

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001026	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/19/2013
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW SURGERYONE	STREET ADDRESS, CITY, STATE, ZIP CODE 11420 PARKVIEW CIRCLE FORT WAYNE, IN 46845
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005407</p> <p>Survey Date: 2/18/2013 through 2/19/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/25/13</p>	S000000		

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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S000010	<p>410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a)</p> <p>Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules.</p> <p>Based on document review, the facility failed to comply with all applicable State laws for 1 of 1 unlicensed/non-certified surgical technician's employee file that was reviewed.</p> <p>Findings include:</p> <p>1. IC 16-28-13-4: a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of employee #16's employee file indicated that he/she</p>	S000010	<p>Parkview SurgeryONE updated the pre-hiring process for staff who provide direct patient care who are unlicensed or uncertified to provide for obtaining a copy of the person's state nurse aide registry report. Employee files were reviewed and a copy of the employee's IN state nurse aid registry report for all unlicensed staff with direct patient care was obtained on 3/1/2013. These reports were placed in the the appropriate personnel file with the criminal history report that was previously obtained upon hire. No negative reports were found for any of the staff members. The Board of Managers were advised of the change in process on 2/22/2013 and the Medical Staff was informed on 2/22/2013. Prevention: The COO has delegated the responsibility of running this report to the Human Resources administrator and it has become a mandatory part of the hiring process. Responisble Party: Board of Managers, COO and Director of Operations</p>	03/01/2013	

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	<p>was hired on 2/22/2010 as a surgical tech and the employee's file lacked documentation of a nurse aide registry report. The surgical tech was not certified.</p> <p>3. At 1:15 PM on 2/21/2013, staff member #1 indicated he/she was unaware that a State nurse aide registry report was to be run on all unlicensed and non-certified health care personnel that have direct patient contact.</p>			

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S000162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on document review and staff interview, the facility failed to ensure health care professionals on the anesthesia team were certified in Pediatric Advanced Life Support (PALS) as per policy for 2 of 2 Anesthesiologists and 1 of 2 CRNAs.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Appropriate Patients for Surgery policy (Last reviewed 1/2012) states, "Members of the Anesthesia team and the nursing staff are trained in ACLS and PALS."</li> <li>Credential files were reviewed</li> </ol>	S000162	<p>All policies pertaining to ACLS and PALS certification for members of the medical and nursing staffs were reviewed and revised to more accurately reflect the practice at the center. On 2/22/2013, personnel files for RNs working in PACU were reviewed and it was verified that all RNs in this area hold current certifications in ACLS and PALS. On 2/22/2013, credentials files for anesthesia providers were reviewed and those who did not show evidence of ACLS and PALS certification were contacted and asked to produce evidence of certification. Appropriate evidence of certifications were obtained and placed in the Credentials files for all anesthesia providers. The Board of Managers were advised on 2/22/2013 and the Medical Staff was advised at their quarterly meeting on 3/7/2013. Prevention:</p>	03/08/2013			

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	<p>for physicians and allied health care workers. Anesthesiologists staff members #17 and #18 and CRNA staff member #19 files lacked evidence of a PALS certification.</p> <p>3. At 2:45 PM on 2/18/2013, staff member #1 indicated the facility accepts patients as young as 4-years old. The staff member confirmed that staff members #17, #18, and #19 did not have a PALS certification.</p>		<p>The Board of Managers delegated ongoing responsibility for credentialing and maintenance of documentation to the Credentials Committee. The Medical Staff clerk will maintain an expiration log and notify staff members of the need to renew certifications 3 months prior to expiration. Medical staff will take appropriate disciplinary action for noncompliance. Responsible Party: Board of Managers, COO, Credentials Committee, Director of Operations</p>		

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S000230	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and staff interview, the facility failed to ensure a peer review of physicians by three or more licensed physicians having no financial interest in the facility.</p> <p>Findings included:</p> <p>1. Peer and Utilization Review Plan composition (adopted November 2012) states, "The Peer and Utilization Review function is conducted by a committee consisting of at least three physicians, the Medical Director, the ASC Director and the</p>	S000230	<p>On 2/22/2013, the Board of Managers determined that the center's bylaws provide that only licensed physicians having no financial interest in the center will perform peer review of physician charts. These physicians will forward their findings and recommendations to the Medical Director, any appropriate Medical Staff committee and/or the Board of Managers as appropriate. The Medical Staff was advised at their quarterly meeting on 3/7/2013.</p> <p>Prevention: The Board of Managers, COO and the Director of Operations have reviewed the membership of the Peer Review Committee to ensure that no physician with financial interest takes part in chart review of the medical staff. Responsible Party: Board of Managers, COO and Director of Operations.</p>	02/22/2013			

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	<p>Administrative Supervisor. Peer and utilization review decisions are made only by the licensed physicians of the committee. The physicians on the committee shall not have any financial interest in SurgeryONE nor are they directly responsible for the care of the patients they are reviewing."</p> <p>2. The Peer Review and Utilization committee meeting minutes were reviewed. The Medical Director of the surgery center was part owner of the facility; therefore, the Medical Director has financial interest in the facility. Fourth Quarter 2012 SurgeryONE Peer Review/Utilization Committee meeting minutes noted the Medical Director was a participating member.</p> <p>3. At 11:00 AM on 2/19/2013, staff member #1 indicated the Medical Director does review peer review physician charts for Parkview SurgeryONE Surgery Center.</p>			



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S000432	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, interview, policy and procedure review, and manufacturer's directions, the infection control committee failed to ensure the appropriate rinsing procedures for high level disinfection of instruments were followed.</p> <p>Findings included:</p> <p>1. During the tour of the facility at 11:05 AM on 02/19/13, accompanied by staff members #P1, P8, and P13, a covered container of Metricide 28 on a counter next to a sink was observed in the OR soiled utility room. Staff member #P8 indicated some instruments such as laryngoscope blades were soaked in the solution for 90 minutes, rinsed with tap water at the sink, then wrapped and stored.</p> <p>2. The facility policy "Anesthesia Intubation Equipment Cleaning", last reviewed 11/2011, and posted on the wall in the utility room, indicated, "1. After use in the O.R., the anesthesia equipment such as laryngoscope blades, circuit connector sensors, or stylets will be placed in an enzymatic pre-soak solution. ...3. The equipment</p>	S000432	On 2/20/2013, the policy on "Anesthesia Intubation Equipment Cleaning" was updated to reflect manufacturer's instructions to rinse equipment disinfected with Metricide 28 in three separate copious volumes of sterile water. On 2/22/2013, the Director of Anesthesia was informed of the update and he informed the Anesthesia Staff of the update. Over the following week, the Infection Preventionist met with all staff who participate in cleaning anesthesia intubation equipment to ensure their knowledge of the change. In addition, a copy of the revised policy and procedure was placed in a prominent location in the soiled utility room for review. The Parkview SurgeryONE staff meeting on 2/25/13 provided for review of the changes to all staff. The Board of Managers was advised on 2/22/2013 and the	03/07/2013			

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	<p>will then be placed in a cold Sterilant solution for 90 minutes at 25 degrees C. or as designated by manufacturer. 4. After high level disinfection has taken place, the equipment will be removed from the cold sterilant and rinsed with water. 5. Laryngoscope blades will be placed in a peel package and stored appropriately."</p> <p>3. The manufacturer's directions for Metricide 28 indicated, "c) Rinsing Instructions: Following immersion in Metricide 28 solution, thoroughly rinse the equipment or medical device by immersing it completely in three separate copious volumes of water. Each rinse should be a minimum of one minute in duration unless otherwise noted by the device or equipment manufacturer. Use fresh portions of water for each rinse. Discard the water following each rinse. Do not reuse the water for rinsing or any other purpose, as it will be contaminated with glutaraldehyde. ...Sterile Water Rinse: The following devices should be rinsed with sterile water, using sterile technique when rinsing and handling. ...3. When practicable, bronchoscopes, due to a risk of atypical Mycobacteria contamination from potable water supply. Potable Water Rinse: For all other devices a sterile water rinse is recommended when practicable, otherwise a high-quality potable tap water rinse is acceptable. ...When using potable water for rinsing, the user should be aware of the increased risk of recontaminating the device or medical equipment with Pseudomonas and atypical Mycobacteria often present in potable water supplies."</p> <p>4. At 11:40 AM on 02/19/13, staff members #P1 and P8 confirmed there were no other facility policies regarding the use of the Metricide and confirmed the manufacturer's directions were not being followed.</p>		<p>Medical staff was advised at their quarterly meeting on 3/7/2013. Prevention: The Infection Preventionist will monitor the cleaning of anesthesia intubation equipment for one month. Appropriate disciplinary action will be taken for noncompliance. Responsible Party: Board of Managers, COO, Director of Operations, Infection Preventionist</p>				

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S001024	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)</p> <p>Pharmaceutical service 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>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>Based on observation, interview, and policy review, the facility failed to ensure syringes of medication were labeled according to policy and standard of practice.</p> <p>Findings included:</p> <p>1. During the tour of the surgical area at 8:40 AM on 02/19/13 with staff member #P1, a plastic basket containing two syringes of a white solution and two syringes of a clear solution were observed in the narcotic cabinet. The syringes of white solution were labeled "Propofol 10 mg./ml." and the syringes with clear solution were labeled "Marcaine with Epi". While the cabinet was open, staff member #P12 took the basket with medications to another counter and proceeded to draw up some additional medications into some syringes. He/she indicated the medications had been pre-drawn by him/her, but he/she was now drawing the narcotic medications into the syringes prior to the procedure.</p>	S001024	<p>Policy on "Medication Control and Accountability: was reviewed and deemed to be appropriate by the Board of Managers on 2/22/2013. The Director of Anesthesia was consulted and a directive was sent to the Anesthesia staff to comply with the center's policy on 2/22/2013. Proper labeling of medications was reviewed with the medical and nursing staffs at the Parkview SurgeryONE satt meeting on 2/26/2013 and the Medical Staff meeting on 3/7/2013. On 3/8/2013, labels were ordered that have spaces for time, initials, medication name, strength and expiration of drawn medications. Prevention: The Infection Preventionist will observe the labeling of medications for 1 month. She will report any instances of</p>	03/08/2013	

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	<p>2. During the case observation at 9:50 AM on 02/19/13, staff member #P11 brought a plastic basket containing a syringe of white solution labeled "Propofol 10 mg./ml." along with the vial of the medication into the operating room and placed it on the anesthesia machine. Staff member #P11 used the syringe of medication for the patient several times during the procedure, connecting it to the intravenous tubing and returning it to the basket.</p> <p>3. The facility policy "Medication Control and Accountability", last revised 12/ 2010, indicated, "3. Labeling: ...c. Medication drawn into a syringe that is not immediately used must be labeled with drug, dosage, date, time and initials of the person preparing the medication."</p> <p>4. Standard of practice for medications that are pre-drawn is to label the syringes with time of draw, initials of the person drawing, medication name, strength and expiration date or time.</p> <p>5. At 2:00 PM on 02/19/13, staff member #P1 confirmed the syringes weren't labeled according to facility policy and standard of practice.</p>		<p>noncompliance to the center's policy to the Director of Operations, who will follow up with re-education. If noncompliance continues, appropriate disciplinary action will occur. Responsible Party: Board of Managers, COO, Director of Operations, Infection Preventionist</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, manufacturer's directions, and interview, the facility failed to ensure a safe working environment for staff cleaning instruments in the surgical area.</p> <p>Findings included:</p> <p>1. During the tour of the facility at 11:05 AM on 02/19/13, accompanied by staff members #P1, P8, and P13, two chemicals, Empower Enzymatic Cleaner and Metricide 28, were observed for use in the OR soiled utility room. No eye protection or eye wash station were observed in the room.</p> <p>2. Manufacturer's label directions on both chemicals indicated eye protection should be worn and eyes should be flushed for at least 15 minutes if any contact or splashing occurred. Directions also indicated medical attention should be sought for any chemical in the eyes.</p> <p>3. At 11:15 AM on 02/19/13, staff members #P8 and P13 indicated one eye wash station was greater than 50 feet away and through four doorways and the other would have to be accessed</p>	S001146	<p>On 2/20/2013, eye protection in the form of goggles were placed in the soiled utility room where equipment is cleaned with Empower enzymatic cleaner and Metricide 28. Nursing and medical staff were educated at the 2/26/2013 Parkview SurgeryONE staff meeting and the 3/7/2013 Medical staff meeting on the proper use of eye protection. In addition, an eye wash station was purchased on 3/4/2013 for installation at a sink within 10 feet of the soiled utility room. Installation of the eye wash station will be completed by 3/15/2013. The Board of Managers were advised on 2/22/2013 and the Medical Staff on 3/8/2013. Prevention: Goggles are located in the soiled utility room and the eye wash station installation will be complete by 3/15/2013. The Infection Preventionist and Safety</p>	03/15/2013			

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	by walking through an operating suite and two doorways. Both confirmed there would not be easy access to an eye wash station if a staff member had difficulty with vision because of chemical contact.		Officer will perform random checks of the use of eye protection and report noncompliance to the Director of Operations. Re-education will be performed. If noncompliance continues, appropriate disciplinary action will occur. Responsible Party: Board of Managers, COO, Director of Operations, Infection Preventionist and Safety Officer	