

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001131		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/30/2013	
NAME OF PROVIDER OR SUPPLIER ELKHART CLINIC ENDOSCOPY AND SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2117 W LEXINGTON AVE ELKHART, IN 46514			
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Q000000	The visit was for a re-certification survey. Facility Number: 003903 Survey Date: 1-28-13 to 1-30-13 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 02/04/13	O000000	3/7/2013				

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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Q000061	<p>416.42(a)(1) ANESTHETIC RISK AND EVALUATION A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that the physical examination and/or pre procedure/anesthesia risk assessment was performed prior to the surgical procedure for 3 patients (pts. # 2, 6 and 8).</p> <p>Findings:</p> <p>1. at 1:00 PM on 1/29/13, review of the policy and procedure "Medical Record Content and Requirements", with a last "Revision Date" of 11/2009, indicated:</p> <p>a. on page 3 under the section "Authentication", it reads: "All entries in the medical record shall be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or ordering the service provided..."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. #2 had a "Pre-operative History & Physical - Surgery" form in which the physician signed and dated (3/21/12) the "Physical Examination" section and the "Procedure/Anesthesia Risk Assessment" section, but failed to write the time of</p>	O000061	<p>Q061</p> <p>1. The deficiency shall be corrected by re-orienting staff, physicians, and Allied Health professionals to the policy "Medical Record Content and Requirements," with specific attention to missing documentation noted in the survey: consistent documentation of the time of authentication for Pre-operative History & Physical: Physical Examination and Procedure/Anesthesia Risk Assessment, to ensure it is evident that those elements were performed prior to the surgical procedure. Re-orientation to the policy shall be provided to the staff at a staff/unit meeting the week of 2/18/13 and provided via email and in person to medical and AHP staff.</p> <p>2. The deficiency shall be prevented in the future by performing random QA audits of patient records to determine that entries are dated, timed, and authenticated as per policy. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy wherever necessary.</p> <p>3. The Administrator shall be responsible for numbers 1 and 2 above.</p>	03/07/2013			

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	<p>these entries making it impossible to determine if they were performed prior to the surgical procedure</p> <p>b. pt. #6 had a "Pre-operative History & Physical - Surgery" form in which the physician signed and dated (10/9/12) the "Physical Examination" section and the "Procedure/Anesthesia Risk Assessment" section, but failed to write the time of these entries making it impossible to determine if they were performed prior to the surgical procedure</p> <p>c. pt. #8 had a "Pre-operative History & Physical - Surgery" form in which the physician failed to sign, date, or time the "Physical Examination" section that was completed and failed to enter a time of the "Procedure/Anesthesia Risk Assessment" done on 12/6/12, making it impossible to determine if these were performed prior to the surgical procedure</p> <p>3. interview with staff member #50 at 4:45 PM on 1/28/13 indicated:</p> <p>a. the patient records for #2, 6, and 8 were lacking documentation as listed in 2. above</p> <p>b. it is very difficult to get the physicians to date and time entries in the medical record</p>		4. The deficiency shall be corrected by 3/7/13.		

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Q000162	<p>416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ol style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to implement its policy related to legible, complete, and accurate medical records for 10 of 20 records reviewed (pts. # 1, 2, 3, 6, 7, 10, 12, 14, 16, and 20).</p> <p>Findings: 1. at 1:00 PM on 1/29/13, review of the policy and procedure "Medical Record Content and Requirements", with a last revision date of 11/2009, indicated: a. under "Policy", it reads: "A medical record shall be maintained for each</p>	O000162	<p>Q162 1. The deficiency shall be corrected by re-orienting staff, physicians, and Allied Health professionals to the policies "Informed Consent" and "Medical Record Content and Requirements," with specific attention to missing or inaccurate documentation noted in the survey, as follows: spelling errors; missing documentation of date and/or time of authentication for Physical Examination, Procedure Risk Assessment, and Anesthesia Risk Assessment; inaccurate documentation of discharge status; missing allergies documentation on the</p>	03/07/2013			

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	<p>patient, which is accurate, legible, complete and comprehensive..."</p> <p>b. under "Content", it reads: "Accurate and complete medical records are written for all patients;..."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. # 1 had a clinic note/history and physical by the physician which read: "Patient Instructions: 1) [pt] has done well from his tonsiullectomy, He does have this bead in hsi ear that I advise we need to remove, I did try to remove in the office but was not successful, I discussed the options with hsi grandmother including removal in The OR, the risks, benefits, complications,...and need for further surgery all discussed..."</p> <p>b. pt. #2 lacked physician documentation of the time the physical examination and "Procedure Risk Assessment" were done (on the "Pre-operative History & Physical - Surgery" form)</p> <p>c. pt. #3 had documentation that the patient was "Discharged to Home" on the "Post -op Record" form, when the patient was actually transferred to the local hospital</p> <p>d. pt. # 6 lacked physician documentation of the time the physical examination and "Procedure Risk</p>		<p>Preoperative History & Physical form; missing procedure room number; missing RN authentication of Anesthesia Pre/Post-Operative Orders; missing documentation of anesthesia provider name and type of provider on Informed Consent for Anesthesia form; and missing PACU Arrival vital signs on the Anesthesia Record. Re-orientation to the policies shall be provided to the staff at a staff/unit meeting the week of 2/18/13 and provided via email and in person to medical and AHP staff.</p> <p>2. The deficiency shall be prevented in the future by performing random QA audits of patient records to determine that entries are accurate, legible, complete, and comprehensive, as per policy. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy wherever necessary.</p> <p>3. The Administrator shall be responsible for numbers 1 and 2 above.</p> <p>4. The deficiency shall be corrected by 3/7/13.</p>				

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	<p>Assessment" were done (on the "Pre-operative History & Physical - Surgery" form)</p> <p>e. pt. # 7 lacked documentation of any allergies (or NKA--no known allergies) on the "Pre-op Record/Patient Physical" form (pt. had 7 allergies noted on the "Pre-op Interview and History" form)</p> <p>f. pt. #10 lacked physician authentication and documentation of the date and time of the physical examination and lacked a time with the dated authentication of the "Pre-Procedure Risk Assessment" that was done (on the "Pre-operative History & Physical - Surgery" form)</p> <p>g. pt. #12:</p> <p>A. lacked documentation of the room number (#1, 2, or Minor) the procedure was performed in (on the "Intra-Operative Nursing Record" form)</p> <p>B. lacked nursing signature and "date/time noted" of the "Anesthesia Pre and Post-op Orders"</p> <p>C. lacked documentation of the anesthesia provider and whether they were an "Anesthesiologist, Certified Registered Nurse Anesthetist, or an associated qualified anesthesia provider" on the "Informed Consent for Anesthesia" signed by the patient</p> <p>h. pt. #14 lacked documentation of the anesthesia provider and whether they were an "Anesthesiologist, Certified</p>						

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	<p>Registered Nurse Anesthetist, or an associated qualified anesthesia provider" on the "Informed Consent for Anesthesia" signed by the patient</p> <p>i. pt. #16 lacked documentation by the anesthesia provider of the time the "Anesthesia Risk Assessment" was performed (on the "Preoperative Patient Assessment" form)</p> <p>j. pt. #20 lacked completion of the "PACU (post anesthesia care unit) Arrival" vital signs (BP [blood pressure], P [pulse], RR [respiratory rate], and SaO2 [oxygen saturation])" on the "Anesthesia Record" form</p> <p>3. interview with staff members #50 and #53 at 2:10 PM on 1/29/13 and 3:10 PM on 1/30/13 indicated:</p> <p>a. documentation is lacking in the medical records as listed in 2 above</p> <p>b. the clinic note by the physician on the medical record #1, should have been reviewed by medical records staff and sent to the physician for correction of errors to ensure legibility and correctness/accuracy</p> <p>c. it was thought that the anesthesia provider for pt. #20 felt that vital signs needn't be documented if the endoscopy patient was transported to phase II recovery, and not phase I--even though other endoscopy patients did have that area of the "Anesthesia Record" form</p>						

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	completed and this is the "practice and expectation" of the facility			

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Q000221	<p>416.50(a)(1) NOTICE OF RIGHTS The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands. Based on review of medical staff rules and regulations, patient medical record review, and staff interview, the facility failed to ensure the disclosure to patients of their rights prior to their procedure for 6 of 20 patients (pts. # 1, 5, 8, 9, 11, and 17)</p> <p>Findings: 1. at 3:55 PM on 1/28/13, review of Medical Staff Rules and Regulations, with a 2/12 "Revision Date", indicated: a. in Section 5 "Patient Admission Requirements", it reads: "...E. Upon admission, the patient or guardian/power of attorney shall sign an acknowledgement of the receipt of information regarding their physician's disclosure of ownership/interest in the ASC (ambulatory surgery center), Patient Rights and Responsibilities, and policy on Advance Directives..."</p> <p>2. review of patient medical records indicated: a. pt. # 1 had a signed "Acknowledgement of ASC Information</p>	O000221	<p>Q221 1. The policy "Patient Rights and Responsibilities" was updated and approved 2/15/13 to include the statement that acknowledgement of the patient's rights and responsibilities shall be obtained for each visit. The form "Acknowledgement of ASC Information Packet" shall be signed by the patient or his/her designee at each visit; the form includes information related to patient rights, disclosure of physician ownership of the Center, and facility policy on Advance Directives. The deficiency shall be corrected by re-orienting staff to the policy "Patient Rights and Responsibilities" with specific attention to missing documentation noted in the survey: lack of signed "Acknowledgement of ASC Information" form at each visit, lack of patient signature and date, lack of signed "Acknowledgement" form altogether. Re-orientation to the policy shall be provided to the staff at a staff/unit meeting the week of 2/18/13. 2. The deficiency shall be</p>	03/07/2013			

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	<p>Packet" form (which included information related to patient rights) dated 3/19/12 for the surgery of that date, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 5/9/12 surgery date</p> <p>b. pt. # 5 pt. # 1 had a signed "Acknowledgement of ASC Information Packet" form dated 7/24/12 for the surgery of that date, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 9/7/12 surgery date</p> <p>c. pt. # 8 had an "Acknowledgement of ASC Information Packet" form, but lacked a signature/date by the patient</p> <p>d. pt. # 9 lacked the "Acknowledgement of ASC Information Packet" form</p> <p>e. pt. # 11 had a signed "Acknowledgement of ASC Information Packet" form dated 10/9/12 for the surgery of 10/17/12, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 11/7/12 and 12/5/12 surgery dates</p> <p>f. pt. #17 had a signed "Acknowledgement of ASC Information Packet" form dated 11/15/12 for the surgery of that date, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 12/14/12 surgery date</p> <p>3. at 2:05 PM on 1/30/13, interview with staff member # 50 indicated:</p>		<p>prevented in the future by performing random QA audits of patient records to determine that an "Acknowledgement" form is present for each visit and that each form is dated and signed by the patient or his/her designee as per policy. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy wherever necessary.</p> <p>3. The Administrator shall be responsible for numbers 1 and 2 above.</p> <p>4. The deficiency shall be corrected by 3/7/13.</p>		

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	<p>a. it was unknown that patients needed to sign the form indicating receipt of patient rights with each procedure at the facility</p> <p>b. it was thought that the signed "Acknowledgement of ASC Information Packet" form was good until the facility made a change to its policy related to patient rights</p>			

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Q000223	<p>416.50(a)(1)(ii) NOTICE - PHYSICIAN OWNERSHIP The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure. Based on review of medical staff rules and regulations, patient medical record review, and staff interview, the facility failed to ensure the disclosure to patients of physician financial interests prior to the procedure for 6 of 20 patients (pts. # 1, 5, 8, 9, 11, and 17).</p> <p>Findings: 1. at 3:55 PM on 1/28/13, review of Medical Staff Rules and Regulations, with a 2/12 "Revision Date", indicated: a. in Section 5 "Patient Admission Requirements", it reads: "...E. Upon admission, the patient or guardian/power of attorney shall sign an acknowledgement of the receipt of information regarding their physician's disclosure of ownership/interest in the ASC (ambulatory surgery center), Patient Rights and Responsibilities, and policy on Advance Directives..."</p> <p>2. review of patient medical records indicated: a. pt. # 1 had a signed "Acknowledgement of ASC (ambulatory</p>	Q000223	<p>Q223 1. The policy "Patient Rights and Responsibilities" was updated and approved 2/15/13 to include the statement that acknowledgement of the patient's rights and responsibilities shall be obtained for each visit. The policy addresses physician ownership of the center. The form "Acknowledgement of ASC Information Packet" shall be signed by the patient or his/her designee at each visit; the form includes information related to patient rights, disclosure of physician ownership of the Center, and facility policy on Advance Directives. The deficiency shall be corrected by re-orienting staff to the policy "Patient Rights and Responsibilities" with specific attention to missing documentation noted in the survey: lack of signed "Acknowledgement of ASC Information" form at each visit, lack of patient signature and date, lack of signed "Acknowledgement" form altogether. Re-orientation to the policy shall be provided to the</p>	03/07/2013			

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	<p>surgery center) Information Packet" form (which included information related to physician financial interests) dated 3/19/12 for the surgery of that date, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 5/9/12 surgery date</p> <p>b. pt. # 5 pt. # 1 had a signed "Acknowledgement of ASC Information Packet" form (which included information related to physician financial interests) dated 7/24/12 for the surgery of that date, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 9/7/12 surgery date</p> <p>c. pt. # 8 had an "Acknowledgement of ASC Information Packet" form (which included information related to physician financial interests) which was not signed/dated by the patient</p> <p>d. pt. # 9 lacked the "Acknowledgement of ASC Information Packet" form</p> <p>e. pt. # 11 had a signed "Acknowledgement of ASC Information Packet" form (which included information related to physician financial interests) dated 10/9/12 for the surgery of 10/17/12, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 11/7/12 and 12/5/12 surgery dates</p> <p>f. pt. #17 had a signed "Acknowledgement of ASC Information Packet" form (which included information related to physician financial interests)</p>		<p>staff at a staff/unit meeting the week of 2/18/13.</p> <p>2. The deficiency shall be prevented in the future by performing random QA audits of patient records to determine that an "Acknowledgement" form is present for each visit and that each form is dated and signed by the patient or his/her designee as per policy. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy wherever necessary.</p> <p>3. The Administrator shall be responsible for numbers 1 and 2 above.</p> <p>4. The deficiency shall be corrected by 3/7/13.</p>				

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	<p>dated 11/15/12 for the surgery of that date, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 12/14/12 surgery date</p> <p>3. at 2:05 PM on 1/30/13, interview with staff member # 50 indicated:</p> <p>a. it was unknown that patients needed to sign the form indicating receipt of patient rights, including physician financial interest, with each procedure at the facility</p> <p>b. it was thought that the signed "Acknowledgement of ASC Information Packet" form was good until the facility made a change to its policy related to patient rights</p>				

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Q000224	<p>416.50(a)(2) ADVANCE DIRECTIVES The ASC must comply with the following requirements:</p> <p>(i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms.</p> <p>(ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care.</p> <p>(iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>Based on review of medical staff rules and regulations, patient medical record review, and staff interview, the facility failed to ensure the disclosure to patients of their rights, related to advance directives, prior to their procedure for 6 of 20 patients (pts. # 1, 5, 8, 9, 11, and 17).</p> <p>Findings: 1. at 3:55 PM on 1/28/13, review of Medical Staff Rules and Regulations, with a 2/12 "Revision Date", indicated: a. in Section 5 "Patient Admission Requirements", it reads: "...E. Upon admission, the patient or guardian/power of attorney shall sign an acknowledgement of the receipt of information regarding their physician's</p>	O000224	<p>Q224 1. The policy "Patient Rights and Responsibilities" was updated and approved 2/15/13 to include the statement that acknowledgement of the patient's rights and responsibilities shall be obtained for each visit. The policy addresses Advance Directives. The form "Acknowledgement of ASC Information Packet" shall be signed by the patient or his/her designee at each visit; the form includes information related to patient rights, disclosure of physician ownership of the Center, and facility policy on Advance Directives. The deficiency shall be corrected by re-orienting staff to the policy "Patient Rights and</p>	03/07/2013			

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	<p>disclosure of ownership/interest in the ASC (ambulatory surgery center), Patient Rights and Responsibilities, and policy on Advance Directives..."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. # 1 had a signed "Acknowledgement of ASC (ambulatory surgery center) Information Packet" form (which included information related to advance directives) dated 3/19/12 for the surgery of that date, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 5/9/12 surgery date</p> <p>b. pt. # 5 pt. # 1 had a signed "Acknowledgement of ASC Information Packet" form dated 7/24/12 for the surgery of that date, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 9/7/12 surgery date</p> <p>c. pt. # 8 had an "Acknowledgement of ASC Information Packet" form, but lacked a signature/date by the patient</p> <p>d. pt. # 9 lacked the "Acknowledgement of ASC Information Packet" form</p> <p>e. pt. # 11 had a signed "Acknowledgement of ASC Information Packet" form dated 10/9/12 for the surgery of 10/17/12, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 11/7/12 and 12/5/12 surgery dates</p> <p>f. pt. #17 had a signed</p>		<p>Responsibilities" with specific attention to missing documentation noted in the survey: lack of signed "Acknowledgement of ASC Information" form at each visit, lack of patient signature and date, lack of signed "Acknowledgement" form altogether. Re-orientation to the policy shall be provided to the staff at a staff/unit meeting the week of 2/18/13.</p> <p>2. The deficiency shall be prevented in the future by performing random QA audits of patient records to determine that an "Acknowledgement" form is present for each visit and that each form is dated and signed by the patient or his/her designee as per policy. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy wherever necessary.</p> <p>3. The Administrator shall be responsible for numbers 1 and 2 above.</p> <p>4. The deficiency shall be corrected by 3/7/13.</p>				

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	<p>"Acknowledgement of ASC Information Packet" form dated 11/15/12 for the surgery of that date, but lacked a signed "Acknowledgement of ASC Information Packet" form for the 12/14/12 surgery date</p> <p>3. at 2:05 PM on 1/30/13, interview with staff member # 50 indicated:</p> <p>a. it was unknown that patients needed to sign the form indicating receipt of patient rights (with information related to advance directives) with each procedure at the facility</p> <p>b. it was thought that the signed "Acknowledgement of ASC Information Packet" form was good until the facility made a change to its policy related to patient rights or advance directives</p>			

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Q000242	<p>416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.</p> <p>Based on policy and procedure review, personnel health file review, observation, and staff interview, the infection control committee failed to implement its policy related to Varicella immunity for 1 RN (registered nurse) hired in 2012 (staff member P1), and the infection control practitioner failed to implement the policy related to surgical attire for one observation in the minor procedure room.</p> <p>Findings: 1. at 10:00 AM on 1/29/13, review of the policy and procedure "Employee Health Service", with an "Effective Date" of 2/12, indicated: a. under section "D. Immunizations", it reads on page 3: "...4. Varicella Vaccine - is offered to all employees who have no evidence of immunity as defined in Appendix A. Evidence of immunity or vaccination is required for ASC (ambulatory surgery center) employees..."</p> <p>2. review of the health file for RN P1,</p>	0000242	<p>Q242 1. (a) The deficiency shall be corrected as follows: A Varicella titer for staff member P1 was completed on 1/31/13. The Elkhart Clinic Human Resources department shall be re-oriented to the policy "Employee Health Service." with specific regard to the requirement of demonstration of Varicella immunity, the week of 2/18/13. The Human Resources administrator has corrected the deficiency in employee P1's personnel file per the policy. 2. (a) The deficiency shall be prevented from happening in the future through random QA audits of both new and existing ASC personnel files. Files shall be audited per the "Employee Health Service" policy to ensure required testing is performed and documentation is filed as required. Deficiencies noted in QA audits shall be brought to the attention of the Human Resources administrator and corrected. Deficiencies shall be noted in the quarterly QAPI dashboard for evaluation of services and reported to the</p>	03/07/2013			

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	<p>hired 5/14/12, indicated:</p> <p>a. the newly hired staff member signed a declination form for the "Titer/Booster" and noted: "Had chickenpox when young"</p> <p>b. the file lacked any documentation of immunity to Varicella, or having had the Varicella immunizations</p> <p>3. interview with staff member #50, the facility administrator, at 10:10 AM on 1/30/13 indicated:</p> <p>a. HR (human resources) should not have allowed staff member P1 to self report having had Varicella as a child, as the facility policy does not allow this</p> <p>b. staff member P1 should not have been allowed by HR to refuse having a Varicella titer, if there was no signed documentation by a practitioner noting P1's having had Varicella as a child</p> <p>c. there was no documentation that staff member P1 had received 2 doses of Varicella as an immunization</p> <p>d. the facility policy related to Varicella immunization status was not implemented when staff member P1 was hired 5/12</p> <p>4. at 2:05 PM on 1/30/13, review of the policy and procedure "Surgical Attire", with a "Revision Date" of 11/09, indicated:</p> <p>a. on page 2 under item 4, it reads: "All personnel entering the semirestricted and</p>		<p>Infection Control Coordinator and Committee. 3. (a) The Elkhart Clinic Human Resources Administrator, the Infection Control Coordinator, and the ASC Administrator shall be responsible for numbers 1 (a) and 2 (a) above. 4. (a) The deficiency shall be corrected by 3/7/13. Q242 1. (b) The deficiency shall be corrected by re-orienting staff to the "Surgical Attire" policy. ASC staff shall be reoriented to the policy at the staff/unit meeting during the week of 2/18/13. 2. (b) The deficiency shall be prevented from recurring in the future by conducting random QA audits of compliance with the Surgical Attire policy after re-education to the policy has been completed. Individuals found in non-compliance with the policy shall be corrected; additional education shall be provided where needed. 3. (b) The ASC Administrator and Infection Control Coordinator shall be responsible for numbers 1 (b) and 2 (b) above. 4. (b) The deficiency shall be corrected by 3/7/13.</p>		

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	<p>restricted areas of the surgical suite will confine or remove all jewelry and watches...b. Other jewelry (e.g. watches, earrings...should be removed or totally confined within the scrub attire..."</p> <p>5. at 9:10 AM on 1/29/13, while observing a patient in the minor procedure room, it was noted that staff member #56, the radiology technician, had a large watch present on their left wrist while manipulating the patient and the C-arm in readiness for the epidural procedure</p> <p>6. interview with staff members #50 and #53 at 2:05 PM on 1/30/13 indicated: a. the minor procedure room is considered a semi restricted area b. watches are not to be worn, per facility policy, within the semi restricted areas unless confined within scrub attire</p>				

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Q000244	<p>416.51(b)(2) INFECTION CONTROL PROGRAM - QAPI [The program is -] An integral part of the ASC's quality assessment and performance improvement program Based on document review and interview, the quality assessment and improvement (QA) program failed to address an ongoing infection control (IC) concern regarding hand hygiene compliance at the center.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assessment/Performance Assurance Plan (approved 2-12) indicated the following: " The Medical Advisory Committee has responsibility for directing all QAPI activities ...The scope of the QA program includes ...IC - rate of surgical site infections, hand hygiene and other IC policy compliance audits ...The MAC shall meet at least quarterly to review all items reported on...If the corrective action is identified as not effectual/appropriate after the presentation of the monitoring results to the MAC committee, the committee chair/Medical Director may recommend other immediate actions to be taken. "</p> <p>2. Documentation indicated that hand hygiene surveillance had been monitored</p>	O000244	<p>Q244 1. The deficiency shall be corrected by through development, recommendation, and implementation of an effective QA plan to address deficient hand washing practice. The Infection Control Committee met on 2/12/13 and established a plan, consisting of the following: immediate re-education of all medical staff, AHP staff, and employees to the WHO Five Moments of Hand Hygiene; establishment of a goal for all ASC providers and employees of achieving a minimum of 75% compliance by 4/4/13 and 90% compliance by 6/30/13; increasing the number of observances per quarter to a minimum of five observances of each physician, in particular; and ensuring that ASC and medical staff leadership takes a direct role in correcting non-compliant behavior. The Medical Advisory Committee also functions as the QAPI committee; MAC is in support of the QA plan and will enforce it.2. The deficiency shall be prevented from recurring in the future by closely monitoring and correcting non-compliant hand hygiene practices. Re-education of staff shall occur at a staff / unit meeting the week of 2/18/13.</p>	03/07/2013

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	<p>since 2010 and reported in the Infection Control (IC), QAPI subcommittee and MAC minutes. Documentation dated 11-09-11 indicated a 2012 project goal to have compliance in the high 90 ' s for the three provider areas (Nurses, Techs and MD/Anesthesia) surveyed and hand hygiene surveillance reported with quarterly MAC meeting minutes failed to indicate greater than 50% compliance for all credentialed medical staff surveyed in 2012.</p> <p>3. The MAC meeting minutes dated 4-12-12 indicated the following: " There was a general discussion of the Q1 Hand Hygiene survey results (see report); compliance was at the lowest rate since monitoring began several years ago... [staff A6] shared that the ASC would soon be changing from gel sanitizer to foam ...the IC committee hopes that this will also help improve compliance with hand hygiene. " The minutes failed to indicate additional committee recommendations in response to the poor compliance with hand hygiene for all staff.</p> <p>4. The MAC meeting minutes dated 7-12-12 and 10-11-12 failed to indicate a QA committee discussion, recommendation or action in response to the reported deficient practice.</p>		<p>Re-education of medical and AHP staff shall occur at a Medical Advisory (QAPI) Committee meeting the week of 2/25/13, as well as via email and in print form individually. All providers and employees shall be re-educated to required hand hygiene and commitment to achieving the goals listed above by 3/7/13. The Infection Control Coordinator shall provide detailed data collected through random observances, including the name of each individual and result of each observance, to the Infection Control Committee and Medical Advisory (QAPI) Committee. Medical / Allied Health staff demonstrating non-compliance shall have peer to peer discussions regarding the non-compliance with either the Medical Director or Medical Advisory (QAPI) Committee Chairman. Employees demonstrating non-compliance shall have discussions regarding the non-compliance with the Infection Control Coordinator and the Administrator. Leadership shall be committed to helping all providers and employees achieve a minimum goal of 75% compliance by 4/4/13 and 90% compliance by 6/30/13. Monitoring of the plan shall be ongoing; progress shall be reported to MAC (QAPI) and the Board of Managers quarterly.3. The Medical Director, Medical Advisory (QAPI) Committee and Chairman, Infection</p>				

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	<p>5. The MAC meeting minutes dated 1-10-13 indicated the following: " Hand Hygiene: see report. There was a general discussion of the report ...[staff A1] asked the [MAC] physicians what the IC Committee could do to help physicians improve their % compliance. " The minutes failed to document a QA committee recommendation or corrective action in response to the ongoing hand hygiene non-compliance.</p> <p>6. During an interview 1-30-13 at 1255 hours, medical staff and governing board member A5 confirmed that the hand hygiene surveillance had been reviewed at the quarterly MAC meetings and confirmed that the 2013 MAC meeting documentation failed to indicate an effective QA program response to address the deficient practice.</p>		<p>Control Committee, ASC Administrator, and Infection Control Coordinator shall be responsible for numbers 1 and 2 above. 4. Re-education of all medical, AHP, and ASC staff to required elements of hand hygiene and renewed commitment to goals stated above shall occur by 3/7/13. Compliance rates shall be recorded 3/7-4/4/13 and reported to the Infection Control Committee and to the Medical Advisory (QAPI) Committee by 4/11/13. Compliance rates and results of peer to peer discussions with individuals observed in non-compliance shall be reported to the Board of Managers by 5/2/13.</p>				

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S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 003903</p> <p>Survey Date: 1-28-13 to 1-30-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/04/13</p>	S000000	3/7/2013		

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S000156	<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 policy and procedure review, employee file review, and staff interview, the chief executive officer failed to implement the facility policy related to annual evaluations for 1 of 2 CST (certified surgical technician) files reviewed (staff member P6), and for 1 of 5 RN (registered nurse) files reviewed (staff member P7).</p> <p>Findings: 1. at 10:00 AM on 1/29/13, review of the policy and procedure "Staff Competency Standards", with a most recent "Effective Date" of 11/2009, indicated: a. under section "B. Job Description", it reads: "...B. Each employee shall receive a written evaluation of performance annually..."</p>	S000156	S156 1. The deficiency shall be corrected by performing and documenting the annual evaluations for staff members P6 and P7 as per policy "Staff Competency Standards." 2. The deficiency shall be prevented from happening in the future through compliance with the policy, and QA audits of ASC personnel files. Files shall be audited per the "Staff Competency Standards" policy to ensure personnel annual performance evaluations are performed per policy and documentation is filed in a timely manner. Deficiencies noted in QA audits shall be corrected. QA audit results shall be noted in the quarterly QAPI reporting and reported to the Medical Advisory Committee and Board of	02/22/2013			

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	<p>2. review of employee files at 1:45 PM on 1/29/13 and 10:45 AM on 1/30/13 indicated:</p> <p>a. staff member P6 had a most recent annual performance evaluation dated 12/11</p> <p>b staff member P7 had a most recent annual performance evaluation dated 12/12/11</p> <p>3. interview with staff member #50 indicated:</p> <p>a. both staff members P6 and P7 are "overdue" for their annual performance evaluations--they should have been done in December of 2012</p>		<p>Managers. 3. The ASC Administrator shall be responsible for numbers 1 and 2 above. 4. The deficiency shall be corrected by 2/22/13.</p>				

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S000328	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the quality assessment and improvement (QA) program failed to address an ongoing infection control (IC) concern regarding hand hygiene compliance at the center.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assessment/Performance Assurance Plan (approved 2-12) indicated the following: " The Medical Advisory Committee has responsibility for directing all QAPI activities ...The scope of the QA program includes ...IC - rate of surgical site infections, hand hygiene and other IC policy compliance audits ...The MAC shall meet at least quarterly to review all items reported on...If the corrective action is identified as not effectual/appropriate</p>	S000328	<p>Q244 1. The deficiency shall be corrected by through development, recommendation, and implementation of an effective QA plan to address deficient hand washing practice. The Infection Control Committee met on 2/12/13 and established a plan, consisting of the following: immediate re-education of all medical staff, AHP staff, and employees to the WHO Five Moments of Hand Hygiene; establishment of a goal for all ASC providers and employees of achieving a minimum of 75% compliance by 4/4/13 and 90% compliance by 6/30/13; increasing the number of observances per quarter to a minimum of five observances of each physician, in particular; and ensuring that ASC and medical staff leadership takes a direct role in correcting non-compliant behavior. The</p>	03/07/2013			

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	<p>after the presentation of the monitoring results to the MAC committee, the committee chair/Medical Director may recommend other immediate actions to be taken. "</p> <p>2. Documentation indicated that hand hygiene surveillance had been monitored since 2010 and reported in the Infection Control (IC), QAPI subcommittee and MAC minutes. Documentation dated 11-09-11 indicated a 2012 project goal to have compliance in the high 90 ' s for the three provider areas (Nurses, Techs and MD/Anesthesia) surveyed and hand hygiene surveillance reported with quarterly MAC meeting minutes failed to indicate greater than 50% compliance for all credentialed medical staff surveyed in 2012.</p> <p>3. The MAC meeting minutes dated 4-12-12 indicated the following: "There was a general discussion of the Q1 Hand Hygiene survey results (see report); compliance was at the lowest rate since monitoring began several years ago... [staff A6] shared that the ASC would soon be changing from gel sanitizer to foam ...the IC committee hopes that this will also help improve compliance with hand hygiene." The minutes failed to indicate additional committee recommendations in response to the poor</p>		<p>Medical Advisory Committee also functions as the QAPI committee; MAC is in support of the QA plan and will enforce it.2. The deficiency shall be prevented from recurring in the future by closely monitoring and correcting non-compliant hand hygiene practices. Re-education of staff shall occur at a staff / unit meeting the week of 2/18/13. Re-education of medical and AHP staff shall occur at a Medical Advisory (QAPI) Committee meeting the week of 2/25/13, as well as via email and in print form individually. All providers and employees shall be re-educated to required hand hygiene and commitment to achieving the goals listed above by 3/7/13. The Infection Control Coordinator shall provide detailed data collected through random observances, including the name of each individual and result of each observance, to the Infection Control Committee and Medical Advisory (QAPI) Committee. Medical / Allied Health staff demonstrating non-compliance shall have peer to peer discussions regarding the non-compliance with either the Medical Director or Medical Advisory (QAPI) Committee Chairman. Employees demonstrating non-compliance shall have discussions regarding the non-compliance with the Infection Control Coordinator and the Administrator. Leadership shall be</p>				

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	<p>compliance with hand hygiene for all staff.</p> <p>4. The MAC meeting minutes dated 7-12-12 and 10-11-12 failed to indicate a QA committee discussion, recommendation or action in response to the reported deficient practice.</p> <p>5. The MAC meeting minutes dated 1-10-13 indicated the following: "Hand Hygiene: see report. There was a general discussion of the report ...[staff A1] asked the [MAC] physicians what the IC Committee could do to help physicians improve their % compliance." The minutes failed to document a QA committee recommendation or corrective action in response to the ongoing hand hygiene non-compliance.</p> <p>6. During an interview 1-30-13 at 1255 hours, medical staff and governing board member A5 confirmed that the hand hygiene surveillance had been reviewed at the quarterly MAC meetings and confirmed that the 2013 MAC meeting documentation failed to indicate an effective QA program response to address the deficient practice.</p>		<p>committed to helping all providers and employees achieve a minimum goal of 75% compliance by 4/4/13 and 90% compliance by 6/30/13. Monitoring of the plan shall be ongoing; progress shall be reported to MAC (QAPI) and the Board of Managers quarterly.3. The Medical Director, Medical Advisory (QAPI) Committee and Chairman, Infection Control Committee, ASC Administrator, and Infection Control Coordinator shall be responsible for numbers 1 and 2 above. 4. Re-education of all medical, AHP, and ASC staff to required elements of hand hygiene and renewed commitment to goals stated above shall occur by 3/7/13. Compliance rates shall be recorded 3/7-4/4/13 and reported to the Infection Control Committee and to the Medical Advisory (QAPI) Committee by 4/11/13. Compliance rates and results of peer to peer discussions with individuals observed in non-compliance shall be reported to the Board of Managers by 5/2/13.</p>		

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S000442	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on policy and procedure review, personnel health file review, and staff interview, the infection control committee failed to implement its policy related to Varicella immunity for 1 RN (registered nurse) hired in 2012 (staff member P1).</p> <p>Findings:</p> <p>1. at 10:00 AM on 1/29/13, review of the policy and procedure "Employee Health Service", with an "Effective Date" of 2/12, indicated:</p> <p>a. under section "D. Immunizations", it reads on page 3: "...4. Varicella Vaccine - is offered to all employees who have no evidence of immunity as defined in Appendix A. Evidence of immunity or vaccination is required for ASC</p>	S000442	<p>S442</p> <p>1. The deficiency shall be corrected as follows: A Varicella titer for staff member P1 was completed on 1/31/13. The Elkhart Clinic Human Resources department shall be re-oriented to the policy "Employee Health Service." with specific regard to the requirement of demonstration of Varicella immunity, the week of 2/18/13. The Human Resources administrator has corrected the deficiency in employee P1's personnel file per the policy.</p> <p>2. The deficiency shall be prevented from happening in the future through random QA audits of both new and existing ASC personnel files. Files shall be audited per the "Employee Health Service" policy to ensure required</p>	03/07/2013			

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	<p>(ambulatory surgery center) employees..."</p> <p>2. review of the health file for RN P1, hired 5/14/12, indicated:</p> <p>a. the newly hired staff member signed a declination form for the "Titer/Booster" and noted: "Had chickenpox when young"</p> <p>b. the file lacked any documentation of immunity to Varicella, or having had the Varicella immunizations</p> <p>3. interview with staff member #50 at 10:10 AM on 1/30/13 indicated:</p> <p>a. HR (human resources) should not have allowed staff member P1 to self report having had Varicella as a child, as the facility policy does not allow this</p> <p>b. staff member P1 should not have been allowed by HR to refuse having a Varicella titer, if there was no signed documentation by a practitioner noting P1's having had Varicella as a child</p> <p>c. there was no documentation that staff member P1 had received 2 doses of Varicella as an immunization</p> <p>d. the facility policy related to Varicella immunization status was not implemented when staff member P1 was hired 5/12</p>		<p>testing is performed and documentation is filed as required. Deficiencies noted in QA audits shall be brought to the attention of the Human Resources administrator and corrected. Deficiencies shall be noted in the quarterly QAPI dashboard for evaluation of services and reported to the Infection Control Coordinator and Committee.</p> <p>3. The Elkhart Clinic Human Resources Administrator, the Infection Control Coordinator, and the ASC Administrator shall be responsible for numbers 1 and 2 above.</p> <p>4. The deficiency shall be corrected by 3/7/13.</p>				

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S000444	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</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>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on policy and procedure review, observation, and staff interview, the infection control practitioner failed to implement the policy related to surgical attire for one observation in the minor procedure room.</p> <p>Findings: 1. at 2:05 PM on 1/30/13, review of the policy and procedure "Surgical Attire", with a "Revision Date" of 11/09, indicated: a. on page 2 under item 4, it reads: "All personnel entering the semirestricted and restricted areas of the surgical suite will confine or remove all jewelry and watches...b. Other jewelry (e.g. watches, earrings...should be removed or totally confined within the scrub attire..."</p>	S000444	<p>S444</p> <p>1. The deficiency shall be corrected by re-orienting staff to the "Surgical Attire" policy. ASC staff shall be reoriented to the policy at a staff/unit meeting during the week of 2/18/13. 2. The deficiency shall be prevented from recurring in the future by conducting random QA audits of compliance with the Surgical Attire policy after re-education to the policy has been completed. Individuals found in non-compliance with the policy shall be corrected; additional education shall be provided where needed. 3. The ASC Administrator and Infection Control Coordinator shall be responsible for numbers 1 and 2 above. 4. The deficiency shall be corrected by 3/7/13.</p>	03/07/2013	

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	<p>2. at 9:10 AM on 1/29/13, while observing a patient in the minor procedure room, it was noted that staff member #56, the radiology technician, had a large watch present on their left wrist while manipulating the patient and the C-arm in readiness for the epidural procedure</p> <p>3. interview with staff members #50 and #53 at 2:05 PM on 1/30/13 indicated:</p> <p>a. the minor procedure room is considered a semi restricted area</p> <p>b. watches are not to be worn, per facility policy, within the semi restricted areas unless confined within scrub attire</p>			

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S000526	<p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on policy and procedure review, employee file review, and staff interview, the facility failed to ensure that skills and competencies of staff were demonstrated on an annual basis, per policy, related to urine HCG (pregnancy testing) and blood glucose (glucometer) testing for 9 of 9 nursing and surgical technician files reviewed (staff members P1 and P2 and P4 through P10).</p> <p>Findings:</p> <p>1. at 4:45 PM on 1/29/13, review of the policy and procedure "Staff Competency Standards", with an "Effective Date" of 11/2009, indicated:</p> <p>a. under "Policy/Procedure", it reads: "...2. Documented competency shall consist of a skills checklist completed during orientation and reviewed annually with the performance appraisal..."</p> <p>2. at 4:45 PM on 1/29/13, review of the policy and procedure "Employee Annual Education and Competency", with a "Revision Date" of 11/2009, indicated:</p>	S000526	<p>S526</p> <p>1. The deficiency shall be corrected by performing and documenting competency assessments for urine HCG and blood glucose (Glucometer) testing as per policy "Staff Competency Standards" for clinical staff performing these tests. Staff shall be re-oriented to the policies "Staff Competency Standards" and "Employee Annual Education and Competency" at a staff / unit meeting during the week of 2/18/13.</p> <p>2. The deficiency shall be prevented from happening in the future through QA audits of personnel files. Files shall be audited per the "Staff Competency Standards" policy to ensure annual urine HCG and blood glucose (Glucometer) testing competency assessments are performed per policy and documentation is filed in a timely manner, for clinical staff performing these tests. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy</p>	03/07/2013			

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	<p>a. under "Policy", it reads: "...5. Competency documentation shall be reviewed at the annual evaluation and shall describe the staff member's performance of required criteria...14. A list of competencies required of staff is attached."</p> <p>b. the attached "Employee Annual Education and Competency Grid" indicates the following disciplines are required to be competent for HCG and Glucometer testing: ASC (ambulatory surgery center) administrator; Supervisor; Infection control RN (registered nurse); OR (operating room) nurse, GI (gastro intestinal) nurse; Pre/Post nurse; surgical tech; medical assistant"</p> <p>3. review of personnel files for nursing and surgical techs P1 and P2, and P4 through P10 indicated a written exam, related to HCG and Blood glucose testing, was administered in 2012, but no skills were observed and checked off by supervisory staff to ensure demonstrated competency</p> <p>4. interview with staff member # 50 at 2:10 PM on 1/29/13 indicated:</p> <p>a. the facility previously did a skills checklist for competency demonstration for HCG and Blood glucose testing</p> <p>b. it is unknown when this changed to a written test in place of skills testing</p>		<p>wherever necessary.</p> <p>3. The ASC Supervisor shall be responsible for numbers 1 and 2 above.</p> <p>4. The deficiency shall be corrected by 3/7/13.</p>				

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	c. currently, the facility is not performing annual demonstration of competency related to HCG and Blood glucose testing			

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S000640	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to implement its policy related to legible and complete medical records for 9 of 20 records reviewed. (pts. # 1, 2, 6, 7, 10, 12, 14, 16, and 20)</p> <p>Findings:</p> <p>1. at 1:00 PM on 1/29/13, review of the policy and procedure "Medical Record Content and Requirements" with a last revision date of 11/2009, indicated:</p> <p>a. under "Policy", it reads: "A medical record shall be maintained for each patient, which is accurate, legible, complete and comprehensive..."</p> <p>b. under "Content", it reads: "Accurate and complete medical records are written for all patients;..."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. # 1 had a clinic note/history and physical by the physician which read: "Patient Instructions: 1) [pt] has doen well from his tonsiullectomy, He sdoes</p>	S000640	S640 1. The deficiency shall be corrected by re-orienting staff, physicians, and Allied Health professionals to the policies "Informed Consent" and "Medical Record Content and Requirements," with specific attention to missing or inaccurate documentation noted in the survey, as follows: spelling errors; missing documentation of date and/or time of authentication for Physical Examination, Procedure Risk Assessment, and Anesthesia Risk Assessment; inaccurate documentation of discharge status; missing allergies documentation on the Preoperative History & Physical form; missing procedure room number; missing RN authentication of Anesthesia Pre/Post-Operative Orders; missing documentation of anesthesia provider name and type of provider on Informed Consent for Anesthesia form; and missing PACU Arrival vital signs on the Anesthesia Record. Re-orientation to the policies shall be provided to the staff at a staff/unit meeting the week of	03/07/2013			

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	<p>have this bead in hsi ear that I advise we need to remove, I did try to remove in the office but was not successful, I discussed the options with his grandmother including removal in The OR, the risks, benefits, complications,...and need for further surgery all discussed..."</p> <p>b. pt. #2 lacked physician documentation of the time the physical examination and "Procedure Risk Assessment" were done (on the "Pre-operative History & Physical - Surgery" form)</p> <p>c. pt. # 6 lacked physician documentation of the time the physical examination and "Procedure Risk Assessment" were done (on the "Pre-operative History & Physical - Surgery" form)</p> <p>d. pt. # 7 lacked documentation of any allergies (or NKA--no known allergies) on the "Pre-op Record/Patient Physical" form (pt. had 7 allergies noted on the "Pre-op Interview and History" form)</p> <p>e. pt. #10 lacked physician documentation of the date and time of the physical examination and lacked a time with the dated authentication of the "Pre-Procedure Risk Assessment" that was done (on the "Pre-operative History & Physical - Surgery" form)</p> <p>f. pt. #12: A. lacked documentation of the room</p>		<p>2/18/13 and provided via email and in person to medical and AHP staff.</p> <p>2. The deficiency shall be prevented in the future by performing random QA audits of patient records to determine that entries are accurate, legible, complete, and comprehensive, as per policy. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy wherever necessary.</p> <p>3. The Administrator shall be responsible for numbers 1 and 2 above.</p> <p>4. The deficiency shall be corrected by 3/7/13.</p>				

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	<p>number (#1, 2, or Minor) the procedure was performed in (on the "Intra-Operative Nursing Record" form)</p> <p>B. lacked nursing signature and "date/time noted" of the "Anesthesia Pre and Post-op Orders"</p> <p>C. lacked documentation of the anesthesia provider and whether they were an "Anesthesiologist, Certified Registered Nurse Anesthetist, or an associated qualified anesthesia provider" on the "Informed Consent for Anesthesia" signed by the patient</p> <p>g. pt. #14 lacked documentation of the anesthesia provider and whether they were an "Anesthesiologist, Certified Registered Nurse Anesthetist, or an associated qualified anesthesia provider" on the "Informed Consent for Anesthesia" signed by the patient</p> <p>h. pt. #16 lacked documentation by the anesthesia provider of the time the "Anesthesia Risk Assessment" was performed (on the "Preoperative Patient Assessment" form)</p> <p>i. pt. #20 lacked completion of the "PACU (post anesthesia care unit) Arrival" vital signs (BP [blood pressure], P [pulse], RR [respiratory rate], and SaO2 [oxygen saturation])" on the "Anesthesia Record" form</p> <p>3. interview with staff members #50 and #53 at 2:10 PM on 1/29/13 and 3:10 PM</p>						

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	<p>on 1/30/13 indicated:</p> <ul style="list-style-type: none"> a. documentation is lacking in the medical records as listed in 2 above b. the clinic note by the physician on the medical record #1, should have been reviewed by medical records staff and sent to the physician for correction of errors to ensure legibility and correctness c. it was thought that the anesthesia provider for pt. #20 felt that vital signs needn't be documented if the endoscopy patient was transported to phase II recovery, and not phase I--even though other endoscopy patients did have that area of the "Anesthesia Record" form completed and this is the "practice and expectation" of the facility 				

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S000832	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(ii)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and postanesthesia as follows:</p> <p>(ii) The completion by the practitioner administering anesthesia of intra-operative anesthesia monitoring and notations, to include vital signs, on each patient in accordance with the center policy.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that the physical examination and/or pre procedure/anesthesia risk assessment was performed prior to the surgical procedure for 3 patients. (pts. # 2, 6 and 8)</p> <p>Findings: 1. at 1:00 PM on 1/29/13, review of the policy and procedure "Medical Record Content and Requirements", with a last "Revision Date" of 11/2009, indicated: a. on page 3 under the section "Authentication", it reads: "All entries in the medical record shall be dated, timed, and authenticated, in written or electronic</p>	S000832	<p>S832</p> <p>1. The deficiency shall be corrected by re-orienting staff, physicians, and Allied Health professionals to the policy "Medical Record Content and Requirements," with specific attention to missing documentation noted in the survey: consistent documentation of the time of authentication for Pre-operative History & Physical: Physical Examination and Procedure/Anesthesia Risk Assessment, to ensure it is evident that those elements were performed prior to the surgical procedure. Re-orientation to the policy shall be provided to the staff at a staff/unit meeting the week of 2/18/13 and provided via</p>	03/07/2013			

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	<p>form, by the person responsible for providing or ordering the service provided..."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. #2 had a "Pre-operative History & Physical - Surgery" form in which the physician signed and dated (3/21/12) the "Physical Examination" section and the "Procedure/Anesthesia Risk Assessment" section, but failed to write the time of these entries making it impossible to determine if they were performed prior to the surgical procedure</p> <p>b. pt. #6 had a "Pre-operative History & Physical - Surgery" form in which the physician signed and dated (10/9/12) the "Physical Examination" section and the "Procedure/Anesthesia Risk Assessment" section, but failed to write the time of these entries making it impossible to determine if they were performed prior to the surgical procedure</p> <p>c. pt. #8 had a "Pre-operative History & Physical - Surgery" form in which the physician failed to sign, date, or time the "Physical Examination" section that was completed and failed to enter a time of the "Procedure/Anesthesia Risk Assessment" done on 12/6/12, making it impossible to determine if these were performed prior to the surgical procedure</p>		<p>email and in person to medical and AHP staff.</p> <p>2. The deficiency shall be prevented in the future by performing random QA audits of patient records to determine that entries are dated, timed, and authenticated as per policy. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy wherever necessary.</p> <p>3. The Administrator shall be responsible for numbers 1 and 2 above.</p> <p>4. The deficiency shall be corrected by 3/7/13.</p>		

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	<p>3. interview with staff member #50 at 4:45 PM on 1/28/13 indicated:</p> <p>a. the patient records for #2, 6, and 8 were lacking documentation as listed in 2. above</p> <p>b. it is very difficult to get the physicians to date and time entries in the medical record</p>			

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S001146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</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>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and staff interview, the facility failed to ensure that no condition was created that might result in a hazard/ill health to employees as related to the staff lounge refrigerator and microwave.</p> <p>Findings: 1. at 1:20 PM on 1/29/13, it was observed in the staff lounge that the: a. refrigerator was dirty (crumbs and food debris) under the vegetable drawers and in the bottom of the refrigerator b. microwave was splattered with various food/liquid debris</p> <p>2. interview with staff member #50 at 2:10 PM on 1/29/13 indicated: a. there is no policy related to cleaning employee appliances b. housekeeping used to clean the staff</p>	S001146	<p>S1146</p> <p>1. The policy "Staff Lounge Use" was developed and approved 2/15/13 to include a process for ensuring that no conditions are created which could result in hazards or ill health to employees. The deficiency shall be corrected by orienting staff to the policy with specific attention to deficiencies noted in the survey: crumbs and food debris present in the refrigerator and microwave in the Staff Lounge. Orientation to the policy shall be provided to the staff at a staff/unit meeting the week of 2/18/13. The supervisor shall develop a rotating schedule for staff assigned to clean the lounge microwave. Housekeeping staff shall clean the refrigerator on a weekly basis. Temperature of the lounge refrigerator shall be monitored by staff each day the center is open/operating.</p>	03/07/2013

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	lounge appliances, but staff are to accomplish this now c. the cleaning of the refrigerator and microwave are not on a cleaning schedule or log		2. The deficiency shall be prevented in the future through compliance with the Staff Lounge Use policy and audited through performance of random Infection Control surveys, observation, and documentation audits. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy wherever necessary. 3. The Supervisor and Infection Control Coordinator shall be responsible for numbers 1 and 2 above. 4. The deficiency shall be corrected by 3/7/13.		

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S001182	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based upon document review and interview, the safety program failed to assure that information about hazards and safety practices were reviewed by the committee for periodic safety hazard surveillance rounding and for 3 of 4 fire drills performed in 2012.</p> <p>Findings:</p> <p>1. The policy/procedure Life Safety Management (approved 4-11) indicated the following: " The Safety and Security Committee shall meet quarterly or sooner when necessary to review life safety activities...[and] ...the following indicators shall be utilized in the evaluation of life safety performance: Number of fire drills conducted (quarterly) ...Evaluation of drills." The policy/procedure failed to indicate a process for the ongoing collection and reporting of information about hazards in</p>	S001182	<p>S1182</p> <p>1. The policy "Safety Management Plan" was updated and approved 2/15/13 to include a process for periodic safety hazard surveillance rounding. The deficiency shall be corrected by re-orienting staff to the policy with specific attention to missing documentation noted in the survey: no indication of a process for ongoing collection and reporting information on hazards in the workplace, no documentation of review of 3 of 4 fire drills conducted. Re-orientation to the policy shall be provided to the staff at a staff/unit meeting the week of 2/18/13.</p> <p>2. The deficiency shall be prevented in the future through compliance with the Safety Management Plan and by performing random QA audits of records to determine that environmental rounds are conducted, information on hazards in the workplace are</p>	03/07/2013	

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	<p>the workplace.</p> <p>2. The Safety/Security minutes dated 5-09-12 indicated that a fire drill was conducted on 5-02-12. Committee minutes dated 1-11, 6-13, 9-05, 10-31, and 12-12 failed to indicate that the safety committee reviewed any additional fire drills conducted at the center in 2011 or 2012. The 2012 committee minutes lacked documentation of periodic safety hazard surveillance.</p> <p>3. During an interview on 1-30-13 at 1400 hours, staff A1 confirmed that the meeting minutes lacked documentation of fire drill review and hazard surveillance by the safety committee.</p>		<p>reported, reviewed, and acted upon, and that all drills are reviewed through the committee as per policy. Deficiencies shall be noted and corrected; individuals shall be re-educated on the policy wherever necessary. Activities of the Safety steering committee shall be reported to the Medical Advisory Committee and the Board of Managers per policy.</p> <p>3. The Administrator shall be responsible for numbers 1 and 2 above.</p> <p>4. The deficiency shall be corrected by 3/7/13.</p>		