

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001013		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/20/2012	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER AT THE INDIANA EYE CLIN				STREET ADDRESS, CITY, STATE, ZIP CODE 30 N EMERSON AVE GREENWOOD, IN 46143			
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005394</p> <p>Survey Date: 6-18/20-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/27/12</p>	S0000					

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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S0110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the facility's governing board failed to review 2 directly-provided services during calendar year 2011 for quality assurance performance improvement (QAPI) activities.</p> <p>Findings:</p> <p>1. Review of the facility's governing board meeting minutes for calendar year 2011, indicated the governing board failed to review QAPI activities for the directly-provided services of transcription and infection control.</p> <p>2. Upon interview, on 6-19-12 at 3:10 pm, employee #A1 indicated there were no governing board minutes for calendar year 2011 which included the above activities and no further documentation was provided by exit.</p>	S0110	<p>Governing Body did not review two directly-provided services at quarterly meetings: transcription and infection control. 1. Transcription: Governing Body members conduct quarterly reviews of all service related vendors including transcription. Documentation is specified in meeting minutes listing all contracted services reviewed at Quarterly Meetings; however exact listing of contracted vendors was not included in meeting minutes. What: Transcription services and all contracted services reviewed by Governing Body. When: Next review of transcription will be conducted July 24, 2012. Who: Governing Body responsible for transcription services evaluations and addressing/correcting any issues through Executive Director. How: Governing Body reviews Contracted Services monitors each quarter and</p>	07/24/2012			

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			reports received in accordance with ASC Policy 4.05 regarding completion. Governing body will review and document in Governing Body minutes. 2. None of the 2011 Quality Assurance Committee (QA) minutes documented review of Infection Control. All members of QA Committee are members of Infection Control Committee and meetings conducted consecutively at same date and time, but Committee's minutes are defined separately. What: All QA committee minutes will reflect review of Infection Control. When: Next quarterly meeting of QA and Infection Control Committees – July 24, 2012. Who: Medical and Executive Directors responsible for assuring QA Committee reviews and documents Infection Control activities. How: At next QA meeting July 24, 2012 with review of all 2011 and 2012 QA activities.		

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S0153	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on personnel file review, policy and procedure review, contract review, and interview, the facility failed to ensure 2 of 2 contracted agency staff (#P11 and P12) and 2 of 2 contracted housekeeping staff (#P13 and P14) received orientation to the facility.</p> <p>Findings included:</p> <p>1. The personnel files for contracted agency staff #P11 and P12 and for contracted housekeeping staff #P13 and P14 lacked documentation of any orientation to the facility or their job requirements.</p> <p>2. The facility policy "Employee Orientation", last approved 12/2011, indicated, "...4. Agency Personnel Orientation Requirements: ...c.) Completed Orientation Checklist pertinent to job description."</p>	S0153	<p>All contract and agency personnel must be oriented to ASC facility. 2 of 2 contracted agency personnel and 2 of 2 housekeeping personnel lacked orientation documentation. What: All contracted agency and environmental services personnel will receive orientation to the ASC. When: Agency staff orientations upon first day at the ASC before providing patient care services. All environmental personnel will receive orientation at the ASC before providing housekeeping services. Current housekeeping personnel will have ASC re-orientation completed by July 13, 2012. Who: Executive Director and ASC staff will orient agency patient care staff. Housekeeping orientation to be completed by Jani-King management and ASC. How: Orientation and re-orientation will be completed by July 13, 2012 utilizing ASC Orientation Checklist. Copy o document will be in each contracted</p>	07/13/2012

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	<p>3. The facility policy "Environmental Services Policy & Procedure", last approved 12/2011, indicated, "...Contracted services for the purpose of environmental service shall be required to complete the following: Completion of orientation checklist."</p> <p>4. The contract with RN Specialties, Inc., Staffing Services Agreement, signed by staff member P1 on 10/10/08, indicated, "...2. Orientation- Client shall orient each Employee assigned to the Client facility to acquaint them with the facility's rules, regulations, policies and procedures, including dress code, physical layout and equipment, and to validate competency and ability of the assigned Employee. Each facility receives one eight hour shift of orientation on a no bill basis."</p> <p>5. At 4:20 PM on 06/19/12, the contracted housekeeping staff members, #P13 and P14, indicated they had been working at this facility since November 2011. They indicated their training through the cleaning service included a 2 hour session of watching a video and taking a test. The supervisor of the service spent about 30 minutes walking them through the facility and showing them the procedures to follow.</p>		housekeeping employee file. All future contracted housekeeping personnel will have Orientations and Checklists completed and in their files.				

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	6. At 10:40 AM on 06/20/12, staff member #P1 indicated they did not use the agency staff very much any more, but called them and reported that the agency RN, #P11, last worked at the facility in September of 2011 and the agency Medical Assistant, #P12, last worked in June of 2010. Staff member #P1 confirmed the contract for agency staff was still in effect and confirmed the lack of orientation documentation in the files.			

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S0156	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on employee file review, policy and procedure review, and interview, the facility failed to ensure 3 of 3 registered nurses (RNs) (#P1, P2, and P3) had current, accurate job descriptions covering their actual duties in the facility.</p> <p>Findings included:</p> <p>1. The employee file for staff RN, #P1, indicated a form "Position Descriptions: Staff Nurse- Operating Room", signed 06/20/11, which listed duties and responsibilities related to the operating room and procedures.</p> <p>2 The employee file for staff RN, #P2, indicated a form "Position Descriptions:</p>	S0156	<p>Governing Body maintains current job descriptions with reporting responsibilities for all ASC personnel including annual job performance evaluations. 3 of 3 RNs did not have accurate job descriptions in personnel files. What: All three RNs have all ASC job descriptions in each employee's folder. When: All RNs have appropriate RN job descriptions signed and in each employee's file as of July 12, 2012. How: RNs reviewed and received copy of all applicable job descriptions including Pre-op, O.R. and post-op; a copy of each job description placed in each employee file. Who: Executive Director and ASC RNs.</p>	07/12/2012

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	<p>Staff Nurse- Pre-Operative", signed 02/24/11, which listed duties and responsibilities related to care given prior to surgery or procedures.</p> <p>3 The employee file for staff RN, #P3, indicated a form "Position Descriptions: Staff Nurse- Pre-Operative", signed 05/01/12, which listed duties and responsibilities related to care given prior to surgery or procedures.</p> <p>4. Review of the facility's policy and procedure manual indicated a form "Position Description: Staff Nurse- Recovery Room" which listed duties post-operatively until discharge. This form was not in any of the nurses' files.</p> <p>5. The facility's policy "Position Descriptions", last approved 12/2011, indicated, "All jobs in the Center shall have written position descriptions which indicate the job function and clearly define responsibilities, requirements, and supervisory relationships." Under Practices and Procedures of the policy was indicated, "1. Job position descriptions shall be developed for all jobs. 2. Position descriptions shall be revised as changes in the job occur."</p> <p>6. When questioned at 10:30 AM on 06/20/12 as to why there were no nurses</p>			

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	with the Recovery Room job description, staff member #P1 indicated the center only had 3 RNs who worked in all of the areas although he/she was the primary operating room nurse. He/she confirmed the job descriptions in the nurses' files did not accurately reflect their duties and responsibilities.			

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S0310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for 2 directly-provided services in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the directly-provided services of transcription and infection control.</p> <p>3. In interview, on 6-19-12 at 3:10 pm, employee #A1 indicated there was no documentation of inclusion of the above activities. No other documentation was provided prior to exit.</p>	S0310	<p>QA program shall be ongoing with written plan of implementation evaluation, but not limited to all contracted services. There is no monitor and standard for transcription and infection control. What: Transcription services will be reviewed through QA program. When: Next review of transcription services will be July 24, 2012. Who: QA Committee through Governing Body responsible for transcription services evaluations and addressing/correcting any issues through Executive Director. How: Contract Service Quarterly Review Form utilized and documented in QA and Governing Body meeting minutes. Within Statement of Deficiencies and Plan of Correction submitted by ISDH's QA committee there is no information related to deficiencies regarding infection control via Tag S-310. Assuming Infection Control for Tag S-310 relates to Tag S-110 in the same manner as transcription the ASC</p>	07/24/2012			

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			submits the following: What: All QA committee minutes will reflect review of Infection Control. When: Next quarterly meeting of QA and Infection Control Committees scheduled July 24, 2012. Who: Medical and Executive Directors assure QA Committee reviews and documents Infection Control activities. How: Next meeting of QA Committee will be July 24, 2012 with review of all 2011 and 2012 QA activities.		

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S0422	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.</p> <p>Based on document review and interview, the facility failed to ensure the staff TB tests were read within 48 to 72 hours as required in 8 of 8 employee medical files reviewed (P1, P2, P3, and P5- P9).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the medical files for staff members P1, P2, P3, P5, P6, P7, and P8 indicated no times were documented either for the placement or the reading of the current TB tests, making it impossible to determine adherence to manufacturer's instructions and CDC guidelines. 2. Review of the medical file for staff member P9 indicated a TB test was placed on 01/24/12 with no time or date or time for a reading documented. 3. At 10:15 AM on 06/19/12, staff member P3 indicated the facility followed CDC guidelines for their infection control program. The guidelines and the 	S0422	<p>Infection Control Committee must review employee exposure incidents and make recommendations to minimize risk. ASC failed to ensure 8 of 8 staff TB tests were appropriately read with timed documentation within 48-72 hours as required from adopted CDC guidelines. What: TB test will be conducted with appropriate documentation including time and date for each test. When: Beginning June 21, 2012 Who: ASC personnel certified in administering TB testing. All documentation reviewed by Executive Director and reported to Infection Control Committee. How: ASC personnel certified in administering Mantoux testing will conduct and document testing including time and date test administered and time and date test read (2-step for new employees) for employees who can submit to Mantoux testing. This process follows CDC guidelines adopted as ASC policy and approved by Governing Body 12/13/2011.</p>	06/21/2012			

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	manufacturer's instructions for the TB testing solution specified the tests were to be read between 48 and 72 hours.			

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S0428	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation.</p> <p>Based on observation, document review, and interview, the facility failed to ensure the surgical suites and patient areas were maintained in a clean, sanitary manner, according to policy.</p> <p>Findings included:</p> <p>1. During the tour of the pre-op area, surgical suites, and recovery area, beginning at 12:15 PM on 06/19/12, accompanied by various staff members, a layer of dust was observed on wall ledges, shelves holding monitors, and bottoms and siderails of patient carts.</p> <p>2. The facility policy "Environmental Services Policy & Procedure", last approved 12/2011, indicated, "...Operating rooms must be visibly clean after each surgical procedure as well as terminally cleaned daily." The schedule</p>	S0428	<p>Infection Control Committee must review and recommend changes pertinent to infection control. Inspection of cleaning procedures indicated dust observed on wall ledges, shelves holding monitors and patient carts including side rails. Interview with environmental cleaning personnel revealed dusting performed every other day and terminal O.R. cleaning does not occur if it appears no surgery performed that day. Cleaning schedule as determined by ASC requires and contracted with housekeeping vendor requires daily dusting and O.R. suites terminally cleaned Monday through Friday when ASC is open. What: Housekeeping contracted service personnel will clean ASC according to documented "Cleaning Schedule" including dusting everyday and terminal O.R cleaning everyday ASC is open Monday through Friday</p>	06/21/2012			

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	<p>attached to the policy indicated, "Pre-Op/Post-OP Area. Daily, 1. Dust and Disinfect Furniture Surfaces. 2. Dust and Disinfect Pre and Post Op beds. ...9. Dust and Disinfect rolling cars and equipment."</p> <p>3. At 4:20 PM on 06/19/12, housekeeping staff member, #P14, indicated he/she usually only dusts the operating suites every other day and doesn't always terminally clean the operating suites if surgery wasn't performed that day. When asked how he/she knew there was no surgery, the staff member indicated that was determined based on whether or not there was trash in the room.</p> <p>4. At 4:35 PM on 06/19/12, housekeeping staff member, #P13, indicated he/she didn't clean the patient carts if the nursing staff had already made them up, but normally raises them up and cleans all areas, including the bottoms. When the layer of dust was wiped off the siderail, the staff member indicated he/she had not cleaned them the night before because they were already made up.</p> <p>5. At 10:30 AM on 06/20/12, staff member #P1 indicated he/she would occasionally tell the housekeeping staff that they didn't have to clean the operating</p>		<p>except holidays. When: Beginning June 21, 2012 Who: Contracted housekeeping personnel including their management (Jani-King), ASC Executive Director and Infection Control nurse How: Review Cleaning Schedule requirements and document understanding these requirements will be met. Additional training to be provided by contracted service (Jani-King) to their personnel and documentation will be included in personnel ASC file by June 29, 2012. Audits will be conducted by ASC staff no less than monthly; recent audited conducted July 9, 2012.</p>		

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	suites, but the housekeeping staff should not be making that decision on their own.				

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S0728	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)</p> <p>(b) The medical staff shall adopt and enforce bylaws to carry out its responsibilities. These bylaws and rules must be as follows:</p> <p>Based on document review and interview, the medical staff failed to follow its bylaws regarding meeting attendance for 2 of 4 quarters in year 2011.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the Medical Staff By-Laws, approved by both the governing board and the medical staff on 12-13-11, SECTION 4, entitled Attendance Requirements, indicated each active staff member of the staff shall be required to attend one meeting of the Medical Staff each year. Review of the medical staff minutes for calendar year 2011 indicated that Medical Staff member MD#8 did not attend any quarterly meetings. Review of the Medical Staff By-Laws, approved by both the governing board and the medical staff on 12-13-11, SECTION 3, entitled Quorum, indicated the presence of fifty percent of the total membership of the active staff at any regular or special 	S0728	<p>Medical staff shall adopt and enforce Bylaws to carry out its responsibilities. ASC Bylaws require active staff members are required to attend one meeting each year. One member of eight did not attend any staff meetings in 2011. Quorum – defined as 50% of total active staff membership is required for regular or special meetings for approval of actions via ASC Bylaws. Two meetings 2/27/11 and 12/13/11 had only 3 of 8 medical staff members in attendance. What: All members of ASC medical staff will attend at least one meeting in 2012 When: Next Quarterly Medical staff July 24, 2012 Who: Three medical staff members have not yet attended a 2012 medical staff meeting: Michael Stennis MD, Leonardo Patron MD & Scott Hobson MD. How: Executive Director and Medical Director will notify all staff members via email and telephone notification of meeting dates and ascertain commitment to attend at least one of the two remaining meetings. Executive and Medical Directors will monitor and</p>	07/24/2012			

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	<p>meeting shall constitute a quorum for purposes of all actions permitted by these by-laws.</p> <p>4. Review of the 4 quarterly medical staff meetings in year 2011 indicated those held on September 27 and December 13 had only 3 of 8 members attending.</p> <p>5. In interview, on 6-19-12 at 3:45 pm, employee #A1 confirmed the above attendances and no further documentation was made available prior to exit.</p>		document attendance.		

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S0772	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on policy review, medical record review, and interview, the facility failed to follow their policy regarding the criteria for patient history and physicals for 7 of 25 records reviewed (#N3, N15, N16, N19, N20, N21, and N22).</p>	S0772	<p>Medical history and physicals will be performed in accordance with requirements. ASC failed to follow established policy regarding patient history and physicals for 7 of 25 reviewed records. All patient history and physicals shall be documented in accordance with ASC standards.</p>	06/25/2012			

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	<p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Medical Records-General", last approved 12/2011, indicated, "...1. all History and Physicals exams shall be performed within thirty (30) days of surgery. 'The comprehensive H&P must be submitted to the ASC prior to the patient's scheduled surgery date, in order to allow sufficient time for review of the H&P by the ASC's medical staff and adjustments if necessary, including postponement or cancellation of the surgery.' 2. Each ASC patient upon admission to the ASC must have a pre-surgical assessment as well. ...The patient's medical record must include documentation that the patient was examined prior to the commencement of surgery for changes since the H&P." The medical record for patient #N3 indicated an H&P dated 05/17/12, the procedure performed on 05/31/12, and the pre-surgical assessment on 06/01/12. The medical record for patient #N15 indicated an H&P dated 05/28/12, but surgery was performed on 05/16/12. The medical record for patient #N16 indicated a form titled History and Physical dated 05/29/12, but the only system reviewed under the physical exam 		<p>What: Comprehensive patient history and physical shall be performed and submitted to ASC no later than thirty (30) days prior to procedure date. Upon ASC admission all patients will have pre-surgical assessment completed prior to procedure starting. When: Completed by June 25, 2012 Who: Executive Director and Medical Director supervised communication and education of all ASC medical staff and personnel. How: Communication to all medical staff and personnel via telephone and various individual meetings with copy of approved policies provided June 21 through June 25, 2012. ASC personnel reminded they are empowered to refuse taking patient to procedure room until confirmation documented, updated history and physical and pre-surgical assessments are in patient medical record. Medical Record audits will be conducted no less than once per quarter. Random audit of June 25, 2012 indicated 100% compliance of 25 medical records. Medical records audits will record compliance with ASC policy indicating reaching or not reaching 100% threshold of compliance.</p>				

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	<p>was HEENT (head, eyes, ears, nose, throat). There was no documentation regarding heart, lungs, or mental status that were included in the other H&Ps. The physician's notation from 06/14/12, the date of the procedure, was "No change in the History and Physical".</p> <p>5. The medical record for patient #N19 indicated a printed form dated 01/11/12 at the top of the form beside "Date of Exam" and dated 02/27/12 at the middle of the form beside "Date of History and Physical", which was also same date as the procedure. A notation in the Operative Report from 02/27/12 indicated the preoperative history and physical was reviewed and there were no changes, making it unlikely that the H&P was done on the second date in the form.</p> <p>6. The medical record for patient #N20 indicated a printed form dated 01/18/12 at the top of the form beside "Date of Exam" and dated 02/27/12 at the middle of the form beside "Date of History and Physical", which was also same date as the procedure. A notation in the Operative Report from 02/27/12 indicated the preoperative history and physical was reviewed and there were no changes, making it unlikely that the H&P was done on the second date in the form.</p>						

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	<p>7. The medical record for patient #N21 indicated a printed form dated 01/13/12 at the top of the form beside "Date of Exam" and dated 02/27/12 at the middle of the form beside "Date of History and Physical", which was also same date as the procedure. A notation in the Operative Report from 02/27/12 indicated the preoperative history and physical was reviewed and there were no changes, making it unlikely that the H&P was done on the second date in the form.</p> <p>8. The medical record for patient #N22 indicated a printed form dated 04/25/12 at the top of the form beside "Date of Exam" and dated 06/05/12 at the middle of the form beside "Date of History and Physical", which was also same date as the procedure. A notation in the Operative Report from 06/05/12 indicated the preoperative history and physical was reviewed and there were no changes, making it unlikely that the H&P was done on the second date in the form.</p> <p>9. At 5:00 PM on 06/19/12, the medical record findings were reviewed with staff members P1, P2, and P10 who confirmed the findings. Staff member P1 indicated the dates on the printed H&P forms should have been the same in both places because those exams were done prior to surgery and not the day of surgery.</p>						

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S1006	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(2)</p> <p>Pharmaceutical services must have the following:</p> <p>(2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed.</p> <p>Based on observation, document review, and interview, the facility failed to provide records of all controlled pharmaceuticals.</p> <p>Findings included:</p> <p>1. During the tour of the recovery area at 1:50 PM on 06/19/12, accompanied by staff member #P2, the double locked narcotic drawer was observed containing numerous boxes of Propofol, Midazolam, and Fentanyl, as well as the prescription pads. Blank sheets for documentation were paper-clipped together and lying on top of the boxes.</p> <p>2. The facility policy "Pharmaceutical Services", last approved 12/2011, indicated, "Pharmaceutical supplies and services shall be maintained and controlled in accordance with acceptable ethical and professional practices and all legal requirements." Under the heading of "Function", the policy continued,</p>	S1006	<p>Records must be maintained of all purchased and dispensed scheduled substances. ASC failed to maintain appropriate recordkeeping. What: Appropriate documentation of all scheduled medications shall include specific inventory all medications and amounts of each medication via documentation. When: Completed June 22, 2012 Who: Executive Director will ensure all ASC RN staff maintains appropriate documentation of inventory controls. Pharmacist consultant received, reviewed and approved new Master Drug Count sheet July 21,2012. Governing Body will approve policy changes July 24, 2012.How: New inventory record sheets (Master Drug Count) developed by ASC RN staff June 22, 2012 and reviewed by Executive Director and Medical Director. Inventory counts conducted by two RNs and documentation of inventory completed each day ASC is open. Pharmacists consultant will</p>	07/24/2012

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	<p>"Procurement, storage, preparation, control and dispensing of all drugs and chemicals as approved and authorized by the medical staff of the ASC. Maintenance of records and files as required by law and as necessary to maintain adequate supply, control, and accountability of all drugs."</p> <p>3. At 2:00 PM on 06/19/12, staff member #P2, indicated there were the same number of blank sheets as there were boxes of medication in the drawer. He/she confirmed there was no running total of exactly how much medication was in the drawer. Another drawer in the recovery area contained the daily use medications with a log of usage, but the inventory drawer had no documentation of amounts.</p>		review and assist ASC with amending Pharamacy policy as needed by July 24, 2012.		

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S1162	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>Based on document review and interview, the facility failed to have a schedule of maintaining 1 piece of equipment.</p> <p>Findings:</p> <p>1. On 6-18-12 at 9:45 am, employee #A1 was requested to provide a facility policy or the manufacturer's manual, in order to determine the schedule of maintaining the facility's nurse emergency call (code) system.</p> <p>2. In interview, on 6-20-12 at 9:30 am, employee #A1 indicated there was no schedule of maintaining the nurse emergency call (code) system and no further documentation was provided prior to exit.</p>	S1162	<p>Patient care equipment must be in good working order and regularly serviced and maintained via schedules of maintenance. There is no schedule of maintenance for the emergency call system. What: Call system maintenance conducted and documentation on-site at ASC. When: Next call system maintenance by July 24, 2012. Who: Emergency call system by Van Ausdall Farrar. Executive Director reviews all reports and contacts Van Ausdall Farrar. How: On-site testing/maintenance conducted via contracted phone system engineers with documentation received and reviewed by Executive Director. Preventative Maintenance testing will be conducted annual for emergency call system.</p>	07/24/2012			

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S1164	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the facility failed to conduct preventive maintenance (PM) on 3 pieces of equipment in accordance with acceptable standards of practice or in accordance with the manufacturer's recommended maintenance schedule.</p> <p>Findings:</p> <p>1. Review of the facility's biomedical engineering reports indicated there was no PM within the past 12 months conducted on a pulse oximeter, the overhead</p>	S1164	Physical plant and ASC must be developed and maintained to assure safety and well-being of patients. Biomedical engineering reports failed to indicate maintenance of three pieces of equipment: pulse oximeter, O.R. lights and emergency call system. What: Pulse oximeter annual maintenance; O.R. light biannual maintenance and annual call system maintenance conducted and documentation on-site at ASC. When: Pulse oximeter and O.R. light maintenance completed by July 20, 2012. Call system maintenance by July 24,	07/24/2012

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	<p>adjustable surgical lights and the nurse emergency call (code) system.</p> <p>2. In interview, on 6-20-12 at 9:30 am, employee #A1 indicated there was no documentation available for PM within the past 12 months conducted on the above-stated pieces of equipment and no further documentation was provided prior to exit.</p>		<p>2012. Who: Pulse Oximeter and O.R. lights by biomedical engineering firm (K&R Medical Equipment Repair); emergency call system by Van Ausdall Farrar. Executive Director reviews all reports and contacts biomedical engineers and Phone Company. How: On-site testing/maintenance conducted by qualified biomedical engineering contracted service and phone system engineers with documentation received and reviewed by Executive Director. Future Preventative Maintenance will be conducted per manufacturers schedule.</p>		