IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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August 4, 2014

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 July 30, 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 **August 17, 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
	13C0001014	A. BUILDING _____ B. WING _____	07/30/2014

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 Medicare recertification survey of your surgery center on 7/23/14 to 7/30/14. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Don Sylvester, RN, HFS Acronyms used in this report include: ASC - Ambulatory Surgery Center IV - Intravenous Line RN - Registered Nurse	Q 000		
Q 241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a sanitary environment for all patients receiving care at the facility. This resulted the potential for patients to experience negative health outcomes due to infections. Findings include: 1. A tour of the facility was conducted with the facility's Administrator on 7/23/14 beginning at 8:45 AM. During the tour, the following was observed: a. The recovery room: - There were 2 Coban dressings, with 2 inch by 2	Q 241	RECEIVED AUG 12 2014 DIV OF LIC & CERT	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 8-11-14

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.

Medical Director 8-11-14

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Q 241	Continued From page 1 inch cloth dressings which were opened and lying on a gurney. The dressings were unused. During the tour, the Administrator stated the 2 opened dressings were left in the room to cover a patient's intravenous sites when discontinued. She confirmed the 2 dressings should not have been opened until a patient's intravenous sites were to be discontinued. - A stack of flattened cardboard boxes was lying on a gurney which was covered with a clean sheet. During the tour, the Administrator stated the cardboard should not be in the recovery room. - Bags of clean linen were commingled with bags of dirty linen. The bags were lying on the floor of the room, propped up against the gurney and cupboards. During the tour, the Administrator stated the dirty linen bag should not be in the recovery room and dirty linen should not be kept in a clean area with clean linen. The Administrator confirmed the practices allowed for possible cross-contamination. b. Operating room 1: - There were 2 opened 2 inch by 2 inch cloth dressings hanging off a cabinet. Each cloth dressing had a strip of paper-tape applied to it. During the tour, the Administrator confirmed the 2-opened dressings were on the cabinet for use during surgery. She stated the dressings should not have been opened until a patient was	Q 241	8-8-14 The surgery department will meet for their monthly meeting. At this time our surgery requests will be reviewed. Education will be done at this time about not that leaving dressings for post op patients is not acceptable to teach on infection control practices. Responsible: Christi Campbell, Administrator Retrain the materials manager that cardboard boxes after emptying are to be taken directly to the trash receptacle outside. Responsible: Christi Campbell, Administrator Retrain staff on the proper location for our dirty linen, this will separate our clean linen from our dirty. This training will be done in our meeting on the 8th Responsible: Christi Campbell, Administrator 8-8-14 With our training in the surgery meeting on pre-prepped dressings will also cover not pre prepping 2x2 gauze for our surgery patient. Each 2x2 gauze will be retrieved to prepped right before use to not ahead of time. Responsible: Christi Campbell, Administrator	8-8-14 cc 8-7-14 cc 8-8-14 cc 8-8-14 cc

* The Plan of Correction in Q241 will be monitored by Administrator, Christi Campbell by weekly facility inspection that staff [illegible] correct infection control

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Q 241	Continued From page 2 prepped for surgery. The facility failed to ensure a sanitary environment was maintained.	Q 241		
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 review of the facility's policies, it was determined the ASC failed to ensure a program to prevent infections, including hand washing protocols, had been developed, implemented and monitored. This directly affected the care of 1 of 2 patients (#16) whose procedures were observed and had the potential to affect all patients at the ASC. The lack of hand washing protocols increased the likelihood of facility acquired infections. Findings include: 1. Patient #16 had cataract extraction surgery at the ASC on 7/29/14. She was observed in the pre-operative holding area beginning at 8:50 AM on 7/29/14. The RN entered the room at 9:25 AM. She interviewed Patient #16 and reviewed the paper medical record. She donned gloves and administered eye drops to Patient #16's operative eye. She removed the gloves. The RN gathered IV supplies. She donned gloves again	Q 242	In our meeting on 8-8-14 surgery staff will be trained & given new policy & procedure on hand hygiene. This will be reviewed & placed in Policy & Procedure book. Administrator will have management staff observe staff 8-12 for hand hygiene compliance & report to Administrator. Anyone failing to follow policy will be written up & retrained. If observed again to not follow policy will be under consideration for termination. Responsible: Christi Campbell, Administrator Policy Enclosed	8-8-14

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Q 242	Continued From page 3 and started the IV. She then wiped the desk where the supplies had been with a sanitary wipe and left the room at 9:40 AM. During that time, the RN was not observed to perform hand hygiene. At 9:42 AM on 7/29/14 the surveyor stated he did not observe the RN performing hand hygiene before administering eye drops and starting the IV. The RN stated she washed her hands before entering the room and was on her way to wash them again. She confirmed she had not performed hand hygiene while she was in the pre-operative room. Staff did not perform hand hygiene prior to providing direct patient care. On 7/29/15 at 10:45 AM, the surveyor requested a hand hygiene policy from the facility's Administrator, who was also the Infection Control Officer. The Administrator produced a policy titled "SURGICAL FOAM HAND SCRUB." The policy discussed scrubbing for surgery. The Administrator stated the ASC had not developed a basic hand hygiene policy which directed staff when to perform hand hygiene. The facility failed to ensure hand washing protocols had been developed, implemented and monitored.	Q 242		