

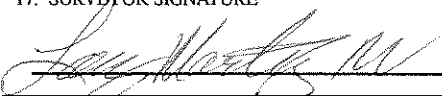
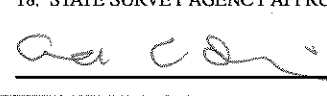
MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 3BT5

Facility ID: 38C0001000

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 38C0001000		3. NAME AND ADDRESS OF FACILITY (L3) LOVEJOY SURGICENTER, INC (L4) 933 NW 25TH AVENUE (L5) PORTLAND, OR (L6) 97210			4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2. STATE VENDOR OR MEDICAID NO. (L2)		7. PROVIDER/SUPPLIER CATEGORY <u>15</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE			FISCAL YEAR ENDING DATE: (L35) 06/30	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		10. THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: <input type="checkbox"/> 1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12) And/Or Approved Waivers Of The Following Requirements: <input type="checkbox"/> 2. Technical Personnel <input type="checkbox"/> 6. Scope of Services Limit <input type="checkbox"/> 3. 24 Hour RN <input type="checkbox"/> 7. Medical Director <input type="checkbox"/> 4. 7-Day RN (Rural SNF) <input type="checkbox"/> 8. Patient Room Size <input type="checkbox"/> 5. Life Safety Code <input type="checkbox"/> 9. Beds/Room				
6. DATE OF SURVEY 06/20/2019 (L34)		11. LTC PERIOD OF CERTIFICATION From (a): To (b):				
8. ACCREDITATION STATUS: <u>0</u> (L10) 0 UNACCREDITED 1 JC 2 AAAHC 3 AAAASF 4 AOA/HFAP 5 DNV GL 6 IMQ		12. Total Facility Beds (L18)		13. Total Certified Beds (L17)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF (L37) 18/19 SNF (L38) 19 SNF (L39) ICF (L42) IID (L43)					15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Recommend continued certification based on an onsite revisit to verify correction of condition level deficiencies and acceptance of a POC for standard level deficiencies cited during a recertification survey completed on 06/20/2019.

17. SURVEYOR SIGNATURE  (L19)	Date: 10/31/2019	18. STATE SURVEY AGENCY APPROVAL  (L20)	Date: 11/1/19
---	-------------------------	---	----------------------

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :	
22. ORIGINAL DATE OF PARTICIPATION 04/12/1984 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		24. LTC AGREEMENT ENDING DATE (L25)	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 00835 (L28) (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 38C0001000	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 10/29/2019
NAME OF FACILITY LOVEJOY SURGICENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NW 25TH AVENUE PORTLAND, OR 97210	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Q0100	Correction	ID Prefix Q0101	Correction	ID Prefix	Correction
Reg. # 416.44	Completed	Reg. # 416.44(a)(1)	Completed	Reg. #	Completed
LSC	10/29/2019	LSC	10/29/2019	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>JRM</i>	DATE 10/13/19	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE 10/13/19
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/20/2019

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO

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

PRINTED: 10/31/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 38C0001000	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/29/2019
NAME OF PROVIDER OR SUPPLIER LOVEJOY SURGICENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 933 NW 25TH AVENUE PORTLAND, OR 97210		
(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 onsite Federal revisit survey of this ASC was completed on 10/29/19 for all previous Condition level deficiencies cited on 10/17/19. An entrance conference was conducted on 10/29/19 at 10:30 AM with the facility's Administrator. The purpose for the survey and the survey needs were explained. An opportunity was provided for questions, answers, and comments. Definitions & Abbreviations: ASC: Ambulatory Surgery/Surgical Center CFR: Code of Federal Regulations	{Q 000}			
{Q9999}	FINAL OBSERVATIONS At the completion of the survey, an exit conference was conducted on 10/29/19 with the facility's Administrator. An opportunity was provided for questions, answers, and comments. Based on the findings of the survey, it was determined that the facility was in compliance with the applicable Code of Federal Regulations. There were no deficiencies cited.	{Q9999}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.