

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001090	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/19/2011
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NAME OF PROVIDER OR SUPPLIER  ALLIED PHYSICIANS SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 53990 CARMICHAEL DR STE 100 SOUTH BEND, IN46635
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O0000	<p>This visit was for a Federal recertification survey.</p> <p>Facility Number: 010984</p> <p>Survey Date: 10-18/19-11</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 11/02/11</p>	O0000	No response required for this specific Tag. Corrective action taken for specific non-compliant Tags listed in report.	
O0043	<p>(1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC.</p> <p>(2) The ASC coordinates the plan with State and local authorities, as appropriate.</p> <p>(3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.</p> <p>Based on staff interview, the facility</p>	O0043	Disaster Preparedness PlanResponse:The present	12/15/2011

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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Q0181	<p>failed to evidence a coordinated all-hazards emergency disaster plan.</p> <p>Findings:</p> <p>1) In interview on October 19, 2011 at 11am, Employee # A2 indicated that no documentation was available to indicate participation in Emergency Disaster Preparedness Planning groups on either a local, district, or state level; an Emergency Disaster Preparedness Plan or exercises of such a plan were not available for review.</p> <p>2) No further documentation was made available prior to survey exit.</p> <p>Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on observation, policy and procedure review, and staff interview, the facility failed to ensure the preparation and administration of drugs according to facility policy and procedure for 1 of 3 (Phase 2) areas toured.</p> <p>Findings:</p> <p>1. While on tour of facility on 10/18/11 at approximately 12:36 PM, in the company of P9, the following was observed in the medication cabinet:</p>	Q0181	<p>policy, Emergency Preparedness Plan, is being revised and expanded to include external disasters that might affect the ASC. This will be coordinated with local emergency preparedness authorities and annual drills will be conducted by these local entities educating all staff. Chuck Strasser, Executive Director, with the assistance of Tracey Opaczewski, QI Coordinator, will be responsible for implementing these changes. Completion Date as soon as can be scheduled with local authorities.</p> <p>Administration of Drugs. Failed to insure the the preparation and administration of drugs according to policy. Response: Medication Guidelines policy revised on 11/10/11 to clarify procedure to determine expiration date will be 28-day from opening of multi-dose vial and each vial is tagged with expiration date upon opening (copy of revised policy attached). Staff was educated during staff meeting on 11/14/11 on policy and procedure and all Registered Nurses were given a medication test to insure their</p>	11/11/2011

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	<p>A. one opened vial of Glycopyrrolate 4 mg/20 ml, opened 8/11/11 at 14:30 PM.</p> <p>B. one opened vial of Dexamethasone (Decadron) 4 mg/ml, opened 8/10/11, time opened blank.</p> <p>C. one opened vial of Neostigmine 1 mg/ml, opened 8/11/11 at 14:35 PM.</p> <p>2. Policy No. CL 9.073.09 titled, "Medication Guidelines - Administration and Storage" reviewed on 10/18/11 at 3:30 PM, indicated on pg. 3, point 12. Medication Expiration section, "a. Multiple-dose vials of medications, sterile saline and sterile water containing preservatives are dated when they are first opened and discarded within 28 days of opening or according to manufacturers outdate."</p> <p>3. Policy No. CL 9.215.01 titled, "Expiration Monitoring for Products, Reagents and Solutions in the Operating Room" reviewed on 10/18/11 at 3:40 PM, indicated on pg. 1, under Procedure section, point 4., "If an item and/or solution has reached its expiration date it will be discarded according to manufacturer recommendations."</p> <p>4. Personnel P15 was interviewed on 10/19/11 at approximately 11:00 AM, and confirmed facility policy and procedure was not being followed related to storage</p>		<p>understanding of this policy.(copy of test attached) Chuck Strasser, Executive Director, responsible for completion. Date completed 11/14/11.</p>		

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O0229	<p>and removal of expired medications from general stock. Also, the above-mentioned medications all contained preservatives.</p> <p>[The patient has the right to -] Be fully informed about a treatment or procedure and the expected outcome before it is performed.</p> <p>Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure a properly executed informed consent form was in the patient's chart as required per facility policy and procedure for 1 of 20 (N1) open patient medical record reviewed and 10 of 20 (N4, N6, N8, N9, N11, N13, N14, N16, N18 and N20) closed patient medical records reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Policy No. AD 3.003.10 titled, "Medical Records" reviewed on 10/19/11 at approximately 2:05 PM, indicated on pg. 3, under Documentation section, point B., "Physician Entries...Authentication may be by written signature, identifiable initials, or computer key and include date and time."</li> <li>2. Review of closed patient medical records on 10/18/11 at 2:30 PM, indicated patients N1, N4, N6, N8, N9, N11, N13, N14, N16, N18 and N20 had a Consent to Procedure, Administration of Anesthetics,</li> </ol>	O0229	<p>Exercise of Rights - Informed Consents - Physician entries must include date and time. Response: Consent form revised 11/15/11 to reflect space for date (copy attached). Policy has been revised to reflect that physician will sign and date Informed Consent (reference to Time removed from policy). (copy of revised policy attached) ADDENDUM - 11/22/11: THE MEDICAL RECORDS DEPARTMENT WILL VERIFY THAT THE PHYSICIAN HAS SIGNED THE CONSENT FORM DURING THEIR ANALYZATION OF THE CHART. IN ADDITION, THIS WILL BE VERIFIED DURING THE 5% MONTHLY AUDIT CONDUCTED BY THE NURSING STAFF. ANY DISCREPANCIES FOUND BY THE MEDICAL RECORDS STAFF OR THE NURSING STAFF DURING THEIR AUDIT WILL BE BROUGHT TO THE ATTENTION OF SHELLEY KILGORE, CLINICAL COORDINATOR. THIS WILL THEN BE REPORTED TO CHUCK STRASSER,</p>	11/15/2011

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S0000	<p>and Rendering of Medical Services dated 10/18/11, 6/27/11, 5/18/11, 9/30/11, 6/24/11, 9/23/11, 9/16/11, 9/29/11, 8/8/11, 6/24/11, and 5/17/11, respectively; and were lacking physician date and time after authentication for the statement: "I have discussed procedural risks and alternatives prior to the procedure with the patient."</p> <p>3. Personnel P11 was interviewed on 10/19/11 at approximately 12:10 PM, and confirmed the above-mentioned open and closed patient medical records lacked the date and time of physician authentication according to facility policy and procedure on the informed consent form.</p> <p>This visit was for a standard licensure survey.</p> <p>Facility Number: 010984</p> <p>Survey Date: 10-18/19-11</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p>	S0000	<p>EXECUTIVE DIRECTOR, FOR RESOLUTION.</p> <p>No response required for this specific Tag. Corrective action taken for specific non-compliant Tags listed in report.</p>				

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S0658	<p>QA: cloughlin 11/02/11</p> <p>410 IAC 15-2.5-3(f)(6)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(6) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure a properly executed informed consent form was in the patient's chart as required per facility policy and procedure for 1 of 20 (N1) open patient medical record reviewed and 10 of 20 (N4, N6, N8, N9, N11, N13, N14, N16, N18 and N20) closed patient medical records reviewed.</p> <p>Findings:</p> <p>1. Policy No. AD 3.003.10 titled, "Medical Records" reviewed on 10/19/11 at approximately 2:05 PM, indicated on pg. 3, under Documentation section, point B., "Physician Entries...Authentication may be by written signature, identifiable</p>	S0658	<p>Exercise of Rights - Informed Consents - Physician entries must include date and time. Response: Consent form revised 11/15/11 to reflect space for date (copy attached). Policy has been revised to reflect that physician will sign and date Informed Consent (reference to Time removed from policy). (copy of revised policy attached) ADDENDUM - 11/22/11: THE MEDICAL RECORDS DEPARTMENT WILL VERIFY THAT THE PHYSICIAN HAS SIGNED THE CONSENT FORM DURING THEIR ANALYZATION OF THE CHART. IN ADDITION, THIS WILL BE VERIFIED DURING THE 5% MONTHLY AUDIT CONDUCTED BY THE NURSING STAFF. ANY</p>	11/15/2011

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	<p>initials, or computer key and include date and time."</p> <p>2. Review of closed patient medical records on 10/18/11 at 2:30 PM, indicated patients N1, N4, N6, N8, N9, N11, N13, N14, N16, N18 and N20 had a Consent to Procedure, Administration of Anesthetics, and Rendering of Medical Services dated 10/18/11, 6/27/11, 5/18/11, 9/30/11, 6/24/11, 9/23/11, 9/16/11, 9/29/11, 8/8/11, 6/24/11, and 5/17/11, respectively; and were lacking physician date and time after authentication for the statement: "I have discussed procedural risks and alternatives prior to the procedure with the patient."</p> <p>3. Personnel P11 was interviewed on 10/19/11 at approximately 12:10 PM, and confirmed the above-mentioned open and closed patient medical records lacked the date and time of physician authentication according to facility policy and procedure on the informed consent form.</p>		<p>DISCREPANCIES FOUND BY THE MEDICAL RECORDS STAFF OR THE NURSING STAFF DURING THEIR AUDIT WILL BE BROUGHT TO THE ATTENTION OF SHELLEY KILGORE, CLINICAL COORDINATOR. THIS WILL THEN BE REPORTED TO CHUCK STRASSER, EXECUTIVE DIRECTOR, FOR RESOLUTION.</p>		

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S1010	<p>410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, policy and procedure review, and staff interview, the facility failed to ensure the storage of drugs according to facility policy and procedure for 1 of 3 (Phase 2) areas toured.</p> <p>Findings:</p> <p>1. While on tour of facility on 10/18/11 at approximately 12:36 PM, in the company of P9, the following was observed in the medication cabinet:</p> <p>A. one opened vial of Glycopyrrolate 4 mg/20 ml, opened 8/11/11 at 14:30 PM.</p> <p>B. one opened vial of Dexamethasone (Decadron) 4 mg/ml, opened 8/10/11, time opened blank.</p> <p>C. one opened vial of Neostigmine 1 mg/ml, opened 8/11/11 at 14:35 PM.</p> <p>2. Policy No. CL 9.073.09 titled, "Medication Guidelines - Administration and Storage" reviewed on 10/18/11 at</p>	S1010	<p>Administration of Drugs. Failed to insure the the preparation and adminitration of drugs according to policy. Response: Medication Guidelines policy revised on 11/10/11 to clarify procedure to determine expiration date will be 28-day from opening of multi-dose vial and each vial is tagged with expiration date upon opening (copy of revised policy attached). Staff was educated during staff meeting on 11/14/11 on policy and procedure and all Registered Nurses were given a medication test to insure their understanding of this policy (copy of test attached). Chuck Strasser, Executive Director, responsible for completion. Date completed 11/14/11. ADDENDUM - 11/22/11: MEDICATION GUIDELINES WILL BE CONTINUOUSLY MONITORED BY A MONTHLY REVIEW BY THE PHASE II STAFF (RATHER THAN THE PACU STAFF MONITORING THEMSELVES).</p>	11/11/2011			

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	<p>3:30 PM, indicated on pg. 3, point 12. Medication Expiration section, "a. Multiple-dose vials of medications, sterile saline and sterile water containing preservatives are dated when they are first opened and discarded within 28 days of opening or according to manufacturers outdate."</p> <p>3. Policy No. CL 9.215.01 titled, "Expiration Monitoring for Products, Reagents and Solutions in the Operating Room" reviewed on 10/18/11 at 3:40 PM, indicated on pg. 1, under Procedure section, point 4., "If an item and/or solution has reached its expiration date it will be discarded according to manufacturer recommendations."</p> <p>4. Personnel P15 was interviewed on 10/19/11 at approximately 11:00 AM, and confirmed facility policy and procedure was not being followed related to storage and removal of expired medications from general stock. Also, the above-mentioned medications all contained preservatives.</p>		ANY DISCREPANCIES WILL BE IMMEDIATELY REPORTED TO SHELLEY KILGORE AND CHUCK STRASSER.		

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S1198	<p>410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on staff interview, the facility failed to evidence a coordinated all-hazards emergency disaster plan.</p> <p>Findings:</p> <p>1) In interview on October 19, 2011 at 11am, Employee # A2 indicated that no documentation was available to indicate participation in Emergency Disaster Preparedness Planning groups on either a local, district, or state level; an Emergency Disaster Preparedness Plan or exercises of such a plan were not available for review.</p> <p>2) No further documentation was made available prior to survey exit.</p>	S1198	<p>Disaster Preparedness PlanResponse:The present policy, Emergency Preparedness Plan, is being revised and expanded to include external disasters that might affect the ASC. This will be coordinated with local emergency preparedness authorities and annual drills will be conducted by these local entities educating all staff. Chuck Strasser, Executive Director, with the assistance of Tracey Opaczewski, QI Coordinator, will be responsible for implementing these changes. Completion Date as soon as can be scheduled with local authorities.</p>	12/15/2011	