

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
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NAME OF PROVIDER OR SUPPLIER INDIANA HAND TO SHOULDER BELTWAY SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8501 HARCOURT RD INDIANAPOLIS, IN 46260
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005400</p> <p>Survey Date: 9-22/24-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 10/28/14</p>	S000000		
S000172	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which</p>			

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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	<p>include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on policy and procedure review and personnel file review, the facility failed to ensure that contracted housekeeping personnel are free of communicable diseases for 2 of 2 personnel files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Facility Policy Number: IPC 7.11, last approved 7/2011 stated: <ol style="list-style-type: none"> Purpose: To foster an environment that is safe from communicable disease transmission to our patients, staff and visitors. Scope: All employees, physicians, students and volunteers. Review of personnel files on 09/24/14 for contracted housekeeping personnel indicated CH1's file lacked documentation of immunity to communicable diseases, except TB (tuberculosis). Staff member #1 was unable to 	S000172	S172 Immunization records for all contracted housekeeping personnel will be obtained and kept in a locked file in the clinical manager's office. The clinical manager will be responsible for contacting the contracted housekeeping service and keeping this information up to date to ensure contracted personnel is free of communicable diseases.	11/28/2014

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S000326	<p>produce immunization records for one housekeeping staff (CH2) and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(3)</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>(3) All services performed in the center with regard to appropriateness of diagnoses and treatments related to a standard of care and anticipated or expected outcomes.</p> <p>Based on document review and interview, the facility failed to ensure inclusion of a review of appropriateness of diagnosis and treatments related to a standard of care for 1 of 2 (AH#1) allied health credential files reviewed.</p> <p>Findings:</p>	S000326	S326 All allied health personnel will be included in the QAPI program with evidence documented in their files for review of appropriateness of diagnosis and treatments related to a standard of practice. The clinical manager will be responsible for gathering this information and presenting it to	11/28/2014

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S000332	<p>1. Review of 2 allied health credential files indicated file AH#1, a Physician Assistant, did not have any documentation of review of appropriateness of diagnosis and treatments related to a standard of care.</p> <p>2. In interview, on 9-24-14 at 11:00 am, employee #A1, Clinical Director, confirmed the above and no other documentation was provided prior to exit.</p> <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: (1) A process for determining the occurrence of the following reportable events within the center: (A) The following surgical events: (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</p>		the QAPI committee for review on a semiannual basis and presented to the credentialing committee at time of reappointment application.	

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	<p>informed consent; or both (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. (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 (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. (BB) Objects present before surgery that were intentionally retained. (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. (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. (B) The following product or device events: (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</p>						

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	<p>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. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (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. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide 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</p>			

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	<p>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: (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> <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: (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</p>			

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	<p>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 the grounds of the center.</p> <p>(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 ensure inclusion of some categories of reportable events as part of its quality assurance and performance improvement program (QAPI).</p> <p>Findings:</p> <p>1. Review of a facility document entitled QA Dashboard indicated it did not include the following reportable events:</p>	S000332	S332 "NEVER" events will be reviewed in entirety by the QAPI committee on at least a quarterly basis. It is the responsibility of the clinical manager to provide this information to the committee for review.	11/28/2014

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	<ul style="list-style-type: none"> - Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. - Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. - Patient death or serious disability associated with patient elopement. - Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. - Patient death or serious disability associated with a medication error, for example, errors involving the wrong drug, dose, patient, time, rate, preparation, or route of administration - Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center - Patient death or serious disability associated with an electric shock while being cared for in the center. - Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances - Patient death or serious disability associated with a burn incurred from any source while being cared for in the 			

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S000400	<p>center.</p> <ul style="list-style-type: none"> - Patient death associated with a fall while being cared for in the center - Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center - Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider - Abduction of a patient of any age - Sexual assault on a patient within or on the grounds of the center - 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>2. In interview, on 9-24-14 at 1:15 pm, employee #A1, Clinical Manager, confirmed the above and no further documentation was provided prior to exit.</p>			

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	<p>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, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors in 7 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 9-23-14 at 2:30 pm in the presence of employee #A1, Clinical Manager, and employee #A2, Facility Director, it was observed in a small basement storage area there were 12 large hand towel dispenser rolls on a shelf. The rolls had no wrapping, were not in a storage container, and had no barrier between the rolls and the room. At the above date and time, it was also observed that the room was used to store housekeeping cleaning equipment and a sink. On 9-23-14 at 2:35 pm in the presence of employee #A1 and employee #A2, it was observed in a small basement storage area there were 5 small holes and 1 large 	S000400	S400 Paper supplies will not be stored in the basement storage area unprotected from dirt and moisture. The clinical manager will ensure this area is checked and documented on a monthly basis and any further issues will be reported to the facility manager.	11/28/2014

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S000676	<p>hole in a wall.</p> <p>4. In all the above situations, there was an infection exposure and risk.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or legally reproduced medical records must be maintained by the center for a period of seven (7) years in accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure.</p> <p>Based on interview, the facility failed to produce an approved waiver to store medical records offsite that were less than 7 years old.</p> <p>Findings:</p> <p>1. In interview, on 9-23-14 at 2:20 pm, employee #A2, Facility Director, indicated the facility stored electronic patient records less than 7 years old at an off-site location. The employee also indicated the facility did not have a copy of</p>	S000676	S676 The Clinical Director has applied and obtained a waiver from the ISDH for offsite storage of medical records.	10/23/2014	

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S000708	<p>the electronic records stored on site. The employee indicated the facility had a waiver but it was for storage of paper records at a different site.</p> <p>2. At the above date and time, the employee was requested to provide documentation the facility received a waiver from the State to store the electronic records offsite.</p> <p>3. In interview, on the above date and time, employee #A2 indicated not being able to produce the waiver for the electronic storage and no further documentation was received prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(3)</p> <p>The medical staff shall do the following:</p> <p>(3) Make recommendations to the governing body on the appointment or reappointment of the applicant for a period not to exceed two (2) years. Based on document review and interview, the medical staff failed to make recommendations to the governing body on the reappointment of the applicant for a period not to exceed two (2) years for 4 of 7 physician and 1 of 2</p>	S000708	S0708 All expired practitioners applications are currently in process with an outside credentialing service to gather information for review. When all information is obtained information will be taken to credentialing committee for	11/28/2014

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	<p>allied health credential files reviewed.</p> <p>Findings:</p> <p>1. Review of a document entitled Medical Staff Bylaws, approved July 16, 2014, indicated a Practitioner may be reappointed to Active Staff membership at the expiration of his or her initial appointment or any subsequent reappointment to Active Staff membership.</p> <p>2. Further review of the Medical Staff Bylaws indicated when assessing an application for reappointment, the Credentials Committee and the Medical Director shall consider the applicant's professional status, performance, judgment and clinical skills as provided by the Medical Staff members, and the applicant's primary hospital.</p> <p>2. Review of the credential files of 7 physician practitioners and 2 allied health practitioners indicated: MD#1, physician, reappointment expired 7-25-14 MD#2, physician, reappointment expired 7-25-14 MD#4, physician, reappointment expired 7-25-14 MD#7, physician, reappointment expired 4-4-14</p>		<p>review and then referred to the Board for final approval. Applications for reappointment will be presented to credentialing committee for approval and recommendations will be taken to the Board for final approval at the December meeting. It is the responsibility of the clinical manager to ensure this is completed and in the future to begin the reappointment process earlier to ensure there is not a lapse in privileges.</p>				

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S000710	<p>AH#2, allied health practitioner, reappointment expired 7-25-14</p> <p>3. In interview, on 9-24-14 at 11:00 am, employee #A1 indicated the facility governing body had decided to change the process and, and as of 9-23-14, had not taken any action regarding the change. Therefore, the reapplication by the 4 physicians and 1 allied health practitioner had not been recommended for reappointment by the Medical Staff by their expiration dates and the practitioners were still performing at the facility.</p> <p>4. In the same above-stated interview, employee #A1 indicated the above-stated physicians and allied health practitioner had not been given temporary privileges.</p> <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>						

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	<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> <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>			

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	<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, 3 (MD#3, MD#5 and MD#7) of 7 physician files failed to delineate privileges approved and 2 (MD#3 and MD#7) of 7 physician files did not document current health status.</p> <p>Findings:</p> <p>1. Review of 7 physician credential files indicated MD#3, reappointed October, 2013, MD#5, reappointed September, 2013, and MD#7, reappointed 4-4-12, had no delineation of privileges approved.</p> <p>2. Review of 7 physician credential files indicated MD#3, reappointed October, 2013, and MD#7, reappointed 4-4-12, had no documentation of current health status.</p> <p>3. In interview, on 9-24-14 at 11:00 am, employee #A1, Clinical Manager, confirmed the above and no further documentation was provided prior to</p>	S000710	S0710 The delineation of privileges lists will be updated and included in on all applications for renewal of credentials. Updated health status will be added to application. Clinical manager will ensure this information is included on all credentialing applications.	11/28/2014			

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S001146	<p>exit.</p> <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. Based on observation, the facility maintained a condition which may result in a hazard to employees in 1 instance.</p> <p>Findings:</p> <p>1. On 9-23-14 at 2:30 pm in the presence of employee #A1, Clinical Manager, and employee #A2, Facility Director, it was observed in a small basement storage area there was an electrical outlet that had no cover plate. This posed a safety hazard to employees.</p>	S001146	S1146 All electrical outlets will have cover plates. This will be checked and documented on a monthly basis. Any violations will be reported to the facility manager to be corrected. The clinical manager will facilitate this information being gathered and reported.	11/28/2014	

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S001154	<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. Based on interview, the facility failed to document operational and maintenance control records for the heating, ventilation, and air conditioning (HVAC) and fire alarm systems being analyzed at least triennially.</p> <p>Findings:</p> <p>1. On 9-22-14 at 9:30 am, employee #A1, Clinical Manager, was requested to provide documentation of the operational and maintenance control records for the heating, ventilation, and air conditioning (HVAC) and fire alarm systems being</p>	S001154	S1154 The operational and maintenance controls for the heating, ventilation, air conditioning and fire alarm systems will be reviewed with the assistance of the facility manager to ensure the most current recommendations are being followed. This action will be reviewed triennially starting this year, 2014. The clinical manager will be responsible for overseeing that this task is completed.	11/28/2014			

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S001170	<p>analyzed at least triennially.</p> <p>2. In interview, on 9-23-14 at 11:10 am, employee #A2, Facility Director, indicated there was no documentation of the operational and maintenance control records for the heating, ventilation, and air conditioning (HVAC) and fire alarm systems being analyzed at least triennially. No documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a</p>						

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	<p>discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, it could not be determined the facility documented defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's defibrillator user manual, provided by the manufacturer, on a page entitled Operator's Shift Checklist for M Series Products (Semi-Automatic) indicated the facility was to perform recommended checks and procedures at the start of each shift, that included Condition, Multi-function Pads, Paddles (if applicable), Inspect cables for cracks, broken wires, connector, Batteries, and Disposable supplies, Review of a document entitled Crash Cart, Critical Equipment & Lab Checklist, dated October, 2013 indicated a column entitled Cardioverter & Equip OK. It could not be determined what types of activities (checks) were conducted to conclude the equipment was functioning properly. In interview, on 9-22-14 at 3:55 pm, employee #A2, Facility Director, 	S001170	S 1170 An updated manufacturers' checklist and been added to the daily log of defibrillator checks. All necessary personnel will be educated concerning the change in protocol. This was completed by October 6, 2014. The clinical manager is responsible for confirming the necessary data is being checked and documented.	11/28/2014

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S001222	<p>confirmed the above and indicated there was no other documentation that referred to or showed compliance with the Operator's Shift Checklist. No further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(e)</p> <p>(e) Safeguards for patients, personnel, and public must be specified, including, but not limited to, the following:</p> <p>(1) Proper safety precautions must be maintained against radiation hazards in accordance with the center's radiation and safety program(s).</p> <p>(2) Hazards and faulty equipment identified must be promptly corrected in accordance with current standards of practice and applicable federal and state rules, including, but not limited to, collimation and filtration and evaluations of equipment performance.</p> <p>Based on policy and procedure review, observation and interview, the facility failed to protect Operating Room personnel from unnecessary exposure to radiation.</p>	S001222	S1222 Radiological policies will be reviewed. In-service will be provided for all staff members to review the safety guidelines. Any policies changes will be taken to the Board for approval. The clinical manager will be responsible for gathering	11/28/2014

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	<p>Findings included:</p> <p>1. Review of the ASC policy titled "Radiation Safety in the Operating Room", #PSF 10.14, last approved on 7/2011, indicated that:</p> <p>Purpose: "To provide relevant medical and technical information for the safe use of ionizing radiation in the operating room and to promote compliance with nationally accepted standards of radiation safety."</p> <p>Scope: "All surgery center personnel, physicians, allied healthcare and supervised allied healthcare staff."</p> <p>Exceptions: "There are no exceptions to this policy."</p> <p>Policy Statements: A. "Maximum permissible doses have been established in order to keep exposure of the radiation worker well below levels at which adverse effects are likely to be observed....." B. Thus, unnecessary radiation should be avoided, and unavoidable exposure should be kept ALARA (As Low As Reasonably Achievable)". D. In general, reduction of exposure to external sources of radiation is accomplished by the use of time, distance, and shielding: 1. exposure is directly related to time</p>		<p>information concerning radiology policies and recommending any changes, if necessary, to the medical staff and the Board for approval. If any changes are to be made it will be presented to the Board at their December meeting.</p>				

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	<p>2. exposure is inversely related to distance</p> <p>3. exposure is inversely related to the thickness of shielding</p> <p>Procedures:</p> <ol style="list-style-type: none"> 1. All non essential personnel should leave the OR when x-rays are being produced. 2. All personnel in the room when the x-ray beam is on during fluoroscopy must wear a lead apron. 3. When the x-ray beam is on, the surgical team should move as far away from the radiation field on the patient as is aseptically safe. 7. Always wear a film badge if one has been assigned. 8. Pregnant staff must leave the room when the x-ray beam is on to avoid unnecessary x-ray exposure to the embryo/fetus. <p>G. When utilizing the C-Arm or the mini-C-Arm, only personnel in the immediate vicinity of the unit must wear a protective lead apron.</p> <p>2. At approximately 11:45 a.m. on 9/23/2014, it was observed that fluoroscopy was used during a patient surgery. Five surgery staff members were in the room. There was no evidence of protective measures being used for staff. There was no announcement to warn non-essential staff to leave the room</p>			

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	temporarily, no lead aprons were being used by staff next to patient, and staff did not wear radiation monitoring badges. 3. Interview with staff member #1, at 12:45 p.m. on 9/24/2014, indicated that "The policy wasn't being followed and needed to be addressed".				