PRINTED: 01/30/2020 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
		38C0001000	B. WING	i		06/1	8/2019
	ROVIDER OR SUPPLIER Y SURGICENTER, IN	C		93	TREET ADDRESS, CITY, STATE, ZIP CODE 33 NW 25TH AVENUE ORTLAND, OR 97210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
E 006	emergency prepar 06/18/19. The facil correction to be in CFR Part 416.54 E Requirements for	nents the findings of the edness survey conducted lity was found to need substantial compliance with 42 Emergency Preparedness Ambulatory Surgical Centers. Hazards Risk Assessment (1)-(2)	E	006			8/17/19
	and maintain an el that must be revie	an. The [facility] must develop mergency preparedness plan wed, and updated at least every must do the following:]	or a second				
	facility-based and	nd include a documented, community-based risk ing an all-hazards approach.*					The state of the s
	(2) Include strateg events identified b	ies for addressing emergency y the risk assessment.					A A A A A A A A A A A A A A A A A A A
	Plan. The LTC factor an emergency preserviewed, and upon must do the follow (1) Be based on a facility-based and assessment, utilized including missing	nd include a documented, community-based risk ing an all-hazards approach, residents.					- Anna Anna Anna Anna Anna Anna Anna Ann
	(2) Include strateg events identified b	gies for addressing emergency by the risk assessment.					
	Plan. The ICF/IID emergency prepa	§483.475(a)(1):] Emergency must develop and maintain an redness plan that must be dated at least every 2 years. The					
LABORATOR		/IDER/SUPPLIER REPRESENTATIVE'S SIG			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.

Facility ID: 38C0001000

08/08/2019

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		38C0001000	B. WING		06	/18/2019	
	PROVIDER OR SUPPLIER Y SURGICENTER, IN	3		STREET ADDRESS, CITY, STATE, ZIF 933 NW 25TH AVENUE PORTLAND, OR 97210	CODE .	710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	plan must do the fo (1) Be based on and facility-based and coassessment, utilizing including missing cl (2) Include strategies events identified by * [For Hospices at § Plan. The Hospice of the emergency prepared reviewed, and update plan must do the fol (1) Be based on and facility-based and coassessment, utilizing (2) Include strategies events identified by including the manage of power failures, not ability to provide carthis STANDARD is Based on observation survey, it was determined by the Owner that with Federal, State and establish and maintager program (CFR 42 Parameters). 1. On 06/18/19, during 10:15AM. and 11:15 for the emergency program agreements with other carthing the company of the company of the emergency program agreements with other carthings.	llowing: d include a documented, community-based risk g an all-hazards approach, ients. es for addressing emergency the risk assessment. 418.113(a)(2):] Emergency must develop and maintain an dness plan that must be ted at least every 2 years. The llowing: d include a documented, community-based risk g an all-hazards approach, es for addressing emergency the risk assessment, ement of the consequences attural disasters, and other could affect the hospice's	EO	06			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		38C0001000	B. WING			18/2019	
	ROVIDER OR SUPPLIER Y SURGICENTER, IN	С		STREET ADDRESS, CITY, STATE, 933 NW 25TH AVENUE PORTLAND, OR 97210			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	へっちゃん カビビビロにいつごり ずん	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
E 026	survey completed and Administrator, she been a documente and/or the signed as 2. On 06/18/19, do 10:15AM and 11:15 the necessary doc facility-based and cassessments utiliz. There were risk as provided for local run interviewing the acknowledged that requirement for factors and Maintenance I existence of these Roles Under a Warder (s): 416.54(b). If (b) Policies and proceplan set forth in passessment at para and the communication this section. The passessment at para and the communication of the communication	a repeat deficiency from the on 06/19/19. In interviewing the confirmed that there has not a dannual review of the plan agreements within the plan. The plan agreements within the provide umentation of both community-based risk ing an all-hazards approach. The plan that risks. The plan that risks. Administrator, she the was not aware of the cility based risk assessment. The plan that risks assessment.	E	026		8/17/19	
	and procedures m (8) [(6), (6)(C)(iv), [facility] under a w	(7), or (9)] The role of the aiver declared by the Secretary,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3BT521

Facility ID: 38C0001000

If continuation sheet Page 3 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		38C0001000	B. WING	i	O.	6/18/2019
	PROVIDER OR SUPPLIER Y SURGICENTER, INC.	С		STREET ADDRESS, CITY, STATE, ZIP CODE 933 NW 25TH AVENUE PORTLAND, OR 97210	7 00	710/2019
(X4) ID PREFIX TAG			ID PREFI TAG		DULD BE	(X5) COMPLETION DATE
E 026	provision of care an care site identified to officials.	nd treatment at an alternate by emergency management	ΕO)26		
	procedures. (8) The waiver declared by with section 1135 of at an alternative car management officia This STANDARD is Based on observat survey, it was determined by the Facility Adn Director that the fac Federal, State and I	s not met as evidenced by: ions and interview during the mined through on-going dialog ninistrator and Maintenance ility failed to comply with ocal EP requirements to ain a comprehensive EP				
70.00	10:15AM and 11:30/ provide documented what the facilities ro	record review between AM, the facility was unable to d policies and procedures for le is for providing care and te care sites under an 1135				
E 030	Surveyor was accon and Maintenance Di existence of these c Names and Contact CFR(s): 416.54(c)(1	Information	E 00	30		8/17/19
	emergency prepared that complies with Fo	t develop and maintain an dness communication plan ederal, State and local laws ed and updated at least every				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	COMPLETED		
		38C0001000	B. WING			06/1	8/2019	
	PROVIDER OR SUPPLIER Y SURGICENTER, IN	С		93	TREET ADDRESS, CITY, STATE, ZIP CODE 33 NW 25TH AVENUE ORTLAND, OR 97210	1 AVENUE		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	DBE	(X5) COMPLETION DATE	
E 030	plan must include a (1) Names and cor following: (i) Staff. (ii) Entities pro- arrangement. (iii) Patients' pl (iv) Other [facil (v) Volunteers. *[For Hospitals at § §485.625(c)] The conclude all of the for (1) Names and cor following: (i) Staff. (ii) Entities pro- arrangement. (iii) Patients' pro- (iv) Other [hose (v) Volunteers. *[For RNHCIs at § communication plate following: (i) Names and cor following: (i) Names and cor following: (ii) Entities pro- arrangement. (iii) Next of kin (iv) Other RNH (v) Volunteers *[For ASCs at §41]	or LTC).] The communication all of the following:] Intact information for the viding services under mysicians lities]. S482.15(c) and CAHs at communication plan must following: Intact information for the viding services under thysicians pitals and CAHs]. 403.748(c):] The fan must include all of the intact information for the following services under the follow	E	030				
	plan must include (1) Names and co	all of the following: ntact information for the						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		38C0001000	B. WING			06	/18/2019
	PROVIDER OR SUPPLIER Y SURGICENTER, IN	C		933 N	ET ADDRESS, CITY, STATE, ZIP CODE IW 25TH AVENUE TLAND, OR 97210	1 00	110/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
E 030	following: (i) Staff. (ii) Entities provarrangement. (iii) Patients' ph (iv) Volunteers. *[For Hospices at §-communication plarfollowing: (1) Names and confollowing: (i) Hospice emp (ii) Entities provarrangement. (iii) Patients' ph (iv) Other hospi *[For HHAs at §484 plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities proviarrangement. (iii) Patients' phy (iv) Volunteers. *[For OPOs at §486 plan must include at (2) Names and contfollowing: (i) Staff. (ii) Entities proviarrangement. (iii) Volunteers. (iii) Ustaff. (iii) Entities proviarrangement. (iii) Volunteers. (iv) Other OPOs	iding services under ysicians. 418.113(c):] The must include all of the fact information for the sloyees. iding services under ysicians. In the following: act information for the ding services under ysicians. 418.113(c):] The communication of the following: act information for the ding services under ysicians. 418.113(c):] The communication of the following: act information for the ding services under ysicians.	E	030			

PRINTED: 01/30/2020 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 933 NW 25TH AVENUE	/2019
933 NW 25TH AVENUE	
LOVEJOY SURGICENTER, INC PORTLAND, OR 97210	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 032 Primary/Alternate Means for 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.	/17/19

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3BT521

Facility ID: 38C0001000

If continuation sheet Page 7 of 16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		38C0001000	B. WING		,	06/18/2019	
	PROVIDER OR SUPPLIER Y SURGICENTER, INC.	C		STREET ADDRESS, CITY, STATE, ZI 933 NW 25TH AVENUE PORTLAND, OR 97210		00/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 032	*[For ICF/IIDs at §4	ge 7 83.475(c):] (3) Primary and communicating with the	E 0	32			
	ICF/IID's staff, Fedelocal emergency matching STANDARD is Based on observat survey, it was determined that the facility failed State and local EP in ICC IID IID	eral, State, tribal, regional, and anagement agencies. In some tas evidenced by: ions and interview during the mined through on-going dialog or and Maintenance Director do to comply with Federal, requirements to establish and tensive EP program (CFR 42)					
	10:15AM and 11:30, properly define prim communication with	record review between AM, the facility failed to ary and secondary means of federal, state, regional, and eparedness personnel within					
E 039		ments	E 03	39		8/17/19	
	HHAs at §484.102, ("Organizations" und	3.748, ASCs at §416.54, CORFs at §485.68, OPO, er §485.727, CMHC at HC at §491.12, ESRD]:					
	(2) Testing. The [fac to test the emergence must do all of the fol	ility] must conduct exercises by plan annually. The [facility] lowing:					

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT AND PLAN O	OF DEFICIENCIES IF CORRECTION	IDENTIFICATION NUMBER:	, .			COMP	LETED
		38C0001000	B. WING			06/1	8/2019
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LOVEJO	Y SURGICENTER, IN	С			33 NW 25TH AVENUE PORTLAND, OR 97210		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	(i) Participate is community-based (A) When not accessible, con exercise every 2 (B) If the [Inatural or man-materization of the enditor of	n a full-scale exercise that is every 2 years; or a community-based exercise is nduct a facility-based functional years; or facility] experiences an actual ade emergency that requires mergency plan, the [facility] gaging in its next required or individual, facility-based exercise following the onset of additional exercise at least posite the year the full-scale or a under paragraph (d)(2)(i) of ducted, that may include, but is following: and full-scale exercise that is or individual, facility-based e; or ack disaster drill; or etop exercise or workshop that for and includes a group a narrated, want emergency scenario, and a stements, directed messages, one designed to challenge ar ze the [facility's] response to an attain of all drills, tabletop mergency events, and 's] emergency plan, as needed.	r i	039			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		38C0001000	B. WING	3	0.6	14012040
	PROVIDER OR SUPPLIER OY SURGICENTER, IN		1	STREET ADDRESS, CITY, STATE, ZIP (933 NW 25TH AVENUE PORTLAND, OR 97210	CODE	6/18/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
	(i) Participate i community based (A) When a not accessible, combased functional ex (B) If the hor man-made emerof the emergency plexempt from engagiscale community-based facility-based facility-based facility-based facility-based functional exercise this section is condunot limited to the foll (A) A second (C) A tablet is led by a facilitator discussion using a noclinically-relevant set of problem stater prepared questions emergency plan. (3) Testing for hospic care directly. The hospic emergency plan (A) Participate in that is community-based (A) When a community-based (A) When	n a full-scale exercise that is every 2 years; or a community based exercise is duct an individual facility ercise every 2 years; or espice experiences a natural gency that requires activation an, the hospital is ing in its next required full issed exercise or individual unctional exercise following ergency event. additional exercise every 2 year the full-scale or under paragraph (d) (2)(i) of leted, that may include, but is owing: a facility based functional disaster drill; or op exercise or workshop that and includes a group arrated, the emergency scenario, and a ments, directed messages, or designed to challenge an est that provide inpatient espice must conduct emergency plan twice per just do the following: an annual full-scale exercise is act an annual individual	EO	039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		38C0001000	B, WING			06/1	8/2019
NAME OF PROVIDER OR SUPPLIER LOVEJOY SURGICENTER, INC				933	REET ADDRESS, CITY, STATE, ZIP CODE NW 25TH AVENUE RTLAND, OR 97210		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	(B) If the hor man-made eme of the emergency pexempt from engage full-scale communifunctional of the emergency (ii) Conduct at that may include, be following: (A) A second community-based exercise; or (B) A mode (C) A table by a facilitator that using a narrated, emergency scenar statements, directed questions and demergency plan. (iii) Analyze the maintain document exercises, and emergency plan. (iii) Analyze the maintain document exercises, and emergency plan. (iii) Conduct exercises and emergency plan. (iii) Analyze the maintain document exercises, and emergency plan. (iii) Analyze the maintain document exercises, and emergency plan. (iii) Participate that is community-(A) When not accessible, conductive per year. The perfect of the following: (i) Participate that is community-(A) When not accessible, conductive per year.	ospice experiences a natural regency that requires activation plan, the hospice is ging in its next required by based or facility-based exercise following the onset event. In additional annual exercise put is not limited to the exercise that is or a facility based functional exercise or workshop led includes a group discussion clinically-relevanted messages, or prepared esigned to challenge an exercise that is exercise that is or a facility based functional exercise or workshop led includes a group discussion clinically-relevanted messages, or prepared esigned to challenge an exercise and revise regency events and revise regency plan, as needed. 41.184(d), Hospitals at at §485.625(d):] PRTF, Hospital, CAH] must to test the emergency plan are [PRTF, Hospital, CAH] must in an annual full-scale exercise based; or a community-based exercise is nduct an annual individual,		039			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Į.	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		38C0001000	B. WING		Of	6/18/2019
	PROVIDER OR SUPPLIER OY SURGICENTER, INC.			STREET ADDRESS, CITY, STATE, 3933 NW 25TH AVENUE PORTLAND, OR 97210		710/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	experiences an actuemergency that requemergency plan, the engaging in its next based or functional exercise emergency event. (ii) Conduct an and that may include following: (A) A second community-based of functional exercise; (B) A mock (C) A tablete is led by a facilitator discussion, using a clinically-relevant set of problem state prepared questions emergency plan. (iii) Analyze the maintain documentate exercises, and emergency plan. (iii) Analyze the maintain documentate exercises, and emergency procedured including unannouncemergency procedured inclu	uial natural or man-made uires activation of the e [facility] is exempt from required full-scale community individual, facility-based following the onset of the [additional] annual exercise or e, but is not limited to the d full-scale exercise that is r individual, a facility-based or disaster drill; or op exercise or workshop that and includes a group narrated, at emergency scenario, and a ments, directed messages, or designed to challenge an [facility's] response to and ation of all drills, tabletop regency events and revise ency plan, as needed. at §483.73(d):] must conduct exercises to colan at least twice per year, bed staff drills using the res. The [LTC facility, following: an annual full-scale exercise ased; or community-based exercise is uct an annual individual,	ΕO	039		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
THE LETTE	38C0001000		B. WING			06/18/2019		
NAME OF PROVIDER OR SUPPLIER LOVEJOY SURGICENTER, INC				ę	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NW 25TH AVENUE PORTLAND, OR 97210	5		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 039	an actual natural or requires activation the LTC facility is erequired a full-scal individual, facifollowing the onse (ii) Conduct a that may include, If following: (A) A sec community-based functional exercise (B) A more (C) A table is led by a facilitate using a narrated, emergency scena statements, direct questions demergency plan. (iii) Analyze the response to and revised events, and revised events, and revised events, and revised emergency plan. *[For ICF/IIDs at § (2) Testing. The ICF/IID must (i) Participate that is community (A) When not accessible, confacility-based functions (B) If the	of the emergency that of the emergency plan, exempt from engaging its next le community-based or lity-based functional exercise to of the emergency event. In additional annual exercise out is not limited to the lity-based functional exercise out is not limited to the lond full-scale exercise that is or an individual, facility based exercise or workshop that or includes a group discussion, clinically-relevant rio, and a set of problem led messages, or prepared lesigned to challenge an literal full-scale exercises, and emergency ethe [LTC facility] facility's maintain documentation of all ercises, and emergency ethe [LTC facility] facility's las needed. [3483.475(d)]: [3483.475(d)]: [36483.475(d)]: [36483.475(039				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		38C0001000	B. WING	3	ne ne	3/18/2019	
NAME OF PROVIDER OR SUPPLIER LOVEJOY SURGICENTER, INC				STREET ADDRESS, CITY, STATE, ZIF 933 NW 25TH AVENUE PORTLAND, OR 97210	CODE	710/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	is exempt from engifull-scale community based functional of the emergency engifull-scale community based functional of the emergency engaging in its next responsible for the emergency engaging in its next responsible for the emergency plan. (iii) Analyze the emaintain documental exercises, and emergency plan. (iii) Analyze the emaintain documental exercises, and emergency emergency plan. (iii) Analyze the emaintain documental exercises, and emergency scenario, statements, directly emergency emergency plan. If the OPO experience emergency plan emergency in the emergency plan emergency in the emergency plan emergency in the emergency plan engaging in its next responsible emergency emergency emergency in the emergency plan engaging in its next responsible emergency emergency emergency in the emergency eme	aging in its next required y-based or individual, facility-lal exercise following the onset went. additional annual exercise that not limited to the following: d full-scale exercise that is r an individual, facility-based or disaster drill; or op exercise or workshop that and includes a group narrated, at emergency scenario, and a ments, directed messages, or designed to challenge an ICF/IID's response to and tion of all drills, tabletop gency events, and revise ency plan, as needed. 360] 360] 360] 360] 360 must conduct exercises y plan. The OPO must do the per-based, tabletop exercise annually. A tabletop exercise	EO	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		38C0001000	B. WING			06/1	18/2019
NAME OF PROVIDER OR SUPPLIER LOVEJOY SURGICENTER, INC							
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 039	(ii) Analyze the maintain documer and emergency evand OPO's] emergines STANDARD Based on docume the survey, it was dialog with the AdDirector that the farederal, State and Preparedness (Emaintain a comprepart 416.54(d)(2)) Findings include: On 06/18/19, during 10:15AM and 11:3 provide proper documergency plan a unannounced star procedures. Testing not limited to, a conference is not avaindividual facility-berformed based. In interviewing the they do tabletops regarding fire emedid not describe the response or known Surveyor was accommended the surveyor was accommended.	e OPO's response to and ntation of all tabletop exercises, vents, and revise—the [RNHCI's gency plan, as needed. is not met as evidenced by: ent review and interview during determined through on-going ministrator and Maintenance acility failed to comply with d local Emergency P) requirements to establish and ehensive EP program (CFR 42)		039			
	and Maintenance						

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		38C0001000	B. WING_		06	/18/2010	
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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 3BT521

Facility ID: 38C0001000

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