

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

PRINTED: 01/30/2020
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 06/18/2019
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
E 000	Initial Comments	E 000			
E 006	<p>This report documents the findings of the emergency preparedness survey conducted 06/18/19. The facility was found to need correction to be in substantial compliance with 42 CFR Part 416.54 Emergency Preparedness Requirements for Ambulatory Surgical Centers. Plan Based on All Hazards Risk Assessment CFR(s): 416.54(a)(1)-(2)</p> <p>[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The</p>	E 006			8/17/19

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

TITLE

(X6) DATE

08/08/2019

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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E 006	<p>Continued From page 1</p> <p>plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on observations and interview during the survey, it was determined through on-going dialog with the Owner that the facility failed to comply with Federal, State and local EP requirements to establish and maintain a comprehensive EP program (CFR 42 Part 416.54 (a)(1)-(2)).</p> <p>Findings include:</p> <p>1. On 06/18/19, during record review between 10:15AM. and 11:15AM., documentation provided for the emergency preparedness plan, including agreements with other sites, were dated 2015 and no documentation of addition review since 2015. SEE NOTE*</p>	E 006			

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E 006	Continued From page 2 * NOTE: This was a repeat deficiency from the survey completed on 06/19/19. In interviewing the Administrator, she confirmed that there has not been a documented annual review of the plan and/or the signed agreements within the plan. 2. On 06/18/19, during record review between 10:15AM and 11:15AM, facility failed to provide the necessary documentation of both facility-based and community-based risk assessments utilizing an all-hazards approach. There were risk assessments within the plan that provided for local risks. In interviewing the Administrator, she acknowledged that she was not aware of the requirement for facility based risk assessment. Surveyor was accompanied by the Administrator and Maintenance Director who acknowledged the existence of these conditions.	E 006			
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 416.54(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the	E 026			8/17/19

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E 026	Continued From page 3 provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on observations and interview during the survey, it was determined through on-going dialog with the Facility Administrator and Maintenance Director that the facility failed to comply with Federal, State and local EP requirements to establish and maintain a comprehensive EP program (CFR 42 Part 416.54(b)(8)). Findings include, but: On 06/18/19, during record review between 10:15AM and 11:30AM, the facility was unable to provide documented policies and procedures for what the facilities role is for providing care and treatment at alternate care sites under an 1135 waiver. Surveyor was accompanied by the Administrator and Maintenance Director who acknowledged the existence of these conditions.	E 026			
E 030	Names and Contact Information CFR(s): 416.54(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every	E 030			8/17/19

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E 030	<p>Continued From page 4</p> <p>2 years (annually for LTC).] The communication plan must include all of the following:]</p> <p>(1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. <p>*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. <p>*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. <p>*[For ASCs at §416.45(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the</p>	E 030			

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E 030	<p>Continued From page 5 following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. <p>*[For Hospices at §418.113(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. <p>*[For HHAs at §484.102(c):] The communication plan must include all of the following:</p> <p>(1) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. <p>*[For OPOs at §486.360(c):] The communication plan must include all of the following:</p> <p>(2) Names and contact information for the following:</p> <ul style="list-style-type: none"> (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the 	E 030			

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E 030	Continued From page 6 OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on observations and interview during the survey, it was determined through on-going dialog with the Administrator and Maintenance Director that the facility failed to comply with Federal, State and local EP requirements to establish and maintain a comprehensive EP program (CFR 42 Part 416.54(c)(1)). Findings include: On 06/18/19, during record review between 10:15AM and 11:30AM, there was documentation provided in the EP communication plan that did not include the names and contact information of staff, resident's physicians and of volunteers in the case of an emergency. Surveyor was accompanied by the Administrator and Maintenance Director who acknowledged the existence of these conditions.	E 030			
E 032	Primary/Alternate Means for Communication CFR(s): 416.54(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies.	E 032			8/17/19

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E 032	Continued From page 7 *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on observations and interview during the survey, it was determined through on-going dialog with the Administrator and Maintenance Director that the facility failed to comply with Federal, State and local EP requirements to establish and maintain a comprehensive EP program (CFR 42 Part 416.54(c)(3)). Findings include: On 06/18/19, during record review between 10:15AM and 11:30AM, the facility failed to properly define primary and secondary means of communication with federal, state, regional, and local emergency preparedness personnel within the EP plan. Surveyor was accompanied by the Administrator and Maintenance Director who acknowledged the existence of these conditions.	E 032			
E 039	EP Testing Requirements CFR(s): 416.54(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:	E 039			8/17/19

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E 039	<p>Continued From page 8</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or</p> <p>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p>	E 039			

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E 039	<p>Continued From page 9</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p>	E 039			

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E 039	<p>Continued From page 10</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH]</p>	E 039			

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E 039	<p>Continued From page 11</p> <p>experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences</p>	E 039			

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PRINTED: 01/30/2020
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 06/18/2019
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
E 039	<p>Continued From page 12</p> <p>an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID</p>	E 039			

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E 039	<p>Continued From page 13</p> <p>is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p>	E 039			

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E 039	<p>Continued From page 14</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by:</p> <p>Based on document review and interview during the survey, it was determined through on-going dialog with the Administrator and Maintenance Director that the facility failed to comply with Federal, State and local Emergency Preparedness (EP) requirements to establish and maintain a comprehensive EP program (CFR 42 Part 416.54(d)(2)).</p> <p>Findings include:</p> <p>On 06/18/19, during document review between 10:15AM and 11:30AM, the facility failed to provide proper documentation of the following:</p> <p>Perform mandated exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. Testing requirements to include, but not limited to, a community-based full-scale exercise. If a community-based full-scale exercise is not available and documented, an individual facility-based exercise shall be performed based on an all-hazards approach.</p> <p>In interviewing the Administrator, she stated that they do tabletops with staff during the year regarding fire emergencies, but documentation did not describe the scenarios and/or staff response or knowledge of the plan.</p> <p>Surveyor was accompanied by the Administrator and Maintenance Director who acknowledged the existence of these conditions.</p>	E 039			

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