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

PRINTED: 06/27/2013
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
	21C0001370	A. BUILDING ______ B. WING ______	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEMI-CARE SURGERY CENTER	66 PAINTERS MILL ROAD #106 OWINGS MILLS, MD 21117

(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 recertification survey was conducted at Femi-Care Surgery Center, LLC on June 11, 14, 15, and 20, 2013. The center performs Obstetrics/Gynecology surgeries. The facility includes two operating rooms. The survey included: an on-site visit; an observational tour of the physical environment; observation of one surgery; interviews regarding instrument cleaning/sterilization process; interview of the facility's physician, office manager, medical assistants', and certified registered nurse anesthetist (CRNA); review of the policy and procedure manual; review of the personnel files; review of quality assurance and infection control program; and review of professional credentialing. A total of ten medical records were reviewed. The surgical procedures that had been performed between January 2013 and June 2013 were reviewed. Findings in this report are based on data present in the administrative records at the time of review. The agency's physician and office manager were kept informed of the survey findings as the survey progressed. The agency administrator was given the opportunity to present information relative to the findings during the course of the survey. A key code for patients, medical staff and employees contained herein was provided to the agency administrator and nurse manager.	Q 000	RECEIVED JUL 17 2013 Office of Health Care Quality	
Q 081	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES	Q 081		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE Medical Director (X6) DATE 7-15-13

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 081	Continued From page 1 (a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors. (a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC. (c)(1) The ASC must set priorities for its performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care. This STANDARD is not met as evidenced by: Based on a review of administrative documents, and interviews of the office manager and physician, the agency's administrative staff failed to develop, implement and maintain a data driven on-going Quality Assessment and Performance Improvement (QAPI) program. The failure of the office manager and physician to utilize the information collected, to analyze and tract the information related to patient outcomes	Q 081		

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Q 081	Continued From page 2 placed the agency staff at risk of not identifying and addressing, clinical or administrative issues that would impact patient care. The findings included: 1. The agency's medical staff fills out a monthly form titled "Quality Outcomes Monitoring." Review of the form revealed the information had been collected monthly since 2010 and the form includes the number of surgeries, number of infections, treatment required for SSI (surgical site infection), number of surgical procedures performed, cardiopulmonary arrest and deaths. There is no documentation that the agency's medical staff measures and analyzes the information that had been tracked from this tool for patient outcomes and performance improvement. 2. Review of administrative documents titled "Quality Outcomes Monitoring" stated, "Bench Marking Standards: unexpected complications secondary to surgery/anesthesia, post anesthesia care unit stay over three hours, cancellation of procedure after admission, unplanned admission to hospital, unexplained return for medical care within 24 hours of discharge, treatment for signs and symptoms of infection within 30 days of surgery, patient grievance specific to facility services, cardiopulmonary arrest during patient procedure, injury to patient during facility stay, death during patient procedure, medical records incomplete, and total number of surgical cases." There was no documented evidence that the program activities are an ongoing component of the QAPI program and that actions were taken in response to data analyses to improve	Q 081	Board of Directors will discuss QAPI @ all meetings. Topics will incl. monthly statistics, plan of action. A specific form will be developed and implemented to ensure these standards are met. Director of Facility and Infection Control officers will sign off QAPI monthly outcomes.	8/1/13

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Q 081	Continued From page 3 performance improvement. There is no documentation that the office manager and physician measures, analyzes the tracked monthly information obtained from this tool for patient outcomes and performance improvement. Interviews with the office manager and physician on 6/20/13 at 2:30 PM, revealed that they were unable to locate any documentation showing analyzation of the Quality Outcomes Monitoring Data/Benchmarking Data the agency collects, upon surveyor's request.	Q 081		
Q 106	416.44(d) EMERGENCY PERSONNEL Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC. This STANDARD is not met as evidenced by: Based on interview of the physician, medical assistant, and the office manager, review of policies and procedures and review of personnel files, the ambulatory surgery center (ASC) health care workers are not current in cardiopulmonary resuscitation (CPR) for two of nine health care workers reviewed. Failure of the physicians and the medical staff to maintain current CPR certification placed the patient at risk for injury and death from untrained workers during an emergency. The findings included:	Q 106	All employees will be notified that they will not be able to work if there ~~[illegible]~~ are not up to date.	7/1/13

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Q 106	Continued From page 4 Health care workers: #6 and 9 Review of the agency policy for medical emergencies revealed, "All clinical staff members are required to have current Basic Life Support Certification." Interview of the medical assistant on 6/15/13 at 10:30 AM revealed the medical assistant was not aware the policy stated that all clinical staff members will be adequately trained in Basic life Support Certification. Interview of the physician on 6/15/13 at 11:30 AM revealed the physician was aware that all clinical staff members were required to have Basic Life Support Certification. Interview of the office manager on 6/20/13 at 2:30 PM revealed the office manager was aware that all clinical staff members were required to have Basic Life Support Certification. Review of two health care workers files (#6 and 9) revealed there is no documentary evidence of current Basic Life Support Certification.	Q 106		
Q9999	FINAL OBSERVATIONS The survey findings were reviewed on 6/20/13. The facility staff was directed to submit a written plan of correction in response to the Federal 2567 form, following the attached guidelines, within ten calendar days. Failure to submit an acceptable plan of correction may result in decertification from the Medicare Ambulatory Surgical Center program.	Q9999		