

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2013
NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514		
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Q0000	<p>The visit was for a re-certification survey.</p> <p>Facility Number: 009555</p> <p>Survey Date: 2-04-13 to 2-06-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/13/13</p>	O0000			

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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Q0106	<p>416.44(d) EMERGENCY PERSONNEL Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC. Based on policy and procedure review, personnel file review, and staff interview, the facility failed to implement its policy related to competency in BLS (basic life support), ACLS (advanced cardiac life support), and PALS (pediatric advanced life support) for 2 (staff members P2 and P7) of 5 pre/post RNs (registered nurses).</p> <p>Findings:</p> <p>1. at 10:00 AM on 2/6/13, review of the policy and procedure "Orientation of New Personnel", policy number ASC-AD-112, with a most recent review date of August 2012, indicated:</p> <p>a. under "Procedure", in the second paragraph, it reads: "...Registered Nurses will be expected to complete BLS, ACLS within 90 days if not current upon hire; PALS will be required for RN's that are cross-trained to work in PACU (post anesthesia care unit) within 90 days if not current upon hire..."</p> <p>2. review of employee files indicated:</p> <p>a. staff member P2 was a pre/post RN hired 11/10/11 who had documentation that:</p> <p>A. their CPR (cardiopulmonary</p>	00106	Policy ASC-AD-112 has been changed to reflect the following: "Registered Nurses will be expected to complete BLS and ACLS within 6 months if not current upon hire; PALS will be required for RN's that are cross trained to work in PACU within 6 months if not current upon hire". This policy will be presented at the February 27, 2013 Board Meeting for their approval. Staff member P2: (PRN, RN) will not be scheduled to work until she successfully completes BLS and ACLS. PRN RN's are not cross trained to PACU at our facility, thus PALS certification is not a requirement for PRN RN's. Staff member P7 will not be assigned to pediatric PACU patients until she successfully completes PALS in March of 2013. The ASC Director will be responsible for assuring this does not occur in the future.	02/27/2013			

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	<p>resuscitation) had expired 10/12</p> <p>B. there was no documentation of ACLS competency/certification</p> <p>b. staff member P7 was a pre/post RN hired 7/25/12 who lacked documentation of PALS competency/certification</p> <p>3. interview with staff member #50, the facility administrator, at 3:30 PM on 2/6/13, indicated:</p> <p>a. staff member P2 has expired for both CPR and ACLS</p> <p>b. this staff member doesn't think that staff member P2 has worked since the expiration of both the CPR and the ACLS</p> <p>c. staff member P7 is beyond the 90 day requirement for PALS certification, as required by policy</p>			

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Q0202	<p>416.49(b) RADIOLOGIC SERVICES</p> <p>(1) The ASC must have procedures for obtaining radiological services from a Medicare approved facility to meet the needs of patients.</p> <p>Based on document review, observation and interview, the center failed to ensure that safety precautions were maintained against radiation hazards for patients and staff.</p> <p>Findings:</p> <p>1. The policy/procedures Radiation Safety (approved 12-12) failed to indicate the following:</p> <p>A. approved locations or recommendations for proper storage of radiation monitoring badges when not in use</p> <p>B. a requirement for pregnant personnel to wear a second radiation monitoring badge at waist level inside the lead shielding in areas where radiation exposure is anticipated or radiology equipment is in use</p> <p>C. a requirement for screening all female patients of child bearing age to determine the possibility of pregnancy and risk of fetal exposure to ionizing radiation.</p> <p>2. During a tour on 2-05-13 at 1140 hours, the following condition was observed with staff A2 in Operating</p>	O0202	<p>The Radiation Safety policy ASC-SA-110 has been changed to include "All female patients of child bearing age will be screened to determine the possibility of pregnancy", and "Pregnant personnel will wear two radiation monitoring badges: one outside the collar of the lead apron and one at the waist inside the lead apron. Badges will be read monthly for pregnant personnel." Every effort is made not to assign a pregnant employee to procedures/surgeries involving ionizing radiation. The policy now includes parameters for proper storage of the Landauer Badges when not being worn. All female patients of child bearing age are screened as indicated in policy ASC-CL-113 "Pregnancy Screening Policy". The updated Radiation Safety Policy will be presented to the Board for their approval on February 27, 2013. The proper radiation safety practices have been reviewed with the ASC staff, contracted anesthesia providers and surgeons. ASC female employees are aware that they are to report if they are pregnant. The Pre-post Lead and the OR lead are responsible for monitoring the compliance of</p>	02/27/2013

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	<p>Room #2: storage of a radiation monitoring badge above the circulating nurse ' s writing tabletop in the area where radiologic equipment was available for immediate use.</p> <p>3. During an interview on 2-08-13 at 1320 hours, staff A2 confirmed that the policy/procedure lacked the indicated safety provisions and that the monitoring badge was improperly stored in the OR room.</p>		<p>their respective staff. The ASC Director will be responsible for the oversight of the adherence of the use of proper lead apparel by ASC staff, contracted anesthesia providers and the physicians.</p>	

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Q0221	<p>416.50(a)(1) NOTICE OF RIGHTS</p> <p>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.</p> <p>Based on patient medical record review, and staff interview, it cannot be determined that the facility ensured the disclosure to patients of their rights prior to their procedure for 4 of 15 patients (pts. # 4, 8, 11 and 12).</p> <p>Findings:</p> <p>1. review of patient medical records indicated:</p> <p>a. pts. #4 and #12 lacked the form titled: "Patient Acknowledgement" (in which the patient checks off the boxes for acknowledgement of patient's rights, physician's financial disclosure, and advance directives, indicating they received this information prior to their procedure)</p> <p>b. pts # 8 and 11 had the "Patient Acknowledgement" form, but lacked the checking of any of the boxes making it unclear if the information had been given to the patient, or not</p> <p>2. interview with staff member # 50, the facility director, at 4:15 PM on 2/6/13 indicated:</p>	O0221	<p>Policy "Notice of Rights" ASC-CL-113 was created to delineate the formal process of how patients are informed of their rights: the information to be distributed to the patient at time of scheduling; or at the ASC Receptionist area for same day add-on's. The ASC Receptionist is responsible for assuring that the patient has been informed of their rights, to include patient right's, prior to the patient being taken to pre-op. This information is documented on a "Patient Acknowledgment Form" which is to be signed by the patient stating that they received: patient rights; physician financial disclosures, advance directive information (and exercise that right if they elect to); and grievance contact information. The ASC Receptionist is accountable for assuring all documentation is complete and signed by the patient, prior to scanning it into the electronic health record. This policy will be presented to the Board on February 27, 2013 for their approval. This process will checked for compliance through chart audits. The ASC Director is</p>	02/27/2013			

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	<p>a. there is no policy that addresses how patients are to receive their rights/what the process is</p> <p>b. there is no "Patient Acknowledgement" form for patients #8 and 11</p> <p>c. the "Patient Acknowledgement" forms for patients # 4 and 12 are not completed</p> <p>d. it cannot be determined that patients #4, 8, 11 and 12 received the patient rights information prior to their surgical procedures</p> <p>e. the process is for the information to be handed out at the clinic, when the surgical procedure is scheduled, and signed at that time</p> <p>f. the facility registration clerk it so be sure the "Patient Acknowledgement" form is present, completed, and signed by the patient upon presentation to the front desk on the day of the procedure</p> <p>g. accountability lies with the front desk registration staff</p>		responsible for the ongoing compliance.		

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Q0223	<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.</p> <p>Based on patient medical record review, and staff interview, it cannot be determined that the facility ensured the disclosure to patients of physician financial interest prior to their procedure for 4 of 15 patients (pts. # 4, 8, 11 and 12).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. review of patient medical records indicated: <ol style="list-style-type: none"> a. pts. #4 and #12 lacked the form titled: "Patient Acknowledgement" (in which the patient checks off the boxes for acknowledgement of patient's rights, physicians financial disclosure, and advance directives indicating they received this information prior to their procedure) b. pts # 8 and 11 had the "Patient Acknowledgement" form, but lacked the checking of any of the boxes making it unclear if the information had been given to the patient, or not 2. interview with staff member # 50, the facility director, at 4:15 PM on 2/6/13 	Q0223	<p>Policy "Notice of Rights" ASC-CL-113 was created to delineate the formal process of how patients are informed of their rights: the information to be distributed to the patient at time of scheduling; or at the ASC Receptionist area for same day add-on's. The ASC Receptionist is responsible for assuring that the patient has been informed of their rights, to include physician's financial disclosure, prior to the patient being taken to pre-op. This information is documented on a "Patient Acknowledgment Form" which is to be signed by the patient stating that they received: patient rights; physician financial disclosures, advance directive information (and exercise that right if they elect to); and grievance contact information. The ASC Receptionist is accountable for assuring all documentation is complete and signed by the patient, prior to scanning it into the electronic health record. This policy will be presented to the Board on February 27, 2013 for their approval. This process will checked for compliance through</p>	02/27/2013			

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	<p>indicated:</p> <ul style="list-style-type: none"> a. there is no policy that addresses how patients are to receive their rights related to physician financial interest b. there is no "Patient Acknowledgement" form for patients #8 and 11 c. the "Patient Acknowledgement" forms for patients # 4 and 12 are not completed d. it cannot be determined that patients #4, 8, 11 and 12 received the patient rights information prior to their surgical procedures e. the process is for the information to be handed out at the clinic and signed at that time f. the facility registration clerk it so be sure the "Patient Acknowledgement" form is present, completed, and signed by the patient upon presentation to the front desk on the day of the procedure g. accountability lies with the front desk registration staff 		<p>chart audits. The ASC Director is responsible for the ongoing compliance.</p>		

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Q0224	<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 patient medical record review, and staff interview, it cannot be determined that the facility ensured the disclosure to patients of their rights related to advance directives prior to their procedure for 4 of 15 patients (pts. # 4, 8, 11 and 12).</p> <p>Findings: 1. review of patient medical records indicated: a. pts. #4 and #12 lacked the form titled: "Patient Acknowledgement" (in which the patient checks off the boxes for acknowledgement of patient's rights, physicians financial disclosure, and advance directives indicating they received this information prior to their</p>	O0224	Policy "Notice of Rights" ASC-CL-113 was created to delineate the formal process of how patients are informed of their rights: the information to be distributed to the patient at time of scheduling; or at the ASC Receptionist area for same day add-on's. The ASC Receptionist is responsible for assuring that the patient has been informed of their rights, to include advance directives, prior to the patient being taken to pre-op. This information is documented on a "Patient Acknowledgment Form" which is to be signed by the patient stating that they received: patient rights; physician financial disclosures, advance directive information (and exercise that right if they elect to); and	02/27/2013			

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	<p>procedure)</p> <p>b. pts # 8 and 11 had the "Patient Acknowledgement" form, but lacked the checking of any of the boxes making it unclear if the information had been given to the patient, or not</p> <p>2. interview with staff member # 50, the facility director, at 4:15 PM on 2/6/13 indicated:</p> <p>a. there is no policy that addresses the process for patients to receive their rights related to advance directives</p> <p>b. there is no "Patient Acknowledgement" form for patients #8 and 11</p> <p>c. the "Patient Acknowledgement" forms for patients # 4 and 12 are not completed</p> <p>d. it cannot be determined that patients #4, 8, 11 and 12 received the patient rights information prior to their surgical procedures</p> <p>e. the process is for the information to be handed out at the clinic and signed at that time</p> <p>f. the facility registration clerk it so be sure the "Patient Acknowledgement" form is present, completed, and signed by the patient upon presentation to the front desk on the day of the procedure</p> <p>g. accountability lies with the front desk registration staff</p>		<p>grievance contact information. The ASC Receptionist is accountable for assuring all documentation is complete and signed by the patient, prior to scanning it into the electronic health record. This policy will be presented to the Board on February 27, 2013 for their approval. This process will be checked for compliance through chart audits. The ASC Director is responsible for the ongoing compliance.</p>	

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Q0226	<p>416.50(a)(3)(ii), (iii), (iv) GRIEVANCES - MISTREATMENT, ABUSE, NEGLECT (ii) All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented. (iii) All allegations must be immediately reported to a person in authority in the ASC. (iv) Only substantiated allegations must be reported to the State authority or the local authority, or both.</p> <p>Based on document review and interview, the center failed to ensure that all allegations of abuse, neglect, or mistreatment which are alleged to have occurred at the center will be fully documented, immediately reported to the responsible person at the center and reported to the State and/or a local authority if authenticated.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 2-04-13 at 1230 hours, staff A1 was requested to provide a policy/procedure indicating a center action in response to an observation or allegation of patient abuse, neglect or mistreatment and none was provided prior to exit. The policy/procedure Patient Complaint and Grievance Reporting Policy (approved 12-12) failed to indicate a process for responding to allegations 	Q0226	<p>Policy ASC-AD-117 "Patient/Visitor Complaint and Grievance Reporting Policy was updated to reflect the following additions: "Staff" has been added to the title of the policy: "Patient/Visitor/Staff Complaint..". In addition, "allegations of abuse in any form will be reported and acted upon immediately" was added to the policy. The types of abuse included in the policy are: mistreatment, neglect, verbal, mental, sexual or physical abuse... The policy defines that any nature of abuse be reported immediately to their supervisor or director for immediate investigation; reporting of any substantial allegations meeting the ISDH National Quality Forums 28 Serious Adverse Reportable Events according to State Guidelines.Policy ASC-CL-119 Medical Errors Reporting contained under item #27 "sexual assault on a patient". This policy was reviewed by the surveyor during the survey</p>	02/27/2013			

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	<p>involving mistreatment, neglect, verbal, mental, sexual, or physical abuse alleged to have occurred at the center.</p> <p>3. During an interview on 2-08-13 at 1245 hours, staff A1 confirmed that the center lacked a policy/procedure for responding to allegations of abuse, neglect, or mistreatment.</p>		<p>process. The updated policy will be presented to the Board for their approval on February 27, 2013. The ASC Director or any member of management will respond to allegations of abuse, neglect or mistreatment. This allows ASC staff to have a mechanism in place if they believe they have been mistreated by the ASC Director.</p>		

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Q0232	<p>416.50(c)(2) SAFETY [The patient has the right to -] Receive care in a safe setting</p> <p>Based on document review and interview, the center failed ensure that the patient or the patient's representative were properly notified of the patient right to receive care in a safe setting.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Patient Bill of Rights (approved 12-12) and written notice of the Patient Bill of Rights provided to the patient failed to indicate the patient right to receive care in a safe setting. 2. During an interview on 2-06-13 at 1300 hours, staff A1 confirmed that the policy/procedure and written notice lacked the patient rights provision. 	Q0232	<p>The Patient's Bill of Rights Policy, ASC-CL-100, and Patient Bill of Rights postings were updated to reflect: "The patient has a right to receive care in a safe setting". This updated policy will be presented to the Board for their approval on February 27, 2013. ASC Director, the ASC staff and physicians are responsible for this provision.</p>	02/27/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2013	
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Q0242	<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, and staff interview, the infection control committee failed to implement its policy related to Varicella immunity for 2 (staff members P2 and P7) of 5 pre/post RNs (registered nurses).</p> <p>Findings:</p> <p>1. at 10:00 AM on 2/6/13, review of the policy and procedure "Orientation of New Personnel", policy number ASC-AD-112, with a review date of August 2012, indicated:</p> <p>a. under "Procedure", in the second paragraph, it reads: "...Titers will be drawn for Hep. B, Varicella, Rubeola, and Rubella as appropriate..."</p> <p>2. review of employee health files indicated:</p> <p>a. staff member P2 was a pre/post RN hired 11/10/11 who had self reported a history of the disease of Varicella</p> <p>b. staff member P7 was a pre/post RN</p>	00242	Policy ASC-AD-112 "Orientation of New Personnel" has been changed to reflect the following: Titers will be drawn for Hep. B, Varicella, Rubeola, and Rubella on all new personnel who do not have documentation by either previous titer, or medical history signed by their physician documenting history of the disease". This policy will be presented at the Board Meeting on February 27, 2013 for their approval. Titers for Varicella will be drawn on staff members P2 and P7 and recorded in their employee health file. The Human Resource Director will be responsible for tracking new hire documentation pertaining to communicable disease history.	02/27/2013			

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	<p>hired 7/25/12 who had self reported a history of the disease of Varicella</p> <p>3. at 4:05 PM on 2/5/13, interview with staff member #50, the facility director, indicated:</p> <p>a. both staff members P2 and P7 self reported their childhood history of disease for Varicella</p> <p>b. facility policy is not clear as to what "as appropriate" means, but the impression is that a titer be drawn for proof of Varicella immunity if the employee cannot provide such proof</p>			

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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 009555</p> <p>Survey Date: 2-04-13 to 2-06-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/13/13</p>	S0000			

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S0110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the governing board failed to follow its By-Laws and perform a quarterly review of the center quality assessment (QA) program for 1 of 4 quarters in 2012.</p> <p>Findings:</p> <p>1. The Governing Body By-Laws (revised 8-21-12) indicated the following: " Review at least quarterly reports of ASC operations, quality improvement matters, scope of patient care provided, results, recommendations, actions, follow-up and any legal or ethical matters concerning the ASC and its staff. "</p> <p>2. Governing board minutes failed to indicate that the governing board held a meeting in the 2rd quarter of 2012 and failed to indicate that the quarterly Utilization Review/Quality Assurance</p>	S0110	<p>The Governing Board of OSMC Outpatient Surgery Center met on nine occasions in 2012 to include the months of Febrauary, March, May, July, August, September, October, November and December; contrary to item #2 under the findings for S110. However the February 8, 2012 UR/QA Committee Meeting Minutes were inadvertently omitted from inclusion in the March 19, 2012 Board Meeting. This was an oversight and nothing more. The February UR/QA occurred consistent with our normal schedule and those meeting minutes are being presented to the Board of Directors at the next scheduled meeting on February 27, 2013. A tickler file has been put into place to insure that this oversight does not occur in the future. Don Hammond, the CEO, will be responsible for this matter.</p>	02/27/2013	

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	<p>(UR/QA) meeting dated 2-08-12 was reviewed by the board.</p> <p>3. During an interview on 2-07-13 at 1335 hours, staff A2 confirmed that the governing board failed to meet between March and July 2012 and confirmed that the governing board failed to review the 2-08-12 UR/QA quarterly report of management operations.</p>			

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S0162	<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 policy and procedure review, personnel file review, and staff interview, the facility failed to implement its policy related to competency in BLS (basic life support), ACLS (advanced cardiac life support), and PALS (pediatric advanced life support) for 2 (staff members P2 and P7) of 5 pre/post RNs (registered nurses).</p> <p>Findings: 1. at 10:00 AM on 2/6/13, review of the policy and procedure "Orientation of New Personnel", policy number ASC-AD-112, with a most recent review date of August 2012, indicated: a. under "Procedure", in the second paragraph, it reads: "...Registered Nurses will be expected to complete BLS, ACLS within 90 days if not current upon hire; PALS will be required for RN's that are cross-trained to work in PACU (post</p>	S0162	<p>Policy ASC-AD-112 has been changed to reflect the following: "Registered Nurses will be expected to complete BLS and ACLS within 6 months if not current upon hire; PALS will be required for RN's that are cross trained to work in PACU within 6 months if not current upon hire". This policy will be presented at the February 27, 2013 Board Meeting for their approval. Staff member P2: (PRN, RN) will not be scheduled to work until she successfully completes BLS and ACLS. PRN RN's are not cross trained to PACU at our facility, thus PALS certification is not a requirement for PRN RN's. Staff member P7 will not be assigned to pediatric PACU patients until she successfully completes PALS in March of 2013. The ASC Director will be responsible for assuring this does not occur in</p>	02/27/2013			

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	<p>anesthesia care unit) within 90 days if not current upon hire..."</p> <p>2. review of employee files indicated:</p> <p>a. staff member P2 was a pre/post RN hired 11/10/11 who had documentation that:</p> <p>A. their CPR (cardiopulmonary resuscitation) had expired 10/12</p> <p>B. there was no documentation of ACLS competency/certification</p> <p>b. staff member P7 was a pre/post RN hired 7/25/12 who lacked documentation of PALS competency/certification</p> <p>3. interview with staff member #50, the facility administrator, at 3:30 PM on 2/6/13, indicated:</p> <p>a. staff member P2 has expired for both CPR and ACLS</p> <p>b. this staff member doesn't think that staff member P2 has worked since the expiration of both the CPR and the ACLS</p> <p>c. staff member P7 is beyond the 90 day requirement for PALS certification, as required by policy</p>		the future.	

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S0172	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on policy and procedure review, employee annual education file review, and staff interview, 2 of 5 pre/post RNs (registered nurses) failed to receive annual education related to infection control and fire/life safety (staff members P1 and P2).</p> <p>Findings: 1. at 1:50 PM on 2/6/13, review of the policy and procedure "Assessment of Employee Competency", policy number ASC-AD-134, with an implementation date of July 18, 2012, indicated: a. under "Procedure", it reads: "...3. Continued position competencies will be tested through annual skill set revalidation and retention of mandatory education requirements for</p>	S0172	<p>Staff member P2 had completed her annual training March 19, 2012. However during the survey process, the ASC Director was not able to locate the documentation to demonstrate staff member P2's completion of the annual training on Infection Control and Fire/Life Safety. The ASC Director did locate the documentation of Staff member P1's formal training on Infection Control and Fire/Life Safety dated January 28, 2013 prior to the exit interview. However, due to the time spent with the administrator surveyor, this information was overlooked and not presented to the nurse (clinical) surveyor prior to their departure. The ASC Director will be responsible for maintaining an organized file containing all of the</p>	02/08/2013			

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	<p>employees...Competencies will be tracked through the Employee In-service Records, mandatory education tools and tests,...4. Position competencies will include but are not limited to, equipment use and function, patient care, OSHA required annual training on Bloodborne Pathogens, Infection control,...Fire and Severe Weather Safety..."</p> <p>2. review of the education binder for employees indicated: a. staff members P1 and P2 (pre/post RNs) lacked documentation of annual education in Infection Control practices and Fire/life safety training for 2012</p> <p>3. interview with staff member #50, the facility administrator, at 11:15 AM on 2/6/13 indicated: a. both staff members listed in 2. above were lacking documentation of annual education for Infection Control and Fire/life safety</p>		center's employees annual training.		

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S0310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the Quality Assurance (QA) program failed to ensure that contracted services were evaluated using specific and objective standards and reviewed by the QA committee.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance (approved 12-12) lacked a provision for evaluating contracted services through the QA program and failed to ensure that objective and measurable standards were applied to each service listed on the OSMC Outpatient Surgery Center Contracted Services Report.</p> <p>2. The 2012 Contracted Services report observed in the governing board minutes dated 1-28-13 failed to indicate the standards for evaluating many providers [" performed per contract "] and lacked</p>	S0310	<p>The 2012 Contracted Services quality tracking information had been presented to the Board on January 28, 2013. The 2012 Contracted Services quality tracking information will be presented at the next UR/QA Committee Meeting scheduled on May 8, 2013. Going forward, the Contracted Services quality information will be reported to the UR/QA Committee Meeting for their evaluation and recommendations followed by presentation to the Board for their approval. The same Contracted Services tool had been utilized since 2005. An example of unsatisfactory performance (CINTAS) and process taken for not meeting the standards was verbally communicated to the Administrator surveyor during the survey process. The ASC Director will create more objective and measurable indicators to indicate that the providers meet the standards per their respective contracts and action taken in response to unsatisfactory</p>	02/22/2013			

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	<p>discrete process and/or outcome indicators for many providers. The report failed to indicate if the providers met the standard or required an action taken in response to unsatisfactory performance.</p> <p>3. The UR/QA Committee meeting minutes for 2012 failed to document a discussion or exhibit the Contracted Services Quality Reports if reviewed.</p> <p>4. During an interview on 2-06-13 at 1350 hours, staff A2 confirmed that the QA plan lacked a provision for reviewing and the QA program failed to review its contracted services. Staff A2 confirmed that the Contracted Services report lacked objective and measurable indicators and failed to indicate that the providers met the standards.</p>		<p>performance. The ASC Director will be responsible for the ongoing quality monitoring and tracking compliance of the Contracted Services.</p>	

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S0442	<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 2 (staff members P2 and P7) of 5 pre/post RNs (registered nurses).</p> <p>Findings:</p> <p>1. at 10:00 AM on 2/6/13, review of the policy and procedure "Orientation of New Personnel", policy number ASC-AD-112, with a review date of August 2012, indicated:</p> <p>a. under "Procedure", in the second paragraph, it reads: "...Titers will be drawn for Hep. B, Varicella, Rubeola, and Rubella as appropriate..."</p>	S0442	<p>Policy ASC-AD-112 "Orientation of New Personnel" has been changed to reflect the following: Titers will be drawn for Hep. B, Varicella, Rubeola, and Rubella on all new personnel who do not have documentation by either previous titer, or medical history signed by their physician documenting history of the disease". This policy will be presented at the Board Meeting on February 27, 2013 for their approval. Titers for Varicella will be drawn on staff members P2 and P7 and recorded in their employee health file. The Human Resource Director will be responsible for tracking new hire documentation pertaining to communicable disease history.</p>	02/27/2013			

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	<p>2. review of employee health files indicated:</p> <p>a. staff member P2 was a pre/post RN hired 11/10/11 who had self reported a history of the disease of Varicella</p> <p>b. staff member P7 was a pre/post RN hired 7/25/12 who had self reported a history of the disease of Varicella</p> <p>3. at 4:05 PM on 2/5/13, interview with staff member #50, the facility director, indicated:</p> <p>a. both staff members P2 and P7 self reported their childhood history of disease for Varicella</p> <p>b. facility policy is not clear as to what "as appropriate" means, but the impression is that a titer be drawn for proof of Varicella immunity if the employee cannot provide such proof</p>			

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S0732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based upon document review and interview, the medical staff failed to review its bylaws, rules and regulations at least triennially.</p> <p>Findings:</p> <p>1. On 2-04-13 at 1230 hours, staff A2 was requested to provide documentation indicating that the medical staff had reviewed its medical staff bylaws, rules and regulations within the past 3 years and none was provided prior to exit.</p> <p>2. Review of the Medical Staff Bylaws, Rules and Regulations (approved 9-09) failed to indicate a provision ensuring that the bylaws would be periodically reviewed by its medical staff at least triennially.</p> <p>3. The medical staff meeting minutes for 3-19-12 and 5-22-12 failed to indicate that the medical staff bylaws had been reviewed and approved by the medical staff.</p>	S0732	The Medical Staff will be reviewing the Bylaws and Rules and Regulation at the February 27, 2013 Board of Managers Meeting. The CEO is responsible for assuring that the Bylaws and Rules and Regulations are reviewed triennially.	02/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2013
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	4. During an interview on 2-06-13 at 1545 hours, staff A1 confirmed that the medical staff bylaws, rules and regulations lacked a triennial provision and had not been reviewed by the medical staff within the past 3 years.				

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S0736	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based upon document review and interview, the medical staff failed to meet at least quarterly in 2012.</p> <p>Findings:</p> <p>1. The Medical Staff Bylaws, Rules and Regulations (approved 9-09) indicated the following: " Regular meetings of the medical staff will be held. The annual meeting will be held in April. " The bylaws failed to indicate a requirement for medical staff meetings at least quarterly.</p> <p>2. Documentation provided for review indicated that the medical staff met on 3-19-12 and 5-22-12 and indicated that no annual meeting was held in April.</p> <p>3. During an interview on 2-05-13 at 1335 hours, staff A2 confirmed that only</p>	S0736	<p>The Medical Staff of OSMC Outpatient Surgery Center did not formally meet as documented by meeting minutes in the 3rd or 4th quarter of 2012. However, the Medical Staff members whom are the same as the Board members (and their guests) met on nine occasions in 2012 and were kept completely informed as to the activities being conducted within the surgery center. Given the specific circumstances of our operations, we believe that the Medical Staff was fully informed and conducted itself consistent with its bylaws throughout calendar year 2012. Due to the frequency of our Board Meetings the Board will be amending the Bylaws to remove the annual meeting in April. In the future, a tickler file will be created in order to insure that four Medical Staff meetings occur, one in each quarter,</p>	02/27/2013	

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	<p>2 medical staff meetings were conducted in 2012.</p> <p>4. During an interview on 2-06-13 at 1545 hours, staff A1 confirmed that no additional meeting minutes were available.</p>		<p>formally documented in the medical staff meeting minutes and that the business conducted at those meetings is consistent with the bylaws. The CEO will be responsible for this matter.</p>	

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S0854	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)</p> <p>Requirements for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>Based on policy and procedure review, medical record review, and staff interview, the facility failed to ensure that its policy related to patient care in regard to surgical time outs was implemented for 2 of 8 general anesthesia patients (Pts. # 3 and 13).</p> <p>Findings:</p> <p>1. at 4:25 PM on 2/6/13, review of the policy and procedure "Verification of Correct Site for Invasive or Surgical Procedures", with a policy number ASC-CL-114, and a last review date of February 17, 2010, indicated:</p> <p>a. under "Policy", it reads: "In the pre-op area and prior to the start of any invasive/surgical procedure confirmation of correct site, procedure, and patient has been completed and documented..."</p> <p>b. under "Procedure", it reads: "...13. Once the patient has been prepped and draped and the site mark is visible, a</p>	S0854	<p>When the surveyor presented her findings during the survey, the ASC Director believed that the "Time Out Process" was being performed according to facility policy. However the process for entering times into the electronic health record is performed by clicking on a "clock" icon. Clicking the clock icon records the present time. Then the "up" and "down" arrows next to the clock need to be clicked until the actual time, that the time out was called, is documented. This process has been reviewed with the ASC staff and the contracted anesthesia providers. This process has been added to the criteria for auditing electronic health records. The two designated staff members that perform chart review are responsible for monitoring this and keeping the ASC Director informed of their findings. The ASC Director will be responsible for ongoing compliance.</p>	02/22/2013			

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	<p>"time out" will be initiated by the physician in the procedure/surgical suite involving the entire team...14. Documentation of "time out" should indicate the following was verified..."</p> <p>2. review of patient medical record indicated:</p> <p>a. pt. #3 had documentation on the "Anesthesia Record" form that indicated the surgery "start" time was 0903 hours and the "time out called" time was 0924 hours</p> <p>b. pt. # 13 had documentation on the "Operating Room Record" form that indicated the surgery "first incision" time was 1056 hours and the "time out" time was 1105 hours</p> <p>3. interview with staff member #50, the facility administrator, at 3:15 PM on 2/6/13 indicated:</p> <p>a. the documentation for patients #3 and 13 indicates the surgical time outs occurred after the surgery start times</p> <p>b. it is thought that the staff completing the forms failed to note the actual time out time, but allowed the computer to note the time the information was entered, making it appear that the time outs were not being done per facility policy</p>						

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S1146	<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 interview, the facility failed to ensure that a condition was not created that could cause a hazard to patients or employees related to infection possibilities in two areas toured (pre/post area and OR suites #1 and #2).</p> <p>Findings: 1. at 10:35 AM on 2/5/13, while on tour of the pre/post area in the company of staff member #50, the facility administrator, it was observed that:</p> <ul style="list-style-type: none"> a. the top cabinet of the Amsco/Steris blanket warmer had dust under the plenum shelf b. the top of the defibrillator was covered with accumulated dust c. the top of the crash cart was covered with accumulated dust d. the drawers of the crash cart had dust and debris at the back of the drawers 	S1146	The blanket warmer shelf had been cleaned recently. However, the interior of the blanket warmer, the difib., and the top of the crash cart have been added to the ASC Job List (cleaning list) to be performed on a weekly basis. The pre-post RN staff will wipe out the drawers of the crash cart monthly when they check for medication outdates. The Pre-post Lead RN will be responsible for assuring the cleaning of the above mentioned items. The OR staff will monitor and pull outdated suture in the Operating Rooms. The OR Lead RN will be responsible for assuring that the suture is checked for expiration dates on a monthly basis. The Leads will keep the ASC Director informed of their findings.	02/07/2013			

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	<p>2. interview with staff member #50 at 10:40 AM on 2/5/13 indicated:</p> <p>a. it was thought that the shelf of the blanket warmer had been recently cleaned</p> <p>b. cleaning of the top of the defibrillator, top of the crash cart, and drawers of the crash cart, will be added to the cleaning list for staff</p> <p>3. at 11:40 AM on 2/5/13, while on tour of OR suite #2, it was observed that:</p> <p>a. >10 Vicryl 6-0 sutures expired January 2013</p> <p>b. 2 packets of V-0 Vicryl sutures expired January 2010</p> <p>4. at 11:45 AM on 2/5/13, while on tour of OR suite #1, it was observed that:</p> <p>a. 1 packet of Ethicon 5-0 Plain Gut suture expired 1/13</p> <p>b. >20 packets of Ethilon 6-0 Monofilament suture expired 1/13</p> <p>5. interview with staff member #50 at 11:45 AM on 2/5/13 indicated:</p> <p>a. sutures had expired as listed in 3 and 4 above</p>			

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S1154	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(C)</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>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Operational and maintenance control records must be established and analyzed at least triennially. These records must be readily available on the premises.</p> <p>Based on document review and interview, the center failed to ensure that a triennial analysis was performed on operational and maintenance records for the mechanical and physical plant equipment at the center.</p> <p>Findings:</p> <p>1. On 2-04-13 at 1230 hours, staff A2 was requested to provide documentation indicating a triennial analysis of operational and maintenance control records for heating, ventilation, air conditioning, fire alarm and/or smoke</p>	S1154	<p>A triennial analysis was performed on operational and maintenance control records for the mechanical and physical plant equipment at the center on February 6, 2013 for the period of January 1, 2010 through 12/31/2012. This information was presented to the administrator surveyor prior to the exit interview and he communicated to the ASC Director to "save this as part of your response". The documentation is available for review. The Maintenance Coordinator will be responsible for performing and reporting the triennial review of operational and maintenance records. The</p>	02/06/2013			

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	<p>detector system was performed and none was provided prior to exit.</p> <p>2. Review of the maintenance schedules and equipment maintenance records failed to indicate that the center records were analyzed at least triennially.</p> <p>3. During an interview on 2-04-13 at 1530 hours, staff A3 confirmed that the center lacked documentation of a triennial analysis of the mechanical systems and equipment records.</p>		<p>ASC Director will be responsible for presenting this to the Safety Committee, UR/QA Committee and at the Board Meeting.</p>	

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NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514			
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S1168	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the center failed to ensure that a triennial analysis was performed on all patient care equipment at the center.</p> <p>Findings:</p> <p>1. On 2-04-13 at 1230 hours, staff A2 was requested to provide documentation indicating that a triennial analysis of patient care equipment preventive maintenance (PM) records was performed and none was provided prior to exit.</p> <p>2. The policy/procedure Preventive</p>	S1168	<p>Policy ASC-MS-104 has been changed to include "A triennial review of the PM records will be done at the center". This policy will be presented at the February 27, 2013 Board Meeting for their approval. The ASC Director will be responsible for obtaining this information from the contracted biomed engineer.</p>	02/27/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2013
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NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
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	<p>Maintenance (approved 12-12) lacked a provision for performing a triennial review of the PM records at the center.</p> <p>3. PM records failed to indicate that a triennial analysis was performed by either center staff or the biomedical engineering services provider for patient care equipment.</p> <p>4. During an interview on 2-06-13 at 1340 hours, staff A2 confirmed that the center lacked documentation of triennial analysis for the patient care equipment PM records.</p>			

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S1170	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review, observation and interview, the center failed to perform defibrillator inspection and testing as recommended by the manufacturer.</p> <p>Findings:</p> <p>1. The policy/procedure Checklist-Crash Cart & Critical Equipment (approved 12-12) and center document Crash Cart Checklist dated January 2013 failed to indicate the process for checking the defibrillator or discharge according to the manufacturer's recommendations.</p>	S1170	The daily discharge log for the defib and PM records were current and available to the surveyor at the time of the survey. Following staff training, the "Suggestions for Inspection and Testing" form for the Lifepak 9 will be implemented. Training will be completed by March 1, 2013. The ASC Director will be responsible for insuring compliance.	03/01/2013			

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NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
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	<p>2. During a tour on 2-05-13 at 1040 hours, a Physio-Control LifePak 9 monitor/defibrillator was observed on top of the crash cart and no copy of the manufacturer ' s Suggestions For Inspection and Testing was available in the area.</p> <p>3. During an interview on 2-04-13 at 1600 hours, staff A2 confirmed that the daily defibrillator checks were not being performed according to the manufacturer's recommendations.</p>			

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S1180	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on document review and interview, the center lacked documentation of an organized safety management program that included a review of safety functions by a committee appointed by the chief executive officer and included representatives from administration and patient care services.</p> <p>Findings:</p> <p>1. The Governing Board Bylaws (reviewed 8-12) indicated the following: " The Infection Control Committee will designate a person to handle the safety program. "</p> <p>2. On 12-04-13 at 1230 hours, staff A2 was requested to provide documentation of a safety management program including committee responsibilities, membership and meeting minutes and none was provided prior to exit.</p>	S1180	<p>UR/QA Committee Minutes includes a section labeled "Safety" which discusses the monitoring, surveillance of safety activities as well as any Incident Reports related to safety issues and follow up. This was presented to the surveyor for their review. However, going forward we will have a formal organized Safety Management Program defining committee responsibilities, membership and separate meeting minutes. The ASC Director will be responsible for this activity.</p>	03/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2013
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. Review of the policy/procedure Quality Assurance (approved 12-12) and Infection Control Program (approved 12-12) failed to indicate the safety program functions and processes to be reviewed through the program.</p> <p>4. During an interview on 2-05-13 at 1610 hours, staff A2 confirmed that the center lacked an organized safety management program.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2013
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S1222	<p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(e)</p> <p>(e) Safeguards for patients, personnel, and public must be specified, including, but not limited to, the following:</p> <p>(1) Proper safety precautions must be maintained against radiation hazards in accordance with the center's radiation and safety program(s).</p> <p>(2) Hazards and faulty equipment identified must be promptly corrected in accordance with current standards of practice and applicable federal and state rules, including, but not limited to, collimation and filtration and evaluations of equipment performance.</p> <p>Based on policy and procedure review, observation, training documentation review, and staff interview, the facility failed to ensure that safety precautions were maintained against radiation hazards for 3 of 5 staff members during a surgical procedure where x-rays were taken (staff members # 53, 54, and 56) failed to ensure that safety precautions were maintained against radiation hazards for patients and staff.</p> <p>Findings: 1. at 5:45 PM on 2/6/13, review of the policy and procedure "Radiation Safety", policy number ASC-SA-110, with a</p>	S1222	The Radiation Safety policy ASC-SA-110 has been changed to include "All female patients of child bearing age will be screened to determine the possibility of pregnancy", and "Pregnant personnel will wear two radiation monitoring badges: one outside the collar of the lead apron and one at the waist inside the lead apron. Badges will be read monthly for pregnant personnel." Every effort is made not to assign a pregnant employee to procedures/surgeries involving ionizing radiation. The policy now includes parameters for proper storage of the Landauer Badges when not being worn. All female patients of child bearing age are	02/27/2013

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	<p>"Revision Date" of January 15, 2009, indicated:</p> <p>a. under "Procedures", it reads: "Occupational exposure to radiation will be minimized by the following practices: a. during radiation exposure, all personnel should be encouraged to stand at least six feet away from the x-ray tube and behind lead shielding...b. Lead shielding is provided to personnel who cannot leave the room..."</p> <p>2. at 9:50 AM on 2/5/13, while observing a closed reduction of the forearm (ulna and radius) in OR (operating room) suite #2, it was observed that:</p> <p>a. x-rays per a C-arm were taken at 9:56 AM and 10:10 AM b. 3 staff members, #53, the surgical tech,; #54, the surgical nurse,; and #56, the anesthesia provider, failed to wear the lead aprons, provided by the facility, for protection against radiation exposure c. staff members #53, 54 and 56 were not 6 feet away from the x-ray/C-arm</p> <p>3. review of employee education files indicated:</p> <p>a. training on 7/26/12 by staff members #53 and #54, related to "Radiation Safety", indicated: "...2. When working with the C-arm or other X-ray equipment what items must an employee wear? a. Radiation Badges b. Aprons. c. Thyroid</p>		<p>screened as indicated in policy ASC-CL-113 "Pregnancy Screening Policy". The updated Radiation Safety Policy will be presented to the Board for their approval on February 27, 2013. The proper radiation safety practices have been reviewed with the ASC staff, contracted anesthesia providers and surgeons. The Pre-post Lead and the OR lead are responsible for monitoring the compliance of their respective staff. The ASC Director will be responsible for the oversight of the adherence of the use of proper lead apparel by ASC staff, contracted anesthesia providers and the physicians.</p>				

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	<p>Collars..." (all three were checked by both staff members)</p> <p>4. interview with staff member # 50, the facility director, at 11:35 AM on 2/5/13, indicated:</p> <p>a. surgery staff should have been wearing lead aprons while the C-arm was in use on the patient in OR suite #2 for the closed arm reduction procedure</p> <p>b. the radiation safety policy was not followed by surgical staff</p> <p>5. The policy/procedures Radiation Safety (approved 12-12) failed to indicate the following:</p> <p>A. approved locations or recommendations for proper storage of radiation monitoring badges when not in use</p> <p>B. a requirement for pregnant personnel to wear a second radiation monitoring badge at waist level inside the lead shielding in areas where radiation exposure is anticipated or radiology equipment is in use</p> <p>C. a requirement for screening all female patients of child bearing age to determine the possibility of pregnancy and risk of fetal exposure to ionizing radiation.</p> <p>6. During a tour on 2-05-13 at 1140 hours, the following condition was observed with staff A2 in Operating Room #2: storage of a radiation</p>			

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	<p>monitoring badge above the circulating nurse ' s writing tabletop in the area where radiologic equipment was available for immediate use.</p> <p>7. During an interview on 2-08-13 at 1320 hours, staff A2 confirmed that the policy/procedure lacked the indicated safety provisions and that the monitoring badge was improperly stored in the OR room.</p>			