

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001088		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/07/2011	
NAME OF PROVIDER OR SUPPLIER  GOSHEN AMBULATORY CARE CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1605 WINSTED DR GOSHEN, IN 46526			
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 011074</p> <p>Survey Date: 12-05-11 to 12-07-11</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/21/11</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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S0148	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c) (4)</p> <p>(c) The governing body shall do the following:</p> <p>(4) Require that the chief executive officer designate in writing an administrative officer to serve during his or her absence.</p> <p>Based on document review and interview, the facility failed to clearly indicate in writing who would be in charge when the chief executive officer was not present.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The policy/procedure Assure Appropriate Management of Facility Absence of Administrator (reviewed 01-26-10) indicated that the Director of Nursing would be in charge in the absence of the Administrator.</li> <li>The Job Description: Director of Nursing (reviewed 01-26-10) indicated the following: " The Director of Nursing, in the absence of the Medical Director, assumes responsibility for the appropriate delivery of patient care. "</li> <li>During an interview on 12-06-11 at 1630 hours, staff #A2 confirmed the policy/procedure and job description failed to mutually indicate that either the</li> </ol>	S0148	<p>Revised Director of Nursing job description to include: "The Director of Nursing, in the absence of the Administrator, will be the acting administrator." This revision was approved by the Quality Assurance Committee on January 19, 2012 and the Board of Directors on January 27, 2012. The corrective action will be monitored by the Administrator by reviewing policies triennially. Addendum: Director of Nursing and Administrator discussed problem and came up with an action plan.</p>	01/06/2012	

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	Director of Nursing or the Medical Director would be in charge when the administrator was not present.				

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S0176	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on document review and interview, the facility failed to document contracted housekeeping personnel competency for cleaning and disinfecting operating rooms and sterile processing areas at the center for four contracted employees.</p> <p>Findings:</p> <p>1. The policy/procedure Housekeeping Personnel File (reviewed 01-26-10) failed to indicate that the personnel file must contain documentation of competency for cleaning the operating rooms and surgical corridor as directed by the infection control committee to assure that the contracted housekeeping performance is consistent with accepted (infection control) standards.</p> <p>2. The policy/procedure Housekeeping Services (reviewed 01-26-10) indicated</p>	S0176	<p>Revised policy I-26 (Housekeeping Personnel File) to include the addition of annual evaluations. The Director of Nursing implemented a new evaluation form, utilizing the CDC guidelines. The form was approved by the Quality Assurance Committee on January 19, 2012 and the Board of Directors on January 27, 2012. The housekeeping personnel will be evaluated by direct observation and interview, utilizing the new evaluation form, referenced above. This will be done on a quarterly basis by the Director of Nursing beginning 1st quarter 2012, and no later than March 31, 2012. Revised policy L-35 (Housekeeping Services) to describe the specific procedure/process for cleaning and disinfecting an operating room and all other areas, in accordance with accepted standards. Policy L-60 (Environmental Cleaning) was</p>	01/06/2012			

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	<p>that the (housekeeping service) " shall be provided with appropriate procedural guides for cleaning all areas of the center.</p> <p>" The policy/procedure failed to describe the specific procedure/process for cleaning and disinfecting an operating room (OR) by housekeeping staff and lacked a provision for documenting the competency of each housekeeping staff by direct observation of specific cleaning objectives (i.e., from high to low, least contaminated to most contaminated, etc.)</p> <p>3. During an interview on 12-06-11 at 1625 hours, staff #A2 confirmed that the 4 housekeeping personnel files lacked documentation of cleaning competency for operating room and sterile processing areas and the policy/procedures failed to indicate the specific cleaning process standards for validating the housekeeping staff performance in the OR.</p>		<p>incorporated into policy L-35 (Housekeeping Services). These changes were approved by Infection Control Committee on January 17, 2012, Quality Assurance Committee on January 19, 2012, and Board of Directors on January 27, 2012. This will be monitored by the Director of Nursing, Infection Control Committee, Quality Assurance Committee and Board of Directors on a quarterly basis, beginning 1st quarter, 2012. Addendum: Director of Nursing and Administrator discussed problem and came up with an action plan.</p>		

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S0212	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(d)(2)(A &amp; B)</p> <p>(d) In accordance with center policy, the governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The center develops, implements, and maintains written medical staff policies and procedures for emergencies, initial treatment, and transfer.</p> <p>(B) The center provides immediate lifesaving measures within the scope of service available, to all persons in the center, to include, but not be limited to, the following:</p> <p>(i) Timely assessment. (ii) Basic life support. (iii) Proper transfer mode.</p> <p>Based on document review and interview, the center failed to maintain its policy/procedures for emergencies and provisions for immediate lifesaving measures for all persons in the center.</p> <p>Findings:</p> <p>1. The publication 'Highlights of the 2010 American Heart Association Guidelines for CPR and ECC' indicated the following: "Healthcare providers who treat cardiac arrest in hospitals and other</p>	S0212	<p>Revised policy K-165 (Management of Cardiac/Respiratory Arrest) to include "attach AED as soon as it is available," after beginning CPR. Also, revised policy K-165 to include "using the most current AHA guidelines" following the use of emergency cardiovascular care algorithms. All clinical staff will be inserviced by March 31, 2012 and annually thereafter on Code Blue by the Director of Nursing. This will be monitored annually by the Quality Assurance Committee and the Board of Directors.The</p>	01/06/2012			

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	<p>facilities with on-site AEDs or defibrillators should provide immediate CPR and should use the AED/defibrillator as soon as it is available. These recommendations are designed to support early CPR and early defibrillation, particularly when an AED or defibrillator is available within moments of the onset of sudden cardiac arrest (page 9-10)."</p> <p>2. The policy/procedure Management of Cardiac/Respiratory Arrest (reviewed 01-26-10) failed to indicate a requirement to attach and use the defibrillator as soon as it is available.</p> <p>3. On 12-06-11 at 1020 hours, staff #A2 confirmed that the policy/procedure failed to ensure immediate use of a defibrillator as soon as it was available.</p>		<p>revision to the policy and actions were approved by Quality Assurance Committee on January 19, 2012 and the Board of Directors on January 27, 2012. Addendum: Director of Nursing and Administrator discussed problem and came up with an action plan.</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. Based on document review and interview, the center failed to evaluate the radiologist group contracted services through the Quality Assurance (QA) program. Findings: 1. The Quality Assurance Plan (revised 10-11) indicated the following: "The Quality Assurance Plan focuses on the process and outcome of care given in areas of direct clinical and support services. These areas include ... The provision and utilization of professional services ...[of] ... radiology ...". 2. Review of facility documentation ' Contracted Services ISDH Monitors ' for the year 2011 failed to indicate a provision for the radiologist group providing chest x-ray interpretations for patients at the center. 3. During an interview on 12-07-11 at</p>	S0310	<p>The Administrator is working on a contract with a private physician (radiologist) to provide necessary radiology services. This process will be completed by February 29, 2012. The Board of Directors approved this action on January 27, 2012. Addendum: Administrator and Medical Director discussed and decided upon contracting with a locum tenens physician (radiologist) for radiology services. This physician will be credentialed, following the same process as all other physicians, and evaluated through the Quality Assurance plan on a quarterly basis.</p>	01/06/2012			

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	1330 hours, staff #A1 confirmed that the radiologist group was not being evaluated through the QA plan.				

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S0526	<p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on policy review, personnel file review and interview, the facility failed to ensure annual competency regarding out of laboratory testing was completed for 14 of 14 staff members who performed this testing (#N1- 8, N10 and N12- 16).</p> <p>Findings included:</p> <p>1. The "Annual Competency Clinical Skills Assessment" for the Registered Nurses indicated, "...Waived Testing: Evaluation includes written evaluation of theory; direct observation of test performance by a qualified proctor; direct observation of quality control methodologies (equipment calibration, outdating, troubleshooting, quality control and remedial actions, documentation of quality control measures), if applicable. List waived testing performed: Blood glucose monitoring, Other- Hemocue, Urine HCG, Urinalysis."</p> <p>2. Review of the personnel files for the registered nurses, staff members #N1-8,</p>	S0526	<p>Revised Nursing Orientation Checklist to include: "demonstrate waived testing - glucometer, hemocue, urinalysis, and urine HCG". Revised Policy F-15 (Inservice &amp; Staff Meetings) to include "Waived Testing - Glucometer, Hemocue, Urinalysis, and Urine HCG" as one of the in-services that will be conducted annually. This will be conducted by the Director of Nursing on an annual basis, beginning 1st quarter, 2012, no later than March 31, 2012. A new form was implemented January 13, 2012 for all employees on required compliance training. This will be monitored by the Director of Nursing on a quarterly basis, beginning 1st quarter, 2012 and no later than March 31, 2012, and on-going thereafter to ascertain that all staff have met required competencies. The above revisions and actions approved by the Quality Assurance Committee on January 19, 2012 and the Board of Directors on January 27, 2012. Addendum: Director of Nursing and Administrator discussed</p>	01/06/2012			

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	N10, and N12- 16, failed to evidence any documentation of annual waived testing written evaluations or observations.  3. At 1:30 PM on 12/07/11, staff member #N11 indicated the current glucometer, the Accucheck Aviva, was put into use in December 2010 and confirmed there was no documentation of staff training in the device. He/she also indicated there was a check-off sheet on the annual evaluations for the waived testing, but confirmed there were no formal educational competencies.		problem and came up with an action plan.		

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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 follow its policy/procedure and ensure all entries in the medical record are authenticated and verified as allowed by center and medical staff policies.</p> <p>Findings:</p> <p>1. The policy/procedure Entries in the Medical Record (reviewed 01-26-2010) indicated the following: "All entries must be initialed or signed with initial of first name, full surname, and credentials ... [and] ... Authorship is verified by checking signatures on ... medical staff applications for practitioners."</p> <p>2. Review of the agreement with the</p>	S0616	<p>The Administrator is working on a contract with a private physician (radiologist) to provide necessary radiology services. This process will be completed by February 29, 2012. The Board of Directors approved this action on January 27, 2012. Addendum: Administrator and Medical Director discussed and decided upon contracting with a locum tenens physician (radiologist) for radiology services. This physician will be credentialed, following the same process as all other physicians, and evaluated through the Quality Assurance plan, on a quarterly basis. This process will provide the means to verify authentication of the radiology provider.</p>	01/06/2012			

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	<p>radiologist service dated 06-23-2003 indicated the following: "...the signed reports will normally be ready within two days. A preliminary report will be faxed within 24 hours."</p> <p>3. Review of the medical record for patient P7 failed to indicate a signature, initials, or other means of authentication by the interpreting radiologist for the faxed pre-operative x-ray report dated 06-07-11.</p> <p>4. During an interview on 12-05-11 at 1420 hours, staff #A1 confirmed that the center lacked credential files for the radiologists providing services for the center.</p> <p>5. During an interview on 12-07-11 at 1330 hours, staff #A1 confirmed that the medical record lacked an authenticated report for patient P7 and that the center lacked an effective means to verify the report authentication by the radiology service providers.</p>				

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S0646	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(3)</p> <p>All entries in the medical record must be as follows:</p> <p>(3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule.</p> <p>Based upon document review and interview, the center lacked a policy/procedure to ensure all entries in the medical record (MR) were dated when signed by the person making the entry.</p> <p>Findings:</p> <p>1. The policy/procedure Entries in the Medical Record (reviewed 01-26-10) indicated the following: " All entries must be initialed or signed with initial of first name, full surname, and credentials." "</p> <p>2. On 12-07-11 at 1330 hours, staff #A1 confirmed the policy/procedure failed to ensure all MR entries would be dated when signed.</p>	S0646	<p>Revised Policy K-10 (Nursing Documentation) #5 to include "All entries on patient's chart will be legible, dated, and signed." Revised Policy J-25 (Entries in the Medical Record) #3 to include "All entries must be dated and initialed or signed with initial of first name, full surname, and credentials." The Director of Nursing will conduct random monitoring of daily chart audits by clinical and administrative staff. Frequency of monitoring will be 6 months, beginning January 1, 2012. The Quality Assurance Committee will determine if furthur monitoring is necessary in July, 2012, following 6 months of auditing by Director of Nursing. The Quality Assurance Committee aproved the above revisions and actions on January 19, 2012 and the Board of Directors on January 27, 2012. Addendum: Director of Nursing and Administrator discussed problem and came up with an action plan.</p>	01/06/2012	

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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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	<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 governing body failed to ensure that the medical staff credential files included a signed statement to abide by the rules of the center for 10 of 10 credentialed staff and failed to delineate privileges requested and privileges granted for 3 of 10 credentialed staff at the center.</p> <p>Findings:</p> <p>1. The Medical Staff Bylaws (approved 01-26-10) indicated the following: " Appointment to the Medical Staff will</p>	S0710	Implemented "Physician Agreement Letter for Reappointments" (which includes a signed statement that the physicians will abide by the rules and bylaws of the center) for medical staff who apply for reappointment of privileges, similar to initial appointment of privileges. Implemented "Reappointment Request for Privileges Form/Department of Anesthesiology" for all anesthesiologists who apply for reappointment of privileges, similar to initial appointment of privileges. Implemented revised	01/06/2012

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	<p>confer no right to continuing membership of clinical privileges or to reappointment .... All applications for appointment to the Medical Staff will [include] ... a signed acknowledgement that the applicant has ... read the Medical Staff policies and agrees to be bound by the terms thereof .... Each application for Medical Staff appointment and reappointment must contain a request for specific clinical privileges desired by the applicant .... A decision and notice to appoint will include the clinical privileges the applicant may exercise ... "</p> <p>2. Review of all (10) credential files failed to indicate a signed statement to abide by the rules and bylaws of the center.</p> <p>3. During an interview on 12-07-11 at 1000 hours, staff #A3 confirmed that the credential files lacked a signed statement to abide by the rules and bylaws of the center.</p> <p>4. Review of the credential file for MD5 indicated a request for specific clinical privileges in Anesthesiology dated 09-28-99 and subsequent reapplications failed to indicate a request for specific clinical privileges in Anesthesiology. The</p>		<p>reappointment notification which indicates the privileges granted. The above additions and revision were approved by the Board of Directors on January 27, 2012. The Administrator and Executive Assistant are responsible for obtaining information for all reappointments, if applicable, effective January 27, 2012.</p>				

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	<p>reappointment notification dated 10-28-11 failed to indicate the specific clinical privileges in Anesthesiology granted by the Board of Directors.</p> <p>5. Review of the credential file for MD8 indicated a request for specific clinical privileges in Anesthesiology dated 12-21-05 and reapplications lacked a request for specific clinical privileges. The reappointment notification dated 02-24-10 failed to indicate the privileges granted.</p> <p>6. Review of the credential file for MD10 indicated the request for clinical privileges in Anesthesiology dated 06-16-05 failed to indicate Class I, Class II, or Class III Privileges requested and reapplications lacked a request for specific clinical privileges. The reappointment notification dated 04-26-11 failed to indicate the privileges granted.</p> <p>7. During an interview on 12-07-11 at 1110 hours, staff #A3 confirmed that the 3 credential files lacked a reapplication request for privileges and lacked a reappointment statement of privileges granted.</p>			

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S0728	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)</p> <p>(b) The medical staff shall adopt and enforce bylaws to carry out its responsibilities. These bylaws and rules must be as follows: Based on document review and interview, the medical staff failed to abide by its bylaws and rules and ensure that only credentialed medical staff provided services to patients at the center.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The Medical Staff Bylaws (approved 01-26-10) indicated the following: "No practitioner will ... provide services to patients in the Surgery Center unless he/she is a member of the Medical Staff ... [and] ... Consulting Medical Staff do not have admitting privileges but may assist or consult in the treatment of patients and the program of care in the Center."</li> <li>2. Facility documentation dated 10-13-2011 indicated that 26 chest x-rays were performed between 07-01-11 and 09-30-11 and interpretations were provided by 5 radiologists not indicated on a list dated 12-05-11 of physicians with Active, Courtesy, or Consulting Privileges at the center.</li> </ol>	S0728	<p>The Administrator is working on a contract with a private physician (radiologist) to provide necessary radiology services. This process will be completed by February 29, 2012. The Board of Directors approved this action on January 27, 2012. Addendum: Administrator and Medical Director discussed and decided upon contracting with a locum tenens physician (radiologist) for radiology services. This physician will be credentialed, following the same process, as all other physicians and evaluated through the Quality Assurance plan on a quarterly basis.</p>	01/06/2012			

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	3. During an interview on 12-05-11 at 1420 hours, staff #A1 confirmed that the radiologists with the group providing chest x-ray interpretations were not members of the credentialed medical staff.				

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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 policy review, medical record review and interview, the facility failed to ensure 7 of 28 surgical patients (#P1, P2, P14, P18, P19, P20 and P27) had complete history &amp; physicals in their record prior to surgery.</p>	S0772	Revised Policy J-20 (Patient Medical Record), #3 to include "The Physician's history and physical will include information pertinent to the procedure being performed and the level of anesthesia given." Physicians will be notified of this requirement and policy update by memo no	01/06/2012			

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	<p>Findings included:</p> <p>1. The facility policy #J-20, "Patient Medical Record", last reviewed on 01/26/10, indicated, "...3. A History and Physical will be completed within 30 days prior to an operative procedure, and be available on the patient chart prior to the start of surgery. ...The Physician's history must include: ...C. Physician examination report is reflective of type of anesthetic specific to proposed procedure. Including at a minimum: assessment of chest/lungs, and neurological/mental status."</p> <p>The policy continued, "...The History and Physical is valid up to 30 days prior to surgery. A pre-procedure note on day of surgery to indicate any significant changes in patient condition."</p> <p>2. The medical record for patient #P1, who had surgery on 10/27/11, evidenced an exam by another physician, #P22, on 10/20/11 on which the notation for Review of Systems indicated, "Per intake sheet, reviewed by me today." The document contained a facility stamp for an Updated History and Physical and was signed by the surgeon, staff member #P23, on 10/27/11, with "No changes Noted." The medical record lacked this "intake sheet" or any documentation regarding a chest/lungs assessment.</p>		<p>later than January 30, 2012. In addition, staff who audit medical records will be inserviced on auditing the medical record H&amp;P no later than January 30, 2012. The Director of Nursing will write the memo and conduct the inservice. The Director of Nursing and Administrator are responsible for monitoring and ensuring compliance. Monitoring will be on-going for six months. In July, 2012, the Quality Assurance Committee will determine whether further monitoring is necessary. The Quality Assurance Committee approved the above revisions and actions on January 29, 2012 and the Board of Directors on January 27, 2012. Addendum: Director of Nursing discussed problem with Medical Records Consultant and Administrator and came up with an action plan.</p>		

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	<p>3. The medical record for patient #P2, who had cataract surgery on 08/24/11, contained a "Short Stay History &amp; Physical" form signed on 08/24/11 by the surgeon, staff member #P24, with "no changes noted". The form contained a comprehensive eye exam, but lacked any vital signs in the spaces provided or any assessment of chest/lungs or neurological/mental status.</p> <p>4. The medical record for patient #P14, who had cataract surgery on 11/09/11, contained a "Short Stay History &amp; Physical" form signed on 11/09/11 by the surgeon, staff member #P24. The form contained a comprehensive eye exam, but lacked any vital signs in the spaces provided or any assessment of chest/lungs or neurological/mental status.</p> <p>5. The medical record for patient #P18 contained a History &amp; Physical from 06/21/11 with an update on 06/27/11; however, the surgery was on 06/28/11.</p> <p>6. The medical record for patient #P19 contained a History &amp; Physical dictated on 08/15/11; however, the surgery was on 08/16/11.</p> <p>7. The medical record for patient #P20 contained a History &amp; Physical from</p>						

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	<p>07/25/11; however, the surgery was on 07/18/11.</p> <p>8. The medical record for patient #P27 contained a History &amp; Physical dictated on 08/02/11; however, the surgery was on 08/03/11.</p> <p>9. At 3:00 PM on 12/06/11, the medical record findings were reviewed and confirmed with staff member #N11.</p>			

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S0840	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(2)</p> <p>(c) The anesthesia service is responsible for all anesthesia administered in the center as follows:</p> <p>(2) A requirement that anesthesia equipment must be checked for operational readiness and safety prior to patient administration. Documentation to that effect shall be included in the patient's medical record.</p> <p>Based on document review and interview, the center failed to ensure that anesthesia equipment was checked for operational readiness and safety before each administration with a patient and documented in the patient record.</p> <p>Findings:</p> <p>1. The policy/procedure Assure Safe Delivery of Anesthesia (reviewed 01-26-10) indicated the following: "At the start of each working day, the anesthesiologist will be responsible to inspect the anesthesia machine." The policy/procedure failed to require an equipment check prior to use with each patient and failed to require documentation of the equipment check in the patient medical record.</p>	S0840	<p>Revised Policy M-10 (Anesthesia Safety Devices), to include "The anesthesia equipment is checked for operational readiness and safety prior to administration of anesthesia, documentation to that effect is on the anesthesia record." Although our policy failed to show our actual practice, our procedure of ensuring that anesthesia equipment is checked for operational readiness and safety before each administration of anesthesia is documented on the anesthesia record. The Director of Nursing will monitor the compliance for 6 months, starting January 1, 2012 and then Quality Assurance Committee will determine further need for monitoring in July, 2012. Compliance rate should be 100%. The policy revision and actions were approved on January 19, 2012 by the Quality Assurance Committee and the</p>	01/06/2012

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	2. During an interview on 12-07-11 at 1320 hours, staff #A1 confirmed that the policy/procedure lacked the required provisions.		Board of Directors on January 27, 2012. Addendum: Director of Nursing and Administrator discussed problem and came up with an action plan.		

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S0862	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(C)</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>(C) A provision for the following equipment and supplies to be available to the surgical and recovery areas:</p> <p>(i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff.</p> <p>Based on document review, observation and interview, the center policy/procedure failed to ensure the availability of emergency equipment for 2 of 9 items of required equipment.</p> <p>Findings: 1. The policy/procedure Crash Cart/Emergency Equipment (reviewed 01-26-10) failed to indicate the location</p>	S0862	Revised Policy K-170 (Crash Cart/Emergency Equipment) to include "pulse oximeter" as being on the the top of the cart. This was completed on January 12, 2012 and the oxygen tank was secured to the side of the cart as of December 16, 2011. The clinical staff will be inserviced by Director of Nursing no later than March 31, 2012. The policy revision was approved by the Quality Assurance Committee on	01/06/2012			

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	<p>of an oximeter and an oxygen tank to be available for use if needed.</p> <p>2. During a tour on 12-06-11 at 1430 hours, no oximeter or portable oxygen tank was observed on or immediately adjacent to the crash cart for use if needed.</p> <p>3. During an interview on 12-06-11 at 1450 hours, staff #A2 confirmed that the policy/procedure failed to indicate the location for the oximeter and oxygen cylinder equipment if not found on the crash cart.</p>		<p>January 19, 2012 and the Board, of Directors on January 27, 2012. Addendum: Director of Nursing and Administrator discussed problem and came up with an action plan.</p>		

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S1040	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAc 15-2.5-6(3)(F)</p> <p>Pharmaceutical service must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(F) Instructions to the patient on the use of take home medication is the responsibility of the prescribing practitioner.</p> <p>Based upon document review and interview, the center failed to have a policy/procedure regarding the physician responsibility of instructing the patient (when indicated) on the use of take home medication.</p> <p>Findings:</p> <p>1. On 12-05-11 at 1130 hours, staff #A1 was requested to provide a policy/procedure regarding dispensing medications to patients while at the center and none was provided prior to exit.</p> <p>2. On 12-07-2011 at 1415 hours, staff #A1 confirmed the center failed to have a policy/procedure indicating the physician responsibility for instructing the patient (when indicated) on the use of take home</p>	S1040	<p>Revised Policy N-20 (Medication Administration) to add "It is the policy of center not to dispense medications upon discharge." Policy J-20 (Patient Medical Record Protected Health Information) #13 added "the surgery center does not dispense medication." This revision was approved by the Quality Assurance Committee on January 19, 2012 and the Board of Directors on January 27, 2012. The Director of Nursing will ensure that the medical staff are aware of the policy revision by memo no later than January 30, 2012. All clinical staff will be inserviced by the Director of Nursing no later than March 31, 2012. Addendum: Director of Nursing and Administrator discussed problem, although our policy failed to show our actual practice, it has always been the</p>	01/06/2012			

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	medication.		policy of the Center not to dispense medication.		

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S1146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, manufacturer's recommendations and interview, the facility failed to ensure supplies were removed from the surgical area to prevent out-dated usage.</p> <p>Findings included;</p> <p>1. During the tour of the surgical area at 9:35 AM on 12/06/11, accompanied by staff member #N11, the following expired items were observed in the crash cart:</p> <p>A. One of one 22 gauge BD Insyte Autoguard, expired 05/2011, in the top drawer.</p> <p>B. One of one 20 gauge BD Insyte Autoguard, expired 10/2011, in the top drawer.</p> <p>C. One of one 18 gauge BD Insyte Autoguard, expired 12/2010, in the top</p>	S1146	<p>Policy K-65 (Supplies-Stocking and Care), #3, indicates that supplies, including medications with expiration dates, will be checked monthly. The Safety Inspection Form was modified on December 21, 2011 to include, "expired supplies removed from shelf". The Director of Nursing or designee, is responsible for ensuring that monthly supplies are checked for expiration dates. The monitoring will be on-going, and randomly audited monthly by the Director of Nursing. The clinical staff will be in-serviced on policy in 1st quarter, 2012, and no later than March 31, 2012. Revised Policy O-10 (Blood Glucose Testing) to include manufacturer's instructions on expiration dates of control solutions and test strips. Clinical staff will be in-serviced on the policy, upon hire, during annual staff compliance training,</p>	01/06/2012

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	<p>drawer.</p> <p>D. One of one 22 gauge BD Insyte Autoguard, expired 10/2006, in the bottom drawer.</p> <p>E. One of one 18 gauge BD Insyte Autoguard, expired 12/2008, in the bottom drawer.</p> <p>F. Two of two 20 gauge BD Insyte Autoguard, expired 08/2007, in the bottom drawer.</p> <p>2. During the tour of the clean room in the surgical area at 9:45 AM on 12/06/11, accompanied by staff member #N11, the following expired items were observed on the shelf:</p> <p>A. Four of four size 4.0 cuffed trach tubes, with a manufacturer's expiration date of 02/2007.</p> <p>B. One of two size 4.5 cuffed trach tubes, with a manufacturer's expiration date of 02/2007.</p> <p>C. Four of four size 5.0 cuffed trach tubes, with a manufacturer's expiration date of 10/2011.</p> <p>3. During the tour of the nurses' station in the surgical area at 10:00 AM on 12/06/11, accompanied by staff member #N11, the blood glucose device and supplies were observed. The 2 bottles of control solution were observed open and dated 04/10/11. Manufacturer's directions</p>		<p>and 1st quarter, 2012, no later than March 31, 2012. The Director of Nursing is responsible for monitoring compliance. The Quality Assurance Committee approved the above policy revision and actions on January 19, 2012. The Board of Directors approved the policy revision and actions on January 27, 2012. Addendum: Director of Nursing and Administrator discussed problem and came up with an action plan.</p>				

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	<p>were to discard the solution 90 days after opening. The container of test strips was open and dated 11/15/11.</p> <p>4. At 10:10 AM on 12/06/11, staff member #N16 working in the area, indicated both the strips and controls should be discarded after 28 days. Staff member #N11 indicated he/she was unsure of the discard dates.</p> <p>5. At 10:30 AM on 12/06/11, staff member #N11 contacted the manufacturer by telephone and was directed to use the printed expiration date on the container of strips since there was no specific information regarding this in the accompanying literature.</p>				

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S1154	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(C)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Operational and maintenance control records must be established and analyzed at least triennially. These records must be readily available on the premises.</p> <p>Based on document review, the center failed to perform a triennial analysis on its operational and maintenance records for all mechanical equipment at the facility.</p> <p>Findings:</p> <p>1) On 12-05-11 at 1130 hours, staff #A1 was requested to provide documentation of triennial analysis for the mechanical equipment in use at the center and none was provided prior to exit.</p> <p>2) On 11-06-11 at 1220 hours, staff #A2 confirmed that the center was not performing a triennial analysis of its</p>	S1154	<p>Revised Policy R-15 (Electrical Equipment Safety Check) to add, "Operational and maintenance control records are analyzed at least triennially by Memorial Health System" our contracted bio-medical service. This policy revision was approved by the Quality Assurance Committee on January 19, 2012 and by the Board of Directors on January 27, 2012. These records are stored in the Director of Nursing and Administrator's office. In addition, the Administrator and Director of Nursing will be responsible for performing a triennial analysis of preventative maintenance (PM) records on all</p>	01/06/2012

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	operational and maintenance control records.		patient care equipment. The triennial evaluation will be monitored by the Quality Assurance Committee and the Board of Directors. On January 13, 2012 Memorial Health System performed a triennial analysis on operational and maintenance records for all mechanical equipment. The Director of Nursing and Administrator will conduct an analysis of PM records on all patient care equipment in 1st quarter, 2012 and no later than March 31, 2012. The Quality Assurance Committee approved the above actions on January 19, 2012 and the Board of Directors on January 27, 2012. Addendum: Director of Nursing and Administrator discussed problem and came up with an action plan.		

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S1168	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the center failed to document preventive maintenance (PM) for its anesthesia equipment and failed to provide documentation of triennial analysis of PM records on all patient care equipment in use at the facility.</p> <p>Findings: 1. On 11-05-11 at 1130 hours, staff #A1 was requested to provide documentation of PM for the anesthesia equipment in use at the center and provide documentation</p>	S1168	<p>Revised Policy R-15 (Electrical Equipment Safety Check) to add, "Operational and maintenance control records are analyzed at least triennially by Memorial Health System" our contracted bio-medical service. This policy revision was approved by the Quality Assurance Committee on January 19, 2012 and by the Board of Directors on January 27, 2012. These records are stored in the Director of Nursing and Administrator's office. In addition, the Administrator and Director of Nursing will be responsible for performing a triennial analysis of preventative</p>	01/06/2012			

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	<p>of triennial analysis of PM records on all patient care equipment and none was provided prior to exit.</p> <p>2. During an interview on 12-06-11 at 1130 hours, staff #A2 confirmed that a triennial review of the PM records had not been performed for the patient care equipment.</p> <p>3. Facility documentation 'Indirect Patient Care Vendors Statement of Quality' for the anesthesia equipment service provider indicated the following: " PM contract - visits 7-21-11 + 9-27-11 PM ' s completed on time. Difficulty locating parts. " On 12-06-11 at 1545 hours, staff #A2 was requested to provide additional documentation of service visits by the provider and none was provided prior to exit.</p> <p>4. During an interview on 11-06-11 at 1635 hours, staff #A2 indicated that additional documentation of PM performed on the anesthesia equipment by the service provider was not available.</p>		<p>maintenance (PM) records on all patient care equipment. The triennial evaluation will be monitored by the Quality Assurance Committee and the Board of Directors. On January 13, 2012 Memorial Health System performed a triennial analysis on operational and maintenance records for all mechanical equipment. The Director of Nursing and Administrator will conduct an analysis of PM records on all patient care equipment in 1st quarter, 2012 and no later than March 31, 2012. The Quality Assurance Committee approved the above actions on January 19, 2012 and the Board of Directors on January 27, 2012. Addendum: Director of Nursing and Administrator discussed problem and came up with an action plan.</p>		

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S1210	<p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1)</p> <p>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:</p> <p>(1) Radiology services must be supervised by a radiologist or radiation oncologist.</p> <p>Based on document review and interview, the facility failed to ensure that the radiology services provided by the center were adequately supervised by a radiologist or radiation oncologist.</p> <p>Findings:</p> <p>1. Review of a letter dated November 2, 2009 indicated Dr. Douglas S. Kuehn had reviewed 3 radiologic policies/procedures (Radiologic Services, Radiology Department Prevention Maintenance and Yearly Inspection, and Ionizing Radiation-Reducing Radiologic Exposure) for the center. Staff #A2 was requested to provide a credential file for the physician and none was provided prior to exit.</p> <p>2. Review of the monthly Occupational Radiation Exposure Reports by MIRION Technologies for 2010 and 2011 failed to</p>	S1210	<p>The Administrator is working on a contract with a private physician (radiologist) to provide necessary radiology services. This process will be completed by February 29, 2012. The Board of Directors approved this action on January 27, 2012. Addendum: Administrator and Medical Director discussed and decided upon contracting with a locum tenens physician (radiologist) for radiology services. This physician will assume the responsibility for supervising all radiologic services. This physician will be credentialed, following the same process as all other physicians and evaluated through the Quality Assurance plan, on a quarterly basis.</p>	01/06/2012			

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	<p>indicate that the supervising radiologist had performed a review of the documentation.</p> <p>3. During an interview on 12-05-11 at 1420 hours, staff #A1 confirmed that the center lacked a privileged radiologist to provide ongoing supervision of the radiologic services for the center.</p>				