

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001166		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2012	
NAME OF PROVIDER OR SUPPLIER BALL OUTPATIENT SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303			
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 012159</p> <p>Survey Date: 2-13-12 to 2-14-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/21/12</p> <p>4/19/12 revised due to IDR</p>			S0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0156	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the center failed to develop its own job descriptions for all employees including contract and agency personnel who provide services at the facility.</p> <p>Findings:</p> <p>1. The policy/procedure Job Descriptions ADM 1.06 (approved 10-10) indicated the following: "All [Ball Outpatient Surgery Center] BOSC staff will be leased from Ball Hospital. All [Ball] employee job descriptions and all [Ball] Human Resource Policies and Procedures will be those used at BOSC." The policy/procedure failed to ensure that adopted job descriptions were presented</p>	S0156	The clinical director is disputing tag 156. The Ball Outpatient Surgery Center believes that they were in compliance at the time of survey based on the following information. We respectfully request that this tag be deleted.All Ball Outpatient Surgery Center personnel are leased via a contractual agreement with IU Health Ball Memorial hospital. Ball Outpatient Surgery Center Policy ADM 1.06 - Job Descriptions states: "All BOSC staff will be leased from Ball Hospital. All employee job descriptions and all Human Resource Policies and Procedures will be those used at BOSC."Compliance with this rule was evidenced by:1.) Ball Outpatient Surgery Center Policy ADM 1.06 - Job Descriptions was	03/30/2012			

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	<p>as BOSC exhibits. The policy/procedure failed to indicate the specific requirements for personnel employment and conduct adopted or incorporated by the center and failed to present the specific policies/procedures for regulating the conduct of center staff as BOSC exhibits.</p> <p>2. During an interview on 2-14-12 at 1020 hours, staff A5 confirmed that the center failed to develop and implement its own job descriptions and human resource policies and procedures.</p> <p>3. During an interview on 2-14-12 at 1200 hours, staff A1 confirmed that the center failed to develop and implement its own job descriptions and specify the human resource policies and procedures adopted or incorporated by the center. A1 confirmed that the policy/procedure failed to indicate the BOSC governing board approval of the human resource policies and procedures to be used at the center.</p>		<p>approved by the governing body.2.) All IU Health Ball Memorial Hospital job descriptions are readily available online.3.) A current copy of each employees job description is maintained with their employee file.Ball Outpatient Surgery Center Policy ADM 1.06 - Job Descriptions is attached to this plan of correction as Exhibit 2.Corrective Action should our request for IDR be denied: The governing body and chief executive officer are responsible to develop job descriptions for all personnell. The Ball Outpatient Surgery Center would attach a list of all job descriptions and policies/procedures as an exhibit to Ball Outpatient surgery center policy Adm 1.06- Job Descriptions. This policy and exhibit would be approved by the board of managers.</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 document review and interview, the center failed to require cardiopulmonary resuscitation (CPR) competency for all health care workers who provide direct patient care.</p> <p>Findings:</p> <p>1. The policy/procedure Cardiopulmonary Resuscitation Competence for Physicians MS 4.08 (approved 10-10) indicated the following: "CPR ...is required for and only for those physicians who must demonstrate CPR competence to comply with the ...policy MS 4.05 Moderate Sedation." The policy failed to require CPR competence for all providers including credentialed allied</p>	S0162	<p>Responsible: The Governing Body, CEO and clinical director of the Ball Outpatient Surgery Center is responsible for policy updates at the Ball Outpatient Surgery Center. It is the policy of the Ball Outpatient Surgery Center to ensure CPR competency for all health care workers pursuant to the following policies: Ball Outpatient Surgery Center Policy MS 4.08 Cardiopulmonary resuscitation Competence for Physicians States that "Cardiopulmonary resuscitation (CPR) or hospital equivalent airway competence is required for and only for those physicians who must demonstrate CPR competence to comply with the Ball Outpatient Surgery Center, LLC policy MS 4.05 Moderate Sedation. Ball Outpatient Surgery Center Policy MS 4.05 requires CPR competence only for physicians</p>	03/30/2012			

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	<p>health providers.</p> <p>2. The policy/procedures Appointment/Reappointment to the Medical Staff MS 4.25 (approved 10-10) and Appointment/Reappointment Allied Health MS 4.26 (approved 10-10) failed to require CPR competence for any practitioners.</p> <p>3. The policy/procedure Job Descriptions ADM 1.06 (approved 10-10) failed to require CPR competence for all personnel who provide direct care.</p> <p>4. On 2-14-12 at 1110 hours, staff A1 confirmed that the policies/procedures failed to require CPR competency for all direct care staff.</p>		<p>requesting moderate sedation privileges and further states "The physician must be specifically credentialed in the appropriate sedation. A qualified physician is defined as: Current BLS/ACLS/ATLS/PANS/NRP certification or the hospital equivalent in CPR and emergency care. Biennial review of moderate sedation educational information, and successful completion of a written moderate sedation exam may be required. Anesthesiologists are considered qualified to administer moderate sedation by virtue of their training and experience. Anesthesiologists do not need to maintain CPR competency." The Ball Outpatient Surgery Center requires CPR Competence for all personnel who provide direct patient care. Employee CPR requirements are listed in each job description. Corrective Action: The Ball Outpatient Surgery Center requires CPR Competence for all credentialed Allied Health Practioners who provide patient care. The Clinical director shall be responsible to amend Ball Outpatient Surgery Center Policy MS 4.26 Appointment/Reappointment Allied Health Staff to state that "CPR Competence is required for all Allied Health Staff providing direct patient care".Staff will be immediately educated on this policy update.Ball Outpatient Surgery Center Policy MS 4.26 -</p>		

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			Appointment/Reappointment Allied Health Staff is attached to this plan of correction as Exhibit 3. Ball Outpatient Surgery Center Policy MS 4.05 - Procedural Sedation is attached to this plan of correction as Exhibit 4. Ball Outpatient Surgery Center Policy MS 4.08 - Cardiopulmonary Resuscitation Competence for Physicians as Exhibit 5.		

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S0300	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>Based on document review and interview, the center failed to follow its Quality Assessment and Improvement (QA&I) plan and failed to ensure ongoing monitoring of all services and important aspects of care.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Plan (approved 10-09) indicated the following: "The scope of the QA&I program includes...safety program effectiveness... [and]...quality control in ancillary services...[and]... complete a review of contracted services quarterly."</p> <p>2. The [safety plan] Management of the Environment of Care EOC 9.01</p>	S0300	<p>Responsible: The clinical director of the Ball Outpatient Surgery Center. Corrective Action: The clinical director shall ensure that the activities of the Ball Outpatient Surgery Center safety (EOC) program are reported to the quality committee. Contracted services monitoring will also be reported to the quality committee. Consistent with existing plan requirements all quality committee activities then flow to the Governing body on a quarterly basis. Ongoing Monitoring: A schedule will be maintained indicating which items will be reviewed by the quality committee to ensure compliance. Ball Outpatient Surgery Center Quality Plan is attached as Exhibit 6.</p>	03/30/2012

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	<p>(approved 10-10) indicated the following: "The EOC Committee shall be responsible for...reporting to the Board of Managers on a regular basis." The Plan failed to indicate a requirement for reporting to the Quality Committee.</p> <p>3. The Quality Committee meeting minutes dated 10-13-11 and 1-12-12 failed to indicate a review of safety program/EOC committee issues and activities or attendance by the safety officer or a review of contracted services.</p> <p>4. During an interview on 2-14-12 at 1630 hours, staff A1 confirmed that the quality committee failed to follow its QA&I plan and ensure that program monitoring objectives were met.</p>				

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S0310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the center failed to follow its Quality Assessment and Improvement (QA&I) plan and 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 Plan (approved 10-09) indicated the following: " Complete a review of contracted services quarterly ... [and] ...the scope of the QA&I program includes ...quality control in ancillary services. " The plan lacked a provision for ensuring objective and measureable standards were applied to each service listed on the Contracted Services Quality Report.</p>	S0310	<p>Responsible: The Clinical Director is responsible for activity of the quality committee.</p> <p>Corrective Action: The clinical director will ensure that contracted services monitoring will be objective and include measurable standards. Results from contracted services monitoring will be reported to the quality committee and flow to the governing body on a quarterly basis. Ball Outpatient Surgery Center contracted services monitor is attached as Exhibit 7.</p>	03/30/2012			

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	<p>2. The 2011 Contracted Services Quality Reports lacked a provision for evaluating each provider over multiple periods and lacked discrete process and/or outcome indicators for many providers.</p> <p>3. The Quality Committee meeting minutes dated 10-13-11 and 1-12-12 failed to document a discussion or exhibit the Contracted Services Quality Reports if reviewed.</p> <p>4. During an interview on 2-14-12 at 1410, staff A1 confirmed that the Contracted Services Quality Reports were not reviewed by the Quality Committee and that the quality plan lacked the indicated provisions.</p>				

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S0404	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the facility failed to maintain an Infection Control Plan which was updated annually or whenever risks significantly change.</p> <p>1. Facility Infection Control Plan "Ball Outpatient Surgery Center, LLC Infection Control Plan", was last reviewed/revised 10-1-2009.</p> <p>2. Facility Infection Control Plan "Ball Outpatient Surgery Center, LLC Infection Control Plan", on page 4, IC 5.10 states the facility will "evaluate/revise the Infection Control program annually and whenever risks significantly change".</p> <p>3. During interview with A1 on 2-14-2012 at 9:00 AM, S1 indicated that:</p> <p>a. A1 is the Chief Nursing Officer for the facility.</p> <p>b. the Infection Control Program last</p>	S0404	<p>Responsible: The clinical director is responsible for the Ball Outpatient Surgery Center Infection Control Plan. Corrective Action: The clinical director shall ensure that the Board of Managers evaluates and when needed revises the infection control plan at least annually or whenever risk changes significantly. Results of the infection control plan are integrated with the overall quality plan for the Ball Outpatient Surgery Center. This requirement will be communicated to the infection control committee.</p> <p>Ongoing Monitoring: A risk assessment will be completed annually to ensure ongoing monitoring and annual revisions, as needed, to the infection control plan.</p>	03/30/2012			

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	<p>reviewed/revised 10-1-2009 was the most recent Infection Control Program and that it had not been evaluated or revised since 2009.</p> <p>c. the Infection Control Program, to be active and effective, must be evaluated/revised at least annually to address current infection control and communicable disease issues in patients and health care workers.</p>			

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S0414	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on policy/procedure review, document review and staff interview, the facility failed to ensure that the Infection Control Committee was composed of the appropriate membership, and failed to meet in 1 of 4 quarters in 2011.</p> <p>1. Facility Infection Control Plan "Ball Outpatient Surgery Center, LLC Infection Control Plan" last reviewed/revised 10-1-2009:</p>	S0414	<p>Responsible: The governing body, CEO and clinical director are responsible to ensure that the center's infection control committee meets quarterly and that attendee representation is complete. Corrective Action: The Ball Outpatient Surgery Center Infection Control committee will at a minimum consist of the infection control preventionist, a member of the medical staff and a member of the nursing staff. Attendees will</p>	03/30/2012

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	<p>a. lacks a provision requiring the Infection Control Committee (ICC) to appoint a representative from the medical staff and the nursing staff.</p> <p>b. lacks a provision requiring at least quarterly meetings of the Infection Control Committee.</p> <p>2. Infection Control meeting minutes from 2011 showed:</p> <p>a. the Infection Control Committee met on May 8, June 6, August 12, and December 29 but no Infection Control Committee meeting was held in the first quarter of 2011</p> <p>b. the meeting on May 8, June 6, and December 29 lacked attendance by an appointed representative from the medical staff or the nursing staff.</p> <p>3. During interview with A1 on 2-14-2012 @ 4:00 PM, S1 indicated that:</p> <p>a. A1 is the Chief Nursing Officer of the facility.</p> <p>b. the ICC did not meet the first quarter of 2011.</p> <p>b. confirmed the above findings that the facility had not appointed a representative from the medical staff nor a representative from the nursing staff to the ICC.</p> <p>c. the Infection Control Plan dated 10-1-2009 was the facility's most recent Infection Control Plan and lacked</p>		<p>be elected by the Ball Outpatient Surgery Center Operating Committee. The Infection Control plan will be amended to specify minimum attendance by a member of the medical and nursing staff. A provision will be added to require quarterly attendance. Meetings will not be held unless the required attendees are present. Ongoing Monitoring: A schedule of Infection control meetings will be communicated to all attendees to ensure compliance. The Ball Outpatient Surgery Center Infection Control Plan is attached as exhibit 19.</p>	

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	<p>provisions requiring the appointment of a medical staff and nursing staff representative to the ICC and lacked a provision requiring quarterly meetings, at a minimum, of the ICC.</p> <p>d. nursing personnel were present at the identified meetings, but that they were not members of the Infection Control Committee.</p> <p>e. after requested, the facility did not provide any further documentation of facility action in 2011 regarding the appointment of a member of the medical and nursing staff to the ICC.</p>			

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NAME OF PROVIDER OR SUPPLIER BALL OUTPATIENT SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303			
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S0616	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on document review and interview, the center failed to ensure all entries in the medical record (MR) are reviewed by the author prior to authentication and failed to require authentication of entries in accordance with medical staff and center policies.</p> <p>Findings:</p> <p>1. On 2-13-12 at 1030 hours, staff A1 was requested to provide documentation ensuring a review of all MR entries by the author prior to authentication and none was provided prior to exit.</p> <p>2. The policy/procedure Content of</p>	S0616	<p>Responsible: They Governing body and clinical director of the Ball Outpatient Surgery Center is responsible for policy and procedure updates. Corrective Action: Medical staff policy MS 4.18 Authentication of Medical Records will be amended to provide the following definition: "Authenticate" means the author or responsible individual reviews prior to and validates an entry in a record by: A full signature including first initial, last name and discipline; or Written initials if full signature appears on the same page; A unique identifier such as a number or computer key; or a signature stamp. All staff will be educated regarding this immediate policy update. The policy will be approved by the Board of Managers by the correction date.</p>	03/30/2012			

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	<p>Medical Records ADM 2.01 (approved 10-10) indicated the following: "Approval for authenticating mechanisms for entries in the medical record is the responsibility of the [hospital] Department of Health Information Management." The policy/procedure failed to indicate the center governing board is responsible for approval of authenticating mechanisms for MR entries by credentialed staff members at the center.</p> <p>3. The policy/procedure Authentication of Medical Records MS 4.18 (approved 10-10) lacked a provision for review by the author prior to authentication by the methods indicated.</p> <p>4. During an interview on 2-14-12 at 1330 hours, staff A1 confirmed that the policy/procedure lacked the indicated provisions.</p>		Ball Outpatient Surgery Center Policy MS 4.18 - Authentication of Medical Records is attached to this plan of correction as Exhibit 10.		

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S0640	<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.</p> <p>Based upon document review and interview, the center lacked a policy/procedure ensuring that all entries in the medical record (MR) were legible. Findings:</p> <p>1. On 2-13-12 at 1030 hours, staff A1 was requested to provide a policy/procedure for verifying entries of questionable legibility and none was provided prior to exit.</p> <p>2. The policy/procedure Completion of Medical Records MS 4.03 (approved 10-10) lacked a provision for verifying illegible MR entries.</p> <p>2. On 2-14-12 at 1440 hours, staff A1 confirmed that the MR policies lacked a provision for verifying illegible entries in the patient record.</p>	S0640	<p>Responsible: The Board of Managers and Clinical Director are responsible for administrative policy updates at the Ball Outpatient Surgery Center. Compliance: Ball Outpatient Surgery Center Policy ADM 2.01 - Content of the Medical Record will be revised to state: 8. Illegible Entries in the Medical Record will be verified with the author to ensure that all entries are legible and clear. Corrections to previously recorded and signed entries may be made by the individual who made the entry or a supervising physician as follows: a. A single line is drawn through the illegible documentation with the notation "error" b. The correction is entered and authenticated by signature, title, and date. All staff will be educated regarding this immediate policy update. The policy will be approved by the Board of Managers by the correction date.</p> <p>Ongoing Monitoring: Will occur through medical record audits. Ball Outpatient Surgery Center Policy ADM 2.01 - Content</p>	03/30/2012	

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			of Medical Records is attached to this plan of correction as Exhibit 11.		

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S0772	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review, the center failed to ensure all preoperative History and Physical (H&P) examinations done prior to the date of the procedure are updated on the day of surgery and documented in the patient record.</p>	S0772	The clinical director is disputing tag 772. The Ball Outpatient Surgery Center believes they were in compliance at the time of survey. We respectfully request that this tag be deleted. Compliance: ADM 2.01 - Completion of Medical Records states the below and does require	03/30/2012			

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	<p>Findings:</p> <p>1. On 2-13-12 at 1030 hours, staff A1 was requested to provide documentation indicating that a medical H&P exam performed prior to the date of surgery shall have an update on the day of admission and none was provided prior to exit.</p> <p>2. The policy/procedure Completion of Medical Records MS 4.03 (approved 10-10) indicated the following: " The History and Physical must be signed and dated on the day of surgery. " The policy/procedure failed to require an update on the day of surgery for all H&P examinations performed prior to the date of the procedure.</p>		<p>that all H&P examinations performed more than 30 days from the date of surgery be updated prior to surgery. 1. History and Physical Examination a. A complete history and physical examination shall be completed prior to surgery. The history should include the following: Chief complaint Inventory of body systems Current physical examination Allergies/Medications/Dosage/Re actions Conclusions, impressions drawn from admission history and physical examination Plan of action b. A durable, legible original or reproduction of a medical history, and a completed physical examination obtained in the physician's office or through an appropriately credentialed practitioner that is documented within thirty (30) days prior to the date of admission, is acceptable if the patient's clinical status information is updated preoperatively on the day of admission.c. The medical record shall document a current, thorough physical examination prior to the performance of surgery or invasive procedures. Ball Outpatient Surgery Center Policy ADM 2.01 Content of the Medical Records is attached to this plan of correction as Exhibit 11.If our request for IDR is denied, BOSC will redefine History & Physical Requirements as "History and Physical (H&P) examinations done prior to the</p>		

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			date of the procedure are updated on the day of surgery, signed and documented in the patient record". The clinical director is responsible for consistent application of this policy. Compliance with this policy will be monitored by chart reviews via the BOSC contracted medical records consultant and utilization review committee finds. This policy and exhibit will be approved by the board of managers.		

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S0780	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on document review and interview, the center failed to ensure that verbal orders were authenticated in the time frame specified by center policy.</p> <p>Findings:</p> <p>1. The policy/procedure Content of Medical Record ADM 2.01 (approved 10-10) indicated the following: "Verbal orders and telephone orders shall be authenticated by the ordering physician within forty-eight (48) hours." The policy/procedure failed to require the authentication including date and time to validate compliance within the indicated time frame.</p> <p>2. On 2-14-12 at 1440 hours, staff A1</p>	S0780	<p>The clinical director is disputing tag 780. The Ball Outpatient Surgery Center believes they were in compliance at the time of survey. We respectfully request that this tag be deleted. Compliance: Policy Adm 2.01 Clearly stated ""Verbal orders and telephone orders shall be authenticated by the ordering physician within forty-eight (48) hours." Since no deficiency was cited the Ball Outpatient Surgery Center believes they were in compliance as the policy clearly provided a timeframe for verbal orders to be authenticated.If our request for IDR is denied, Ball Outpatient Surgery Center Policy ADM 2.01 - Content of the Medical Record shall be amended to state ""Verbal orders and telephone orders shall be</p>	03/30/2012	

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	confirmed the policy/procedure lacked the indicated provision to ensure compliance with center policy.		authenticated by the ordering physician within forty-eight (48) hours. Authentication shall include a date and time" All staff would be educated regarding this immediate policy update. The clinical director is responsible to ensure that Ball Oupatient Surgery Center policies. Compliance with this policy will be monitored by chart reviews via the BOSC contracted medical records consultant and utilization review committee findings. The policy would be approved by the Board of Managers. Ball Outpatient Surgery Center Policy ADM 2.01 Content of the Medical Records is attached to this plan of correction as Exhibit 11.		

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S0782	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(O)</p> <p>These bylaws and rule must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(O) A provision for personnel authorized to take a verbal order.</p> <p>Based upon document review and interview, the center failed to determine what categories of personnel may receive a verbal order.</p> <p>Findings:</p> <p>1. The policy/procedure Content of Medical Record ADM 2.01 (approved 10-10) indicated the following: "Verbal orders ...may be recorded ...by authorized licensed professionals including registered nurses." The policy/procedure failed to identify the "authorized licensed professionals."</p> <p>2. The policy/procedure Verbal Orders MS 4.07 (approved 10-10) indicated the following: "Qualified professionals ...may receive and record verbal orders." The policy/procedure failed to specify what qualified professionals may receive verbal orders.</p> <p>3. During an interview on 2-14-12 at</p>	S0782	<p>Responsible: The clinical director is responsible for maintenance of policies and procedures at the Ball Outpatient Surgery Center.</p> <p>Corrective Action: The clinical director will ensure that a definition of authorized licensed professional is added to ADM 2.01 - Content of Medical Record Policy.</p> <p>The clinical director will also add the below definition to the scope of policy MS 4.07- Verbal Orders. for qualified professionals. This policy applies to all disciplines that receive, document, or implement verbal orders from Physicians. Qualified professionals within their scope of practice and limits of their respective disciplines may receive and record verbal orders. Qualified professionals include registered nurses.</p> <p>All staff will be educated regarding this immediate policy update. The policy will be approved by</p>	03/30/2012			

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	0910 hours, staff A1 confirmed that the policy/procedures failed to specify the licensed professionals authorized to receive verbal orders at the center.		the Board of Managers by the correction date. Ball Outpatient Surgery Center Policy MS 4.07 Verbal Orders is attached to this plan of correction as Exhibit 15.		

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S0888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement 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>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review, medical record review, and interview, the facility failed to ensure that an operative report was required to be written or dictated immediately following surgery.</p> <p>1. Facility policy "Content of Medical Records", last reviewed/revised October 2009, provides on page 8, Operative Procedures Reports, a. "Operative reports must be dictated within 48 hours of any surgical or invasive procedure ...".</p> <p>2. Closed medical record review of N4's chart revealed:</p>	S0888	<p>Responsible: The medical staff and clinical director will ensure that Ball Outpatient Surgery center policy is followed. Corrective Action: Consistent with medical staff policies a written or operative report is required to be completed immediately following surgery. Operative reports are to be dictated within 48 hours of surgery. Physicians found to be violating this policy are suspended in accordance with center policy. Delinquent medical record documentation is routinely tracked and deficiencies are identified with the author.</p> <p>Ongoing Monitoring:</p>	03/30/2012			

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	<p>a. N4 had an operative procedure on 12-6-2011.</p> <p>b. N4's medical record lacked documentation of an operative report.</p> <p>3. Interview with A2 on 2-14-2012 S2 indicated that:</p> <p>a. A2 is the nurse manager of the surgery area</p> <p>b. verified that N4's electronic medical record lacked documentation of an operative report.</p>		<p>Compliance with this policy will be monitored by the clincial director on a ongoing basis.</p>		

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S1020	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(D)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(D) Reporting of adverse reactions and medication errors to the practitioner responsible for the patient and the appropriate committee, and documented in the patient's record.</p> <p>Based on document review and interview, the center failed to have a policy/procedure ensuring that medication errors would be documented in the patient record.</p> <p>Findings:</p> <p>1. The policy/procedure Medication Use Process (approved 10-10) failed to indicate that the medication variance [error] will be documented in the patient record.</p> <p>2. During an interview on 2-14-12 at 0910 hours, staff A1 confirmed the policy/procedure lacked the requirement to document the error in the patient record.</p>	S1020	<p>The clinical director is disputing tag 1020. The Ball Outpatient Surgery Center believes that they were in compliance at the time of survey based on the following information. Policy We respectfully request that this tag be deleted. Compliance with this rule was evidenced by Ball Outpatient Surgery Center Policy Policy POS 5.05 - Medication Use Process to state ""All adverse drug reactions and/or medication variances should be reported to the physician responsible for the patient and documented." Corrective Action should our request for IDR be denied:: Ball Outpatient Surgery Center Policy POS 5.05 - Medication Use Process would be amended to state ""All adverse drug reactions and/or medication variances should be reported to</p>	03/30/2012	

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			the physician responsible for the patient and documented in the medical record. " The clinical director is responsible for consistent application of this policy. Compliance with this policy will be monitored by chart reviews via the BOSC contracted medical records consultant and utilization review committee findings. This policy and exhibit will be approved by the board of managers.All staff would be educated regarding this policy update. Ball Outpatient Surgery Center Policy POS 5.05 Medication Use Process is attached as Exhibit 16 to this plan of correction.	

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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 lacked documentation of electrical current leakage testing or triennial analysis of preventive maintenance (PM) records on all patient care equipment in use at the center.</p> <p>Findings:</p> <p>1. Documentation of 2011 PM on patient care equipment in use at the center failed to indicate that ground current leakage</p>	S1168	<p>Responsible: The clinical director is responsible to ensure that Clinical Equipment Maintenance is performed per contract. Corrective Action: The clinical director is responsible to ensure that the contracted clinical equipment maintenance vendor performs ground leakage testing on all patient care equipment. The clinical equipment maintenance vendor is also required to perform a triennial analysis of preventative maintenance performed on patient care equipment. A meeting has already been held with the vendor to clarify these</p>	03/30/2012			

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	<p>testing was performed for all indicated patient care equipment.</p> <p>2. During an interview on 2-14-12 at 1025 hours, staff A8 confirmed that ground current leakage measurements were not routinely documented and confirmed that a triennial analysis of the patient care equipment PM was not being performed.</p>		<p>requirements. Continued compliance will be verified on Clinical Equipment Maintenance reports.</p> <p>Ongoing Monitoring: The clinical director shall ensure ongoing compliance by reviewing clinical equipment maintenance reports.</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 failed to establish a 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. On 2-13-12 at 1030 hours, staff A1 was requested to provide a copy of the safety plan. Staff A1 indicated the safety plan was incorporated in the environment of care management plan.</p> <p>2. The policy/procedure Management of the Environment of Care EOC 9.01 (approved 10-10) failed to indicate a process for periodic review of safety functions by a committee, membership requirements, safety officer, and schedule for meetings.</p> <p>3. During an interview on 2-14-12 at 1230 hours, staff A5 confirmed that the policy/procedure lacked the indicated provisions.</p>	S1180	<p>Responsible: The governing body, CEO and clinical director are responsible to ensure that the center follows its written safety management program.</p> <p>Corrective Action: Ball Outpatient Surgery Center Policy EOC 9.01 - Management of the Environment of Care is the safety plan for the Ball Outpatient Surgery Center. The plan provides for periodic review of safety functions by the EOC(Safety) committee and that meetings be held quarterly. All staff will be re-educated regarding this policy. Ball Outpatient Surgery Center Policy EOC 9.01 - Management of the Environment of Care is attached to this plan of correction as exhibit 17. Ongoing Monitoring: The clinical director shall ensure ongoing compliance by monitoring EOC activity and attendance.</p>	03/30/2012			

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S1182	<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 center failed to develop a written safety management program that indicated an ongoing, center wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Findings:</p> <p>1. The policy/procedure Management of the Environment of Care EOC 9.01 (approved 10-10) failed to establish a formal framework for integrating several center practices into a concise and organized process. The Plan failed to prioritize its safety processes and lacked program elements (committee membership, meeting frequency, etc) process elements (sampling methods, frequency, tools, etc) and accountability elements (policy/procedure review,</p>	S1182	<p>Responsible: The governing body, CEO and clinical director are responsible to ensure that the center follows its written safety management program.</p> <p>Corrective Action: Ball Outpatient Surgery Center Policy EOC 9.01 - Management of the Environment of Care is the safety plan for the Ball Outpatient Surgery Center. The plan provides for periodic review of safety functions by the EOC(Safety) committee and that meetings be held quarterly. Ball Outpatient Surgery Center Policy EOC 9.01 - Management of the Environment of Care further defines: The Ball Outpatient Surgery Center shall take actions necessary to maintain an environment that is safe, functional and effective for patients, staff, and other individuals through the implementation of an Environment of Care Program. The Environment of Care (EOC) Program shall assess the</p>	03/30/2012	

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	<p>radiation badge monitoring, peer education, etc). The Plan lacked committee accountability including a clear statement for ensuring that committee actions are taken to correct and improve facility safety at the center. The policy/procedure also indicated: "Environment of Care [EOC] policies are included in the surgery center EOC Manual." 2. On 2-13-12 at 1220 hours, the EOC binder was provided for review. No policies/procedures were observed in the binder. During an interview on 2-13-12 at 1630, staff A1 confirmed that the binder lacked the policies/procedures. 3. During an interview on 2-14-12 at 1630 hours, staff A1 confirmed that the safety program plan was disorganized, lacked the indicated provisions, and failed to ensure that the safety program objectives were met.</p>		<p>potential risks of injury to patients, staff and visitors and the risk of loss or damage to facilities or equipment assets and shall implement programs to minimize such risks All staff will be re-educated regarding this policy. Ongoing Monitoring: A The clinical director shall ensure that the EOC plan is followed by ongoing monitoring of committee activities. Center Policy EOC 9.01 - Managment of the Environment of Care is attached to this plan of correction as exhibit 17.</p>		

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S1184	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 2.5-7(c)(3)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(3) The safety program includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety.</p> <p>Based on document review and interview, the center failed to develop an organized safety management program that addressed patient, public, visitor, and health care worker safety.</p> <p>Findings:</p> <p>1. The policy/procedure Management of the Environment of Care EOC 9.01 (approved 10-10) failed to indicate an organized program with emphasis on patient safety, health care worker safety, and public/visitor safety. The Plan indicated the following: "(14)(a) The surgery center quality committee for its scope, objectives, performance, and effectiveness shall evaluate management plans for each function annually." and failed to identify, incorporate or exhibit the referenced plans.</p>	S1184	<p>Responsible: The clinical director is responsible to ensure that the center follows its written safety management program.</p> <p>Corrective Action: Ball Outpatient Surgery Center Policy EOC 9.01 - Management of the Environment of Care is the safety plan for the Ball Outpatient Surgery Center. The plan provides for periodic review of safety functions by the EOC(Safety) committee and that meetings be held quarterly. The clinical director will ensure that the results of safety committee activities will be reported to the quality committee. All staff will be re-educated regarding this policy. Ball Outpatient Surgery Center Policy EOC 9.01 - Management of the Environment of Care is attached to this plan of correction as exhibit 17.</p>	03/30/2012	

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	<p>2. The Quality Committee meeting minutes dated 10-13-11 and 1-12-12 failed to document the review or discussion of safety program/environment of care committee issues and activities.</p> <p>3. During an interview on 2-14-12 at 1630 hours, staff A1 confirmed that the center policy/procedure or safety management plan lacked the indicated provisions and failed to ensure that the safety program objectives were met.</p>			

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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 document review, the center failed to ensure that proper radiation safety precautions were maintained and that services were provided in a safe and effective manner and reported through the safety program.</p> <p>Findings:</p> <p>1. On 2-13-12 at 1030 hours, staff A1 was requested to provide copies of all radiation policies/procedures for the center.</p>	S1222	<p>Responsible: The clinical director is responsible for providing documentation that dosimetry reports are reviewed by a consulting radiologist.</p> <p>Corrective Action: Future dosimetry reports will contain a signature by the consulting radiologist indicating the reports were reviewed before being provided to the Ball Outpatient Surgery Center. The radiology support services agreement is an exhibit to a signed, dated and governing body approved agreement between the Ball Outpatient Surgery Center and Indiana University Health Ball Memorial Hospital.</p> <p>Ongoing Monitoring: The</p>	03/30/2012			

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	<p>2. The agreement <u>Radiology - Scope of Services</u> (undated, unsigned, no effective date, no center header, etc) indicated that the center was responsible for reviewing the quarterly radiation exposure badge reports.</p> <p>3. The policy/procedures Radiology Safety in the Operating Room POS 4.03 (approved 10--10) lacked a provision to ensure that health care worker radiation exposure monitoring reports will be reviewed by a qualified person and reported through the safety program for the center.</p> <p>4. Dosimetry reports for 2011 lacked an indication or validation that they had been reviewed by a qualified person or the consultant radiologist for the center.</p> <p>5. On 2-13-12 at 1430 hours, staff A1 confirmed that the center lacked documentation of radiation exposure monitoring review by a radiologist or qualified person and reported through the safety program.</p>		<p>clinical director will ensure that future dosimetry reports are signed off by the consulting radiologist signs off on dosimetry reports. The Ball Outpatient Surgery Center support services Radiology exhibit is attached as exhibit 18.</p>		