

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/13/2012
NAME OF PROVIDER OR SUPPLIER  RIVERVIEW SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1276 NORTH PLAZA DRIVE ROCKPORT, IN 47635		
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S0000	<p>This visit was for an initial State licensure survey.</p> <p>Facility #: 012742</p> <p>Survey Dates: 8-13-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 08/22/12</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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S0153	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review and interview, the facility failed to ensure 3 of 3 (B#4 - B#6) contracted housekeeping staff were provided with orientation to the facility and applicable facility policies.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of personnel files on 8-13-12 for 3 of 3 (B#4 - B#6) contracted housekeeping staff lacked documentation that they had received orientation to the facility and applicable facility policies.</li> <li>Interview with B1 on 8-13-12 at 1755 hours confirmed the 3 housekeepers contracted to clean the facility had not received orientation to the facility or facility policies applicable to their job duties.</li> </ol>	S0153	<p>S 153I. None of the previous housekeepers are currently contracted at Riverview Surgery Center. The current housekeepers will be oriented to the facility, and applicable policies, by the administrator, or designee on August 28, 2012. A copy of this orientation will be kept on file at the facility.II. To prevent future deficiencies, the contracted housekeeping company will notify the Administrator, 24 hours in advance, of any new housekeepers' arrival, and an orientation date &amp; time will be set. The new housekeeper will receive orientation to the facility and applicable policies per the Administrator, Infection Control Nurse or designee, prior to his/her first shift.III. The Administrator or designee, will be responsible for monitoring the orientation of housekeeping staff to the facility and applicable policies, and will report any new housekeeping employee orientation to the Infection Control Nurse, who will report</p>	08/31/2012			

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			any new housekeeping staff/orientation to the Infection Control Committee. The Administrator will forward this report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.IV. Completion date: August 31, 2012		

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S0154	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (D)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(D) Ensuring that all health care workers, including contract and agency personnel, for whom a license, registration, or certification is required, maintain current license, registration, or certification and keep documentation of same so that it can be made available upon request.</p> <p>Based on document review and interview, the governing board failed to ensure 2 of 3 (AH#2 and AH#3) Certified Registered Nurse Anesthetists (CRNA) had proof of a current advanced practice nursing licensure in their credential files and that 1 of 3 (AH#2) CRNAs had documentation of certification as a CRNA in their credential file.</p> <p>Findings included:</p> <p>1. Review of credential files on 8-13-12 lacked evidence that 2 of 3 (AH#2 and AH#3) Certified Registered Nurse Anesthetists (CRNA) had proof of a current advanced practice nursing licensure for the State of Indiana in their credential files and that 1 of 3 (AH#2)</p>	S0154	<p>S 154 I. Certified Registered Nurse Anesthetist's are not required to have advanced practice licensure in Indiana. The advanced practice certifications by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) were obtained for AH#2, and AH#3 and placed on the chart on August 14 th . The Indiana online licensing verification of AH#2's certification as a registered nurse was obtained and placed on the chart on August 13 th .</p> <p>All credential files were reviewed by the Administrator for licensures/certifications on August 28 , 2012. II. To prevent further deficiencies, the Administrator will obtain licensure and advanced practice</p>	08/31/2012			

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	<p>CRNA's lacked documentation of certification as a CRNA in their credential file.</p> <p>2. Review of facility policy title CREDENTIALS OF ANESTHESIA PERSONNEL, approved on 6-25-12, on 8-13-12 indicated the following: All Certified Registered Nurse Anesthetists are licensed to practice nurse anesthesia in the state of Indiana. All CRNAs are certified by the American Association of Nurse Anesthetists. Copies of their license will be maintained in their medical staff file at Riverview Surgery Center.</p> <p>3. Review of the Medical Staff Bylaws on 8-13-12 indicated the following on 3, D.: Each member of the AHP Staff must be qualified by academic and clinical training to function in a medical support role and hold a license, certificate, and/or other legal credential required by state law for the specific category of AHP.</p> <p>4. Interview the B#1 on 8-13-12 at 1755 hours confirmed the facility failed to maintain credential files with documentation of advance practice nursing licenses in the State of Indiana for 2 of 3 (AH#2 and AH#3) Certified Registered Nurse Anesthetists (CRNA) and documentation of certification for 1 of 3 (AH#2) CRNAs in their credential files.</p>		<p>certification verification within 24 hours of receiving the credentialing applications. No privileges will be granted without proof of licensure/certifications.III. The Administrator will be responsible for reporting any new Allied Health personnel credentialing applications to the Medical Director for review within 24 hours. The Administrator will forward this report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction. IV. Completion Date: August 31, 2012</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 facility failed to address cardiopulmonary resuscitation (CPR) competency requirements for physicians and allied health professionals for 8 of 9 (MD#1 - MD#5 and AH#1, 2, and 4) credential files reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of facility Medical Staff ByLaws/Rules and Regulations and facility policies on 8-13-12 lacked evidence that the facility had addressed CPR competency requirements for physicians and allied health professionals.</li> <li>2. Review of credential files on 8-13-12 lacked evidence of CPR competency for 5 of 5 physicians (MD#1 - MD#5) and 3 of 4 allied health professionals (AH#1, 2, and 4).</li> </ol>	S0162	<p>S162 I. The facility implemented a policy stating that Allied Health Staff and Anesthesiologists are required to have CPR, but Surgeons are not required. All Allied Health &amp; Anesthesiology staff was notified by August 31, 2012.</p> <p>II. To ensure the deficiency does not recur, the Administrator will ensure that a copy of CPR certification is received for each Allied Health Staff &amp; Anesthesiologist, and that Surgeon's state licensure and/or board certification is received upon receipt of each new credentialing application. No privileges will be granted without receipt of proof of current CPR for Allied Health and Anesthesiologist, or state licensure/board certification for Surgeon's.</p> <p>III. The Administrator will be</p>	08/31/2012

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	3. Interview with B#1 on 8-13-12 at 1755 hours confirmed the Medical Staff ByLaws/Rules and Regulations and facility policies do not address CPR competency requirements for physicians and allied health professionals; B#1 confirmed that 5 of 5 physicians (MD#1 - MD#5) and 3 of 4 allied health professionals (AH#1, 2, and 4) do not have documented CPR competencies.		responsible for reviewing the credentialing applications for Surgeons, Anesthesiologists and Allied Health, and submitting to the Medical Director for review within 24 hours of receipt. The Administrator will report any new credentialing applications to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.IV. Completion Date: August 31, 2012				

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S0332	<p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the center:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention.</p>			
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	<p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide</p>			

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	<p>resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p>			

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	<p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on</p>						

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	<p>the grounds of the center. (iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p> <p>Based on document review and interview, the facility failed to establish a policy and process to determine the occurrence of reportable events in the center reportable to the Indiana State Department of Health (ISDH).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of facility documents on 8-13-12 lacked evidence that the facility had established a policy and process to determine the occurrence of reportable events reportable to the ISDH.</li> <li>Interview with B#1 on 8-13-12 at 1430 hours confirmed the facility policy titled ADVERSE EVENT does not address a process to determine the occurrence of reportable events, those required by the ISDH.</li> </ol>	S0332	<p>S332 I. The facility revised the policy titled "adverse events" on August 27 th to include the identified 28 state reportable events. II. To prevent the recurrence of this deficiency, all staff were inserviced on reportable adverse events &amp; revised policy on August 29 th . III. The Staff will be responsible for completing incident occurrence reports in relation to adverse events, and notifying the Supervisor or Administrator. The Supervisor will be responsible for notifying the Administrator upon each occurrence, as notified by the staff. The Administrator will be responsible for reviewing incident occurrence reports to identify state reportable adverse events, and will report them to the Indiana State Department of Health within 15 working days. The Administrator will report all adverse events (incident occurrence reports) to the QA Committee, Medical Executive Committee, and Board of Managers, quarterly for review. The Administrator is responsible for the implementation and monitoring of this Plan of Correction. IV. Completion Date:</p>	08/31/2012			

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S0334	<p>410 IAC 15-2.4-2.2(a)(2) QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) center employee involved;</p> <p>or any other information.</p> <p>(2) A potential reportable event may be identified by a center that:</p>						

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	<p>(A) receives a patient as a transfer; or (b) admits a patient subsequent to discharge; from another health care facility subject to a reportable event requirement. In the event that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually.</p> <p>(e) Any serious reportable listed in subsection (a)(1) that: (1) is determined to have occurred within the center between: (A) January 1, 2009; and (B) the effective date of this rule; and (2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)</p>			

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	<p>Based on document review and interview, the facility failed to develop a process to report adverse events, those determined by the Quality Assessment and Performance Improvement (QAPI) committee and reportable to the Indiana State Department of Health (ISDH), in a specified timeframe.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of facility documents on 8-13-12 lacked evidence that the facility had developed a process to report adverse events, those determined by the Quality Assessment and Performance Improvement (QAPI) committee and reportable to the Indiana State Department of Health (ISDH), in a specified timeframe.</li> <li>Review of the facility policy titled ADVERSE EVENT on 8-13-12 indicated the following: Contact the Department of Health and Mental Hygiene @ 410-402-8040 and fax the information over within 48 hours.</li> <li>Interview with B#1 on 8-13-12 at 1420 hours confirmed the facility had not developed a policy/process to report adverse events to the ISDH or a timeframe for reporting the event.</li> </ol>	S0334	<p>S334</p> <ol style="list-style-type: none"> <li>The facility revised the policy titled "adverse events" on August 27 th to include the process for notification of the Indiana State Department of Health for state reportable events.</li> <li>To prevent the recurrence of this deficiency, on August 29 th the staff were inserviced on the reporting process for state reportable adverse events &amp; the revised policy.</li> <li>The Staff will be responsible for completing incident occurrence reports in relation to adverse events. The Administrator will be responsible for reviewing incident occurrence reports to identify state reportable adverse events. The Administrator will be responsible for reporting state reportable events to the Indiana State Department of Health within 15 working days. The Administrator will forward this report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly for review. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.</li> <li>Completion Date:</li> </ol>	08/31/2012			

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S0400	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and staff interview, the facility failed to provide an environment that minimized risk to patients for 1 surgical area toured.</p> <p>Findings include:</p> <p>1. During tour of the surgical area beginning at 3:05 p.m. on 8/13/12, the following was observed:</p> <p>(A) Three (3) large trash bags of trash were stored in the janitor closet with one stacked on top of a mop bucket containing liquid. The mop bucket was identified by staff as one that would be used by housekeeping to clean the operating rooms (OR's).</p> <p>(B) Three (3) boxes of surgical caps were stored in the female restroom in front of the commode.</p> <p>(C) One (1) package of IV tubing was found opened out of sterile package and in the patient drawer in the post operative bay #1.</p> <p>(D) One (1) IV start kit labeled as sterile was opened in the patient drawer in the post operative bay #2.</p>	S0400	<p>S400</p> <p>I. The staff were instructed on August 13 th , and acted immediately to remove trash from the janitor's closet and place into the facility dumpster, to prevent the cross-contamination of the clean mop bucket.</p> <p>II. To prevent this deficiency from recurring, all Staff were inserviced on August 14 th &amp; 15 th on the emptying of trash, and the significance of cross-contamination with the mop bucket in the janitor's closet.</p> <p>III. All OR staff will be held responsible for emptying the trash, daily, and as needed, and preventing cross-contamination in the janitor's closet. The OR nurse(s) will visually monitor the room daily, and as needed, for confirmation of the emptying of trash and prevention of cross-contamination. The Infection Control (IC) Nurse will audit the facility's infection control practices, monthly, and report findings to the IC</p>	08/31/2012			

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	2. Staff member #1 verified the above during the tour (beginning at 3:05 p.m.) and indicated the mop bucket observed in the janitor closet would be used by housekeeping for cleaning the ORs.		committee quarterly. The Administrator will forward this report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.  IV. Completion Date: August 31, 2012				

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S0444	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on document review and observation, the facility failed to ensure adherence to facility dress code policy for one (1) surgical tech observed.</p> <p>Findings include:</p> <p>1. Facility policy titled "Dress Code, Clinical Staff" with an effective date of 6/25/12 states on page 2: "F. Footwear 1. Leather tennis shoes 2. Safe duty type clogs....."</p> <p>2. Staff member #N2 was observed in the restricted area with brown western type leather boots.</p>	S0444	<p>S444</p> <p>I. This staff member's designated OR shoes are a leather suede workboot, which she wears for gait stability. She was instructed on August 13 th to wear shoe/boot covers pending policy amendment. The Dress Code: Clinical Staff policy was revised on August 27 th to include suede, leather, and rubber shoes or boots for footwear attire, per AORN recommended practices.</p> <p>II. To prevent further recurrence of this deficiency, all staff were inserviced on August 14 th &amp; 15 th on the current policy for compliance. All staff were inserviced on August 29 th of the Dress Code: Clinical Staff policy revision.</p>	08/31/2012			

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			<p>III. All clinical staff will be held responsible for compliance with the dress code policies. The IC Nurse will conduct a monthly audit of the facilities IC practices, and report findings to the IC Committee, quarterly. The Administrator will forward this report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.</p> <p>IV. Completion Date: August 31, 2012</p>		

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S0612	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on document review and staff interview, the facility failed to ensure the accurate date was on the history and physical (H&amp;P) for 2 of 13 medical records (patients #N5 and N7).</p> <p>Findings include;</p> <p>1. Facility policy titled "Medical Records" with effective date of 6/25/12 states on page 2: "A. All clinical entries in the patient's medical record shall be accurately dated and authenticated....."</p> <p>2. Review of patient #N5 medical record indicated the following: (A) The patients H&amp;P was dated 8/8/12 (date of procedure), however the H&amp;P had been faxed to the facility and the date stamp for the faxed copy was dated 8/7/12.</p> <p>3. Review of patient #N7 medical record</p>	S0612	<p>S612</p> <p>I. The Podiatry physicians were notified on August 14 th of the requirement that all H &amp; P's done 30 days or less prior to the day of surgery must be updated on the day of surgery to indicate any possible changes or lack thereof.</p> <p>II. To prevent further recurrence, the Staff were inserviced on August 14 th of the need to have all surgeons fill out the H&amp;P update form, on the day of surgery. The surgeons were notified &amp; inserviced on August 23 rd at the board meeting.</p> <p>III. The Preop Nurse will be responsible for obtaining updated H&amp;P's for the charts, daily. The Staff Nurse performing the weekly chart audits will confirm the updated H&amp;P's. The Administrator will review weekly chart audits, and report findings to the Quality Assurance Committee, Medical Executive</p>	08/31/2012			

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	<p>indicated the following:</p> <p>(A) The patient's H&amp;P was dated 8/1/12 (date of procedure), however the H&amp;P had been faxed to the facility and the date stamp for the faxed copy was dated 7/31/12.</p> <p>4. Staff member #1 verified the above beginning at 5:30 p.m. on 8/13/12.</p>		<p>Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.</p> <p>IV. Completion Date: August 31, 2012</p>				

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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. Based on document review and staff interview, the facility failed to ensure physician orders were completed for 11 of 13 medical records (patients #N1-N9 and N12 and N13).</p> <p>Findings include;</p> <p>1. Review of patients' #N1-N9 and N12 and N13 medical records indicated the following: (A) The medical records contained a pre-printed order form signed by the anesthesia provider with no specific medications circled/selected making it possible for nursing staff to select medications and administer numerous medications including, but not limited to, Fentanyl, Demerol, Morphine, Dilaudid, Lortab, Zofran, and Dexamethsone.</p> <p>2. Staff member #1 verified the above in interview beginning at 5:30 p.m. on 8/13/12.</p>	S0640	<p>S640</p> <p>I. Anesthesia providers were inserviced on August 14 th to instruct them that any pre-printed orders must be marked in a way to indicate the specific orders that apply.</p> <p>II. To prevent further recurrences, all Staff Nurses were inserviced on August 14 th &amp; 15 th to ensure that anesthesia pre-printed orders were marked to indicate orders applicable to that patient.</p> <p>III. All Anesthesia providers will be responsible for marking applicable orders on pre-printed forms. All Staff Nurses will be responsible for ensuring that their patient's chart has anesthesia orders indicated. The Staff nurse performing weekly chart audits will monitor that anesthesia is marking pre-printed orders. The Administrator will review chart audits weekly, and forward this</p>	08/31/2012			

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			<p>report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.</p> <p>IV. Completion Date: August 31, 2012</p>		

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S0658	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(6)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(6) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and staff interview, the facility failed to ensure a completed anesthesia consent was obtained for 4 of 11 medical records (patients #N2, N4, N6, and N12).</p> <p>Findings include:</p> <p>1. Facility policy titled "Required Documentation" with an effective date of 6/25/12 states on page 2: "Anesthesiologist shall personally obtain informed consent from patient or patient guardian or representative."</p> <p>2. Review of patients #N2, N4, N6, and N12 anesthesia consents indicated the following: (A) The anesthesia consent states in paragraph 2: ".....I understand that the type of anesthesia services checked below</p>	S0658	<p>S658</p> <p>I. Anesthesia providers were inserviced on August 14 th to instruct them that any anesthesia consent must be marked in a way to indicate the specific type of anesthesia that applies.</p> <p>II. To prevent further recurrences, all Staff Nurses were inserviced on August 14 th &amp; 15 th to ensure that anesthesia consents were marked to indicate the type applicable to that patient.</p> <p>III. All Anesthesia providers will be responsible for marking applicable type of anesthesia on the consent forms. All Staff Nurses will be responsible for ensuring that their patient's chart has anesthesia type indicated on the consent.</p>	08/31/2012			

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	<p>will be used for my procedure.....". The type of anesthesia was not checked on the form for each patient.</p> <p>3. It could not be determined that the patient was informed of the type of anesthesia they would be receiving by review of the anesthesia consents.</p> <p>4. Staff member #1 verified in interview, the type of anesthesia was not specified on the consent beginning at 5:30 p.m. on 8/13/12.</p>		<p>The Staff nurse performing weekly chart audits will monitor that anesthesia is marking the type of anesthesia on the consent. The Administrator will review chart audits weekly, and will forward this report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.</p> <p>IV. Completion Date: August 31, 2012</p>				

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S0710	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p>						

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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>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on document review and interview, the medical staff failed to maintain complete credential files according to the Medical Staff ByLaws/Rules and Regulations for 2 of 5 physicians (MD#1 and MD#5) and 3 of 4 allied health professionals (AH#1- AH#3).</p> <p>Findings included:</p> <p>1. Review of credential files on 8-13-12 indicated the following:</p> <p>a.) MD#1's credential file lacked admitting privileges at a hospital in</p>	S0710	<p>S710</p> <p>I. MD# 1's had privileges reviewed by the Credentialing Committee at Deaconess Gateway Hospital on August 2, and the Board Meeting approval on August 27, 2012. MD#5 was temporary anesthesia staffing via agency, and is no longer providing services at Riverview, however, an updated malpractice was placed on file. An inservice was held on August 14 th with the anesthesia contracted service consultant to</p>	08/31/2012			

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	<p>Spencer County or an adjacent county (privileges were at a rehabilitation hospital in Vanderburgh County, which is not adjacent to Spencer County).</p> <p>b.) MD#5's credential file lacked current malpractice insurance (expired 2-28-09) and no documentation of hospital privileges in Spencer County or an adjacent county.</p> <p>c.) AH#1's credential file lacked evidence of CSR registration or malpractice insurance.</p> <p>d.) AH#2's credential file lacked proof of an advanced practice nursing license for the State of Indiana, certification as a nurse anesthetist, and the malpractice insurance expired on 8-8-12.</p> <p>e.) AH#3's credential file lacked proof of an advanced practice nursing license for the State of Indiana.</p> <p>2. Review of the Medical Staff Bylaws/Rules and Regulations on 8-13-12 indicated the following on page 3, B.: In addition to the foregoing requirements for appointment to the Staff, each Active Staff member shall hold current staff privileges at one or more acute care hospital in the community in which Riverview Surgery Center is located and which are accredited by the Joint Commission on Accreditation of Health Organizations.</p> <p>3. Review of the Medical Staff Bylaws/Rules and Regulations on 8-13-12</p>		<p>inform him of hospital privilege requirements for any anesthesia physicians who perform pain management, including temporary agency staffing. CRNA's are not required to have CSR's or advanced practice licenses, however, on August 29 th AH 1, 2, &amp; 3's credential files were audited and updated nursing licenses, advance practice certifications, and malpractice policies were placed in their files. AH#1 and AH#2 were temporary agency staffing and are no longer at the facility.</p> <p>II. To prevent this recurrence, the Administrator audited all credential files for current dates and presence of documents on August 29 th . The Business Office Manager (BOM) will track the expiration dates of credential file documents, monthly, and request updated documents, as indicated, from the physicians and allied health personnel.</p> <p>III. The BOM will be responsible for maintaining updated credential files, monthly. The BOM will report any noncompliance to the Administrator. The Administrator will review the noncompliance report monthly &amp; request the information from the physicians and allied health. The Administrator will forward this report to the Quality Assurance</p>				

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	<p>indicated the following on page 3, D.:</p> <p>Each member of the AHP Staff must be qualified by academic and clinical training to function in a medical support role and hold a license, certificate, and/or other legal credential required by the state law for the specific category of AHP.</p> <p>4. Interview with B#1 on 8-13-12 at 1755 hours confirmed MD#1 does not have hospital admitting privileges at a hospital in Spencer County or an adjacent county; MD#5's malpractice insurance expired 2-28-09, provides pain management procedures at the facility, and does not have admitting privileges at a hospital in Spencer County or an adjacent county; AH#1 does not have a CSR registration or proof of malpractice insurance in the credential file; AH#2 does not have proof of an advanced practice nursing license in the State of Indiana, proof of certification as a nurse anesthetist, and the malpractice insurance expired 8-8-12; AH#3 does not have proof of a current advanced practice nursing license in the State of Indiana.</p>		<p>Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.</p> <p>IV. Date of Completion: August 31, 2012</p>				

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S0906	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(a)(2)</p> <p>(a) Patient care services must require the following:</p> <p>(2) That personnel with appropriate training are available at all times to handle possible emergencies involving patients of the center. Based on document review and staff interview, the facility failed to ensure nursing staff received orientation and for 2 of 5 nursing personnel files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Facility policy titled "Employee Files" with an effective date of 6/25/12 states on page 1: "Personnel folders shall be maintained on each employee. Personnel folders shall include: .....Orientation checklist"</li> <li>2. Nursing staff members #N1 and N3 personnel files lacked an orientation and checklist.</li> <li>3. Staff member #1 verified the above in interview at 5:00 p.m. on 8/13/12.</li> </ol>	S0906	<p>S906 I. Orientation checklists were completed and placed in the files of N1 and N3 on August 27 th . II. To prevent this recurrence, all personnel files were audited for orientation checklists by the Administrator on August 29 th . The BOM will perform monthly audits of personnel files for updated information needed, and submit the report to the Administrator. III. The BOM will perform monthly audits of personnel files, and submit the report to the Administrator. The Administrator will review the report, and obtain the necessary forms. The Administrator will forward this report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction. IV. Date of Completion: August 31, 2012</p>	08/31/2012			

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S1000	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6</p> <p>The center shall provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services. Pharmaceutical services must have the following: Based on document review, observation and interview, the facility failed to ensure anesthesia drugs were provided in a safe manner for 3 of 3 anesthesia carts observed.</p> <p>Findings include:</p> <p>1. Facility policy titled "Multi-dose Vials" with an effective date of 6/25/12 states under procedure: "Multi-dose vials are to be dated for 30 days when expired and initialed when opened. Single use vials are opened and discarded after one time use....."</p> <p>2. The following was observed in the anesthesia block cart maintained in the pre-operative area at 3:05 p.m. on 8/13/12. Anesthesia services were completed for the day at the time of the tour: (A) Two (2) 30 ml vials of .5% Bupivacaine HCL opened with partial</p>	S1000	<p>S1000</p> <p>I. All medications found on August 13 th to be opened, unlabeled, or drawn-up in any anesthesia cart were thrown away. The anesthesia providers were inserviced on August 14 th of the survey findings, and regulations pertaining to these findings. The Clinical Staff were inserviced on August 14 th &amp; 15 th on the survey findings and regulations pertaining to these findings.</p> <p>II. To prevent this from recurring, the policy "multi-dose vials" was amended on August 27 th to state multi-dose vials will expire in 28 days from opening. All staff were inserviced on August 29 th on the revised policy.</p> <p>III. The Anesthesia providers and Clinical Staff will be</p>	08/31/2012

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	<p>contents gone. The vials were marked as single dose vials (SDV).</p> <p>3. The following was observed in the anesthesia cart in operating room (OR) #1 beginning at 3:30 p.m. on 8/13/12:</p> <p>(A) One (1) 10 ml vial of Rocuronium Bromide opened with 2/3 of contents used. The vial was labeled as a multi-dose vial (MDV), however was not initialed and dated as to when it was opened.</p> <p>(B) One (1) 50 ml vial of 2% Lidocaine opened with 2/3 of contents used. The vial was labeled as a MDV and was not initialed and dated as to the date it was opened.</p> <p>(C) One (1) 30 ml. vial of 1 % Lidocaine opened with 1/2 of contents used. The vial was labeled as a SDV and should have been discarded.</p> <p>(D) One (1) 20 ml vial of Diprivan opened with 2/3 of contents used. The vial was labeled as a SDV and should have been discarded.</p> <p>(E) One (1) 1 ml vial of Nalaxone HCL opened with 3/4 of contents used. The vial was labeled as a SDV and should have been discarded.</p> <p>4. The following was observed in the anesthesia cart in OR #2 beginning at 3:45 p.m on 8/13/12:</p> <p>(A) One (1) 50 ml vial of Lidocaine 2%</p>		<p>responsible for disposing of all single-use vial medications properly, ensuring proper labeling of any multi-use vials, and securing all medications per regulations. The IC nurse will perform a monthly audit of the facility, and report those findings to the IC Committee, quarterly. The Administrator will forward this report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.</p> <p>IV. Date of Completion: August 31, 2012</p>				

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	<p>opened. The vial was labeled as a MDV, however was not dated or initialed as to date it was opened.</p> <p>(B) One (1) 20 ml. vial of Diprivan opened with 2/3 of contents used. The vial was labeled as a SDV and should have been discarded.</p> <p>(C) One (1) 10 ml vial of Rocuronium Bromide with 1/2 of contents used. The vial was labeled as a MDV and was not initialed or dated as to when it was opened.</p> <p>(D) One (1) Metoprolol Tartrate vial opened and 1/4 of contents used. The vial was labeled as a SDV and was dated 9/9 (known date error).</p> <p>5. Staff member #1 verified the above findings during the tour of each area.</p>			

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S1012	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(B)</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>(B) Drug administration according to established center policies and acceptable standards of practice.</p> <p>Based on document review and staff interview, the facility failed to ensure medications were administered according to a physician order and facility policy for 1 of 11 medical records reviewed (patient #N3).</p> <p>Findings include;</p> <p>1. Facility policy titled "MEDICATION ADMINISTRATION" with an effective date of 6/25/12 states on page 2: "2. No medication can be given without a physician's order."</p> <p>2. Review of patient #N3 medical record indicated the following: (A) The record indicated RN #N4 administered "Remazon" (known spelling error) 1 cc at 1125 and 1155 on 7/30/12.</p>	S1012	<p>S1012</p> <p>I. The Staff Nurse had received a verbal order from the CRNA and failed to write it on the medical chart for N3. The Staff Nurse placed a late entry written verbal order on the chart for the Romazicon ordered on 7/30/12.</p> <p>II. To prevent this from recurring, all Staff Nurses were inserviced on August 14 th &amp; 15 th regarding proper transcription of verbal orders.</p> <p>III. All Staff Nurses are responsible for writing and transcribing on the medical chart any verbal orders received. The Staff Nurse performing weekly chart audits will monitor for transcription of orders for medications given. The Administrator will review weekly</p>	08/31/2012			

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	(B) The record lacked an order for the medication.  3. Staff member #1 verified there was no order for the above medication beginning at 5:30 p.m. on 8/13/12.		chart audits, and will forward this report to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.  IV. Completion Date: August 31, 2012				

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S1198	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the facility failed to coordinate emergency and disaster preparedness with a governmental agency.</p> <p>Findings include:</p> <p>1. Review of facility documents on 8-13-12 lacked evidence that the facility had coordinated emergency and disaster preparedness with a governmental agency.</p> <p>2. Interview with B#1 on 8-13-12 at 1630 hours confirmed that the facility had not coordinated emergency and disaster preparedness with a governmental agency.</p>	S1198	<p>S1198</p> <p>I. The BOM contacted the Spencer County Emergency Management Agency (EMA) on August 28 th , to coordinate disaster preparedness planning with Riverview. The Administrator set up a meeting with the head of the Spencer County EMA for August 31st at 3:00pm for review of the facility's disaster preparedness plan, and coordination with the Spencer County EMA.</p> <p>II. To prevent this from recurring, the Administrator, or designee, will review the disaster plans, annually, and coordinate planning, annually, with the Spencer County EMA.</p> <p>III. The Administrator or designee, will be responsible for coordinating the facility disaster plan with the county EMA, annually. The Administrator will</p>	08/31/2012			

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			<p>forward this data to the Quality Assurance Committee, Medical Executive Committee, and Board of Managers, quarterly. The Administrator is responsible for the implementation and monitoring of this Plan of Correction.</p> <p>IV. Completion Date: August 31, 2012</p>		