STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	330005	A. BUILDING _____ B. WING _____	C 08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KALEIDA HEALTH	**726 EXCHANGE STREET, SUITE 522 BUFFALO, NY 14210**

(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
A 000	INITIAL COMMENTS NOTE: THE FEDERAL DEFICIENCIES BELOW ARE CITED AS A RESULT OF THE TITLE XVIII ALLEGATION SURVEY PERFORMED IN CONNECTION WITH COMPLAINT #NY00118877. THE CONDITIONS OF PARTICIPATION FOR GOVERNING BODY, QUALITY ASSURANCE, MEDICAL STAFF AND SURGICAL SERVICES WERE SURVEYED. THE PLAN OF CORRECTION, HOWEVER, MUST RELATE TO THE CARE OF ALL PATIENTS AND PREVENT SUCH OCCURRENCES IN THE FUTURE. INTENDED COMPLETION DATES AND THE MECHANISM(S) ESTABLISHED TO ASSURE ONGOING COMPLIANCE MUST BE INCLUDED.	A 000		
A 273	PROGRAM SCOPE, PROGRAM DATA CFR(s): 482.21(a), (b) (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and	A 273		

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.

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A 273	Continued From page 1 (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: Based on interview and document review there is no evidence to indicate the Pediatric Surgical Department has mechanisms in place to identify, analyze and evaluate the quality of care provided to surgical patients in a timely manner. Findings include: Interview on 8/17/12 at 11:15 with Staff #16 revealed each department has a department specific quality assurance program. Quality review generally consists of morbidity and mortality reviews, root cause analysis outcomes and any other concerns that are brought forth. There is no standard criterion for case review. Each specialty conducts their own review and will refer cases to other disciplines or departments for additional review as needed. Review of the Monthly Quality Assurance Reports for Pediatric & Thoracic Surgery from December 2010 to February 2012 revealed mortality, morbidity, complaints, and utilization/antibiotic prophylaxis for acute non-perforated appendicitis are reviewed monthly. The following issues were identified: -No reports were found for March 2012 to August 2012. -In October 2011 morbidity review with discussion was noted to be pending for Patient #3 and in	A 273		

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A 273	Continued From page 2	A 273		

January 2012 for Patient #2 with no further documentation regarding the outcome of the review in subsequent minutes.

Review of the Department of Pediatric Surgery Morbidity and Mortality Conference meeting minutes from 12/8/11 to 7/2/12 revealed the following case reviews:
-On 12/22/11 Patient #3 was discussed.On 10/5/11 a G-tube was placed into the colon instead of the stomach. It was identified intra-operatively and replaced into the stomach. The nature of the complication was error in judgment but a rare expected occurrence. The discussion included placement of the G-tube lap as open, use of contrast studies and co morbidities. However, no evidence was found to indicate whether the recommendations listed in the discussion were implemented or that the results of the review were reflected in the monthly Quality Assurance Report for Pediatric and Thoracic Surgery.
-On 7/5/12 Patient #2 was discussed. The patient had a laparoscopic cholecystectomy on 1/25/11 and a laparoscopic lymph node biospy on 2/8/12 with a diagnosis of lymphoma. The nature of the complication was noted to be a delay in lymphoma diagnosis. The initial diagnostic laparoscopy did not reveal the mass at the root of the mesentery. A complete review of the initial imaging did not reveal the mass. There was no evidence to indicate the case was reviewed in a timely manner or whether any quality improvement recommendations were identified.
-On 7/5/12 Patient #1 was discussed. On 9/1/11 the patient experienced bleeding after a mediport flush. An 8 ml (100u/ml) heparin flush was administered with post procedure bleeding. The nature of complication was due to error in

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A 273	Continued From page 3 technique and patient disease. The discussion involved a large dose of heparin flush and no documentation of the amount given intraoperatively. Quality improvement recommendations included creating a policy for heparin flush of mediport due to lack of intra-operative documentation of heparin administration. No evidence was found to indicate this case had been reviewed in a timely manner or included in the monthly Quality Assurance Report for Pediatric and Thoracic Surgery. Review of the STARS (incident reporting system) report for facility events revealed the following cases were reported: -Patient #21 involved a foster baby who received the same surgery twice. An investigation with interviews was conducted and a corrective action was identified. However there was no evidence to indicate how the corrective action will be monitored and evaluated. -Patient # 22 involved a bright blood post Foley catheterization. There was no evidence found to indicate if an investigation was conducted, if the issue was resolved or if further follow up was required.	A 273		
A 340	MEDICAL STAFF PERIODIC APPRAISALS CFR(s): 482.22(a)(1) The medical staff must periodically conduct appraisals of its members. This STANDARD is not met as evidenced by: Based on document review and credential review, surgical privileges were not reviewed and/or updated at least every 24 months for 1 of 6 pediatric surgical staff (Staff #4).	A 340		

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A 340	Continued From page 4 Findings include: Review of the Kaleida Health Bylaws of the Medical/Dental Staff dated 2/2011 revealed the following: -The primary responsibility delegated to each clinical service is to review and evaluate the provision of patient care in order to preserve and continuously improve the quality and efficiency of patient care provided in the clinical service. Each clinical service will conduct continuing review of the clinical care and professional performance of all members of the clinical service and health professional affiliates having privileges in the clinical service. -The chief of service is responsible for continuing surveillance of the professional performance of all individuals who have delineated clinical privileges, recommends criteria for granting clinical privileges, submits recommendations for clinical privileges for each member/applicant, continuously assesses and improves the quality of care and services provided maintaining quality control programs and provides orientation/continuing education to all person in the clinical service. -The credentials committee duties include evaluation of the qualification of individuals applying for appointment/reappointment to the staff and privileges, integrate quality review, risk management and utilization review findings and information into the process used to evaluate appointment/reappointment applications and grant privileges, make recommendations to the Medical Executive committee to grant or deny applications. Review on 8/20/12 of the credential file for Staff	A 340		

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A 340	Continued From page 5 #4 revealed the following: -No evidence of a current reappointment letter. The last reappointment letter is dated 4/9/10 and indicates reappointment from 4/7/10 to 1/31/12. -The Kaleida Health Medical/Dental Staff Bi-Annual Performance Review report for reappointment ending 1/31/12 is blank and unsigned by the chief of service. -Two Delineation of Privilege forms dated 9/11/11 and 2/9/12 are not signed by the chief of service. No evidence of current/approved privileges was found in the file. Review of the email dated 8/21/12 received from Staff #1 revealed Staff #5 has not signed off on Staff # 4's reappointment and an alternate physician for credentialing sign off has not been designated.	A 340		
A1005	OUTPATIENT POST-ANESTHESIA EVALUATION CFR(s): 482.52(b)(3) [The policies must ensure that the following are provided for each patient:] A post-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures, which have been approved by the medical staff and which reflect current standards of anesthesia care. This STANDARD is not met as evidenced by:	A1005		

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A1005	Continued From page 6 Based on document review and medical record review the facility did not ensure a post operative anesthesia evaluation was completed for 4 of 16 patients (Patient #1, 10, 12 and 16). Findings include: Review of policy #SS_24 " Standard of Care and Discharge from Post Anesthesia Care Unit " last revised 9/05 revealed once discharge criteria are met, the anesthesiologist will document on the anesthesia record KH00408 and discharge the patient from Phase I post anesthesia care unit. Review of medical records for Patient #1, 10, 12 and 16 revealed the post operative anesthesia assessment is either blank and/or incomplete.	A1005		