 patients (#5, #6, #10, #13, #15, #16, and #19) whose records were reviewed. This resulted in in a lack of clarity as to the patients' course of treatment during their time in the ASC. Findings include: 1. Patient medical records did not include accurate documentation of titrated medications (medications given in small doses over a period of time). a. Patient #5's medical record documented a 30 year old male admitted to the ASC on 6/12/14 for a colonoscopy and EGD. Patient #5's "PROCEDURE RECORD," dated 6/12/14, documented Patient #5 received propofol 120 mg at 8:42 AM and 100 mg was given at 9:05 AM. The medication given to Patient #5 was documented as total doses and not documented as titrated throughout his procedures. b. Patient #6's medical record documented an 81 year old female admitted to the ASC on 7/09/14 for a colonoscopy and EGD. Patient #6's "PROCEDURE RECORD," dated 7/09/14, documented Patient #6 received propofol 40 mg at 10:30 AM and 90 mg was given	Q 162	To address this deficiency the procedure record was changed to ensure better, more concise documentation of the medications administrated to the patient during a procedure. At the recommendation of our anesthesia providers, the improved *Procedure Record,* includes a section for each dose of a particular medication as well as a time the medication was given and a slot for total dose of a medication. In addition, a second segment was added for the medication Propofol to be utilized for patients undergoing 2 procedures, such as and EGD and a colonoscopy in the same visit. The Registered Nurse administrating the medication is listed on the left side of the form. On August 5' 2014 the surgical Center staff were introduced to the new form and given extensive instruction on the completion of the new patient record with all staff verbalizing understanding of the documentation standard. The Director of Nursing will complete ongoing monitoring of the new form to ensure compliance by all staff members. (Please see attached)	Aug 5 2014

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Q 162	Continued From page 2 at 10:55 AM. The medication given to Patient #6 was documented as total doses and not documented as titrated throughout her procedures. c. Patient #10's medical record documented a 63 year old female admitted to the ASC on 6/26/14 for a colonoscopy. Patient #10's "PROCEDURE RECORD," dated 6/26/14, documented Patient #10 received propofol 120 mg at 1:36 PM. The medication given to Patient #10 was documented as a total dose and not documented as titrated throughout her procedure. d. Patient #13's medical record documented a 39 year old female admitted to the ASC on 6/02/14 for a colonoscopy and EGD. Patient #13's "PROCEDURE RECORD," dated 6/02/14, stated she received 160 mg of IV propofol at 7:18 AM and 120 mg of IV propofol at 7:35 AM. The same "PROCEDURE RECORD" stated she also received 50 mcg of IV fentanyl at 7:15 AM and 50 mcg of IV fentanyl at 7:33 AM. The medications given to Patient #13 were documented as total doses and not documented as titrated throughout her procedure. e. Patient #15's medical record documented a 58 year old female admitted to the ASC on 6/30/14 for a colonoscopy and EGD. Patient #15's "PROCEDURE RECORD," dated 6/30/14, documented Patient #15 received propofol 60 mg at 3:01 PM and 80 mg was given at 3:35 PM. The medication given to Patient #15 was documented as total doses and not	Q 162	To address this deficiency the procedure record was changed to ensure better, more concise documentation of the medications administrated to the patient during a procedure. At the recommendation of our anesthesia providers, the improved *Procedure Record,* includes a section for each dose of a particular medication as well as a time the medication was given and a slot for total dose of a medication. In addition, a second segment was added for the medication Propofol to be utilized for patients undergoing 2 procedures, such as and EGD and a colonoscopy in the same visit. The Registered Nurse administrating the medication is listed on the left side of the form. On August 5' 2014 the surgical Center staff were introduced to the new form and given extensive instruction on the completion of the new patient record with all staff verbalizing understanding of the documentation standard. The Director of Nursing will complete ongoing monitoring of the new form to ensure compliance by all staff members. (Please see attached)	

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Q 162	Continued From page 3 documented as titrated throughout her procedures. f. Patient #19's medical record documented a 21 year old female admitted to the ASC on 6/10/14 for a colonoscopy and EGD. Patient #19's "PROCEDURE RECORD," dated 6/10/14, stated she received 30 mg of IV propofol at 8:09 AM and 50 mg of IV propofol at 1:02 PM. The same "PROCEDURE RECORD" stated she also received 50 mcg of IV fentanyl at 8:09 AM and 2 mg of IV versed at 8:09 AM. The medications given to Patient #19 were documented as total doses and not documented as titrated throughout her procedure. Additionally, Patient #19's "PROCEDURE RECORD," documented her procedure ended at 8:36 AM. The documentation of propofol administration at 1:02 PM was not accurate. The DON reviewed the patients' medical records listed above on 7/10/14 beginning at 2:00 PM. She confirmed the incorrect documentation of time Patient #19 received propofol. She also confirmed medications were given in small doses over a period of time and were not given in large single doses as documented in the patients' medical records. The DON agreed this led to a lack of clarity regarding the patients' medication administration. 2. Patient medical records included a "GRAND TETON SURGICAL CENTER CHECKLIST." The checklists, for Patient #5 (dated 6/12/14), Patient #6 (dated 7/09/14), Patient #10 (dated 6/26/14), Patient #13 (dated 6/02/14), Patient #15 (dated 6/30/14), and Patient #19 (dated 6/10/14) all	Q 162	This chart was pulled and the medication times were reviewed. To me, Teresa Wellard, RN, it looks as if there is a / mark and a time of 8:21 for the second dose of propofol. Nevertheless, legible documentation is crucial and the matter was addressed with all employees on July 24, 2014 at a staff meeting. Staff were reminded of the importance of legible entries into a patient's chart as well as possible legal ramifications. Improving the readability of entries in a patient's chart is a requirement that will leave little question as to what an entry may be and make our charting process improved. The Director of Nursing will randomly review the finished charts on an ongoing basis to ensure compliance to this standard.	July 24 2014

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Q 162	Continued From page 3 documented as titrated throughout her procedures. f. Patient #19's medical record documented a 21 year old female admitted to the ASC on 6/10/14 for a colonoscopy and EGD. Patient #19's "PROCEDURE RECORD," dated 6/10/14, stated she received 30 mg of IV propofol at 8:09 AM and 50 mg of IV propofol at 1:02 PM. The same "PROCEDURE RECORD" stated she also received 50 mcg of IV fentanyl at 8:09 AM and 2 mg of IV versed at 8:09 AM. The medications given to Patient #19 were documented as total doses and not documented as titrated throughout her procedure. Additionally, Patient #19's "PROCEDURE RECORD," documented her procedure ended at 8:36 AM. The documentation of propofol administration at 1:02 PM was not accurate. The DON reviewed the patients' medical records listed above on 7/10/14 beginning at 2:00 PM. She confirmed the incorrect documentation of time Patient #19 received propofol. She also confirmed medications were given in small doses over a period of time and were not given in large single doses as documented in the patients' medical records. The DON agreed this led to a lack of clarity regarding the patients' medication administration. 2. Patient medical records included a "GRAND TETON SURGICAL CENTER CHECKLIST." The checklists, for Patient #5 (dated 6/12/14), Patient #6 (dated 7/09/14), Patient #10 (dated 6/26/14), Patient #13 (dated 6/02/14), Patient #15 (dated 6/30/14), and Patient #19 (dated 6/10/14) all	Q 162	2. To address the chart incompleteness, a **"TIME"** segment was added to the top of the Surgical Checklist that will be utilized to record the time the actual time out was completed. This change was made on July 11, 2014 and to date there has been total compliance by staff members. The Director of Nursing will monitor compliance to this addition to the checklist. (Please see attached)	July 11, 2014

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Q 162	Continued From page 4 stated a procedural time-out was conducted for the patients, but the records did not document the time it occurred in relation to their procedures. The DON reviewed the patients' medical records listed above on 7/10/14 beginning at 2:00 PM. She confirmed the procedural time-out was conducted but the time was not documented. 3. Patient #16's medical record documented a 17 year old female who had an EGD performed on 4/19/13. Patient #16's included a "RECOVERY AREA RECORD," dated 4/19/13 at 2:31 PM, which included RN documentation that Patient #16 was having "Petite seizures." The RN note stated the physician examined Patient #16 at 2:50 PM and ordered her to be transferred to a hospital for evaluation of the seizures. A progress note by the physician, which included his findings during the examination, was not present in Patient #16's medical record. The DON reviewed Patient #16's medical record on 7/10/14 beginning at 9:20 AM. She stated the physician examined Patient #16 when she had seizures and ordered the patient to be transferred. She stated a progress note detailing the physician's findings was not present in the medical record. The facility failed to ensure patient medical records contained comprehensive, accurate information.	Q 162	To address the deficiency and to ensure a comprehensive and accurate patient information, a new ***Hospital Transfer Record*** has been created. The new form includes boxes to be checked by nursing that will ensure all the proper patient information is included in the patient record. This form was created on July 25, 2014 and staff were inserviced on the same date. The Director of Nursing will ensure compliance to this new standard by ongoing monitoring of compliance and chart completeness. Please see attached.	July 25 2014
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered	Q 181	A late entry was made by the physician for patient #16 completing the chart.	ongoing

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Q 181	Continued From page 5 according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, and staff interview it was determined the ASC failed to administer medications in accordance with acceptable standards of practice for 1 of 3 patients (#6) whose procedures were observed and had the potential to impact all patients receiving medications at the center. This resulted in the potential for a patient to experience negative health outcomes due to infection. Findings include: 1. Patient #6 was admitted to the ASC on 7/09/14 for a colonoscopy and EGD. Beginning at 10:25 AM, Patient #6's procedures were observed. At 10:28 AM, the sedation nurse prepared propofol (an anesthetic) to be administered during the procedure. The sedation nurse placed the syringe of propofol on the counter and then turned, knocking the syringe on to the floor. The sedation nurse picked up the syringe and changed the needle. He laid the syringe on the counter and used the medication during the procedure. The sedation nurse failed to discard the syringe and medication that fell on the floor. The sedation nurse was interviewed on 7/10/13 at 3:40 PM. He confirmed that he should have discarded the medication. The facility failed to administer medications in accordance with acceptable standards of practice.	Q 181	To address this unacceptable Deficiency, the nurse in the Endoscopy suite as the time of the incident was called into the Director of Nursing's office on July 11, 2014 during the evening hours. Nursing discussed the matter at length. This nurse acknowledged the importance of proper medication administration and infection control compliance. An addition was made to the Medication Policy and discussed with all staff members at a staff meeting held July 24' 2014. In addition the matter was further discussed at an Infection Control meeting on the same date. It is certain that the nursing staff has been re-educated on medication safety practices. To ensure compliance the Director of Nursing will observe nursing administering medication and reiterate the importance of proper procedures on An ongoing basis.	July 24 2014 ongoing

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