Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001059	02/01/2019
Name of Provider or Supplier	**Street Address, City, State**	
Fort Sutter Surgery Center, A Ca Limited Partnership	2801 K Street, Suite 525, Sacramento, CA	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
Q0162	FORM AND CONTENT OF RECORD CFR(s): 416.47(b) 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 (as applicable); (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. (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 interview and document review, the Ambulatory Surgery Center (ASC) failed to ensure medical records were complete and accurate in accordance with medical staff rules and regulations and ASC policies for 4 of 21 patient records reviewed (Patients 3, 11, 12, and 13). This failure put patients at risk for errors and harm made by providers who relied on the content of these records for care decisions. Findings:

Review of the ASC's Medical Staff Rules and Regulations, approved 1/22/19, documented the following requirements:

Section II-A-6 - Both the patient and the responsible practitioner shall sign the informed consent document prior to the procedure being performed to indicate that the practitioner has personally provided specific information on which the patient has based his consent.

Section IV-A-1 - Accurate and complete medical records shall be prepared and maintained for each patient receiving care.

Section IV-A-2 - The medical record must be clear, concise, complete and accurate.

Section IV-A-9 - Pertinent progress notes shall be recorded at the time of observation and shall suffice to assure continuity of care and transferability. They should provide a chronological report of the patient's course in the center and should reflect any change in condition and the results of treatment.

Section IV-A-10 - Allergies and untoward reactions to drugs or adverse drug events must be recorded in the medical record.

Section IV-A-14 - A full procedural or operative report should be dictated as soon as possible after completion of the procedure...contain...condition of patient on conclusion of procedure...When a full procedural or operative report is not immediately available after the procedure, a post-op/procedure note must be written immediately after the procedure, comprehensive enough to permit continuity of care.

Section IV-A-17 - The attending physician shall be responsible for the preparation of a complete medical record for each patient he/she admits. The record should include... diagnosis or diagnostic impression, preoperative testing results, surgical and anesthesia consents, report of surgical procedure...and a discharge summary.

A review of Patient 3's medical record with the Director of Nursing (DON) on 2/1/19 at 1:45 p.m. confirmed the following:

Patient 3,had eye surgery on 1/29/19.

The Universal Protocol- Safe checklist for Surgical and Nonsurgical Invasive Procedures, "Allergies/ sensitivities" listed as "NKA" (no known allergies);

The Medication Reconciliation form, listed "+ food allergies, Gluten...+environmental allergies, everything..." and "Motrin", a non-steroidal anti-inflammatory medication used for pain;

From a history and physical, "Allergies as of 1/16/2019" listed as, "Diovan [valsartan]", (blood pressure lowering medication) with the reaction as "cough", "Lisinopril", (also a blood pressure lowering medication) with the reaction as "cough", and "Statins", (cholesterol lowering class of medications) with the reaction as "muscle pain";

In the Anesthesia Record, the allergies were listed as "Motrin";

The green colored nursing form (untitled) completed intraoperatively, indicated the allergies as "NKA" (no known allergies).

The ASC's policy, Medication Administration (ID 3549439), directed, "II. Patient Information/ Drug Reconciliation 1. Upon or prior to admission to a center, a patient history, including medications, vitamin, and herbals currently being taken and any known drug allergies and reactions they manifest, must be completed and recorded in the medical record. The information shall include at a minimum:... F. Patients allergies and sensitivities..."

Review of medical records with Nurse Manager (NM) 3 on 2/1/19 at 10:30 a.m. confirmed the following:

Pediatric Patient 13 had head and neck surgery on 5/3/18. An ASC form to verify an understanding of the surgical procedure with signed consent by Patient 13's legal representative was not found in the patient record.

Patient 11 had left neck surgery on 8/30/18. A written operative report by the surgeon was not found in the patient record.

Patient 12 had low back spine surgery on 7/18/18. Patient 12 had co-existing high risk conditions of high blood pressure, heart rhythm disorders, asthma and chronic lung disease. A physician assessment office visit record dated 6/12/18 noted Patient 12 reported shortness of breath and the surgeon planned to obtain clearance for surgery from the patient's heart specialist. The clearance documentation was not found in the patient record or referenced by the operating surgeon on his 7/18/18 pre-operative assessment.

The surgery for Patient 12 on 7/18/18 started at 9:19 a.m. Sedative and narcotic pain medications, plus steroid and local anesthetic injections, were administered during the surgery. At the end of surgery, Patient 12 became short of breath with distress. Multiple rescue interventions were ordered and administered over the next 45 minutes. At least two physicians participated in managing Patient 12's care, a surgeon and an anesthesiologist. Patient 12 was transferred to a local hospital at 10:34 a.m.

A complete and accurate operative report documented immediately after surgery was not found in the patient record. The ASC later presented a typed "Progress Notes" document that was organized like an operative report for the 7/18/18 encounter. That report was printed on 7/19/18 (after transfer) and documented details of Patient 12's breathing event and the results of her care at the hospital. However, that report retained additional language identical to a previous encounter dated 10/31/16 [template language], "There were no apparent complications. The patient tolerated the procedure well and was carefully escorted to the recovery room in stable condition [not accurate]. After meeting discharge criteria, the patient was discharged home [not accurate]."

No summary or progress notes written by any of the physicians involved in managing Patient 12's life-threatening condition to accurately portray her condition, at the time of transfer, and to supply to the hospital receiving providers, were filed in the patient record.

In a review of the ASC's transfer policy (ID 3549256 titled Hospital Transfers) with the DON on 2/1/19 at 11 a.m., DON confirmed that a physician was responsible to provide a written summary of the patient's condition and care at the ASC to accompany the patient to the hospital. DON acknowledged that Patient 12's record did not contain such documentation.