

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001021	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2014
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NAME OF PROVIDER OR SUPPLIER  SCP INDIANAPOLIS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7430 N SHADELAND AVE STE 100 INDIANAPOLIS, IN 46250
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S000000	This visit was for a State licensure survey.  Facility Number: 005402  Survey Date: 2-24/26-14  Surveyors: Jack I. Cohen, MHA Medical Surveyor  John Lee, RN Public Health Nurse Surveyor  QA: clauglin 03/07/14	S000000		
S000106	4/10/14 revised due to IDR 410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)  The governing body shall do the following:  (3) Review the bylaws at least triennially.  Based on document review and interview, it could not be determined that the governing body adopted governing body bylaws within the past three (3) calendar years. Findings: 1. Review of a document entitled Board of Managers Responsibilities [governing board bylaws] indicated no date of adoption and/or	S000106	<b>Plan of Correction;</b> The Governing Board recognized that the language of By-Laws were not satisfied in 2013 and is prepared to reintroduce their By-Laws and Responsibilities to the Medical Staff and Board of Managers on May 22nd, 2014. All minutes will be documented with language that satisfies rule <u>410 IAC</u>	05/22/2014

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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S000110	<p>review.</p> <p>2. In interview on 2-26-14 at 3:30 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the governing board failed to review quality activities for six directly-provided services/activities and six contracted services in calendar year 2013 in its quality assessment performance improvement (QAPI) program. Findings: 1. Review of governing board minutes for calendar year 2013 indicated there were no reports of quality activities reviewed by the governing board for the directly-provided</p>	S000110	<p>15-2.4-1 (a)(3), including review and adoption of the By-Laws and Responsibilities. Any change in the Governing Board members will be followed with new review and adoptions of these regulatory commitments and reviewed at least triennially. All By-Laws and Responsibilities will be reviewed and adopted at least triennially without such a change. This satisfies rule 410 IAC 15-2.4-1 (a)(3).</p> <p><b>Plan of Correction;</b> Format of reporting structure has been changed to specifically outline QA activities of the Center. Such information will be ascertained and reported from the QAPI/ IC subcommittee, chaired by Atteet Shah, MD. Nursing, Discharge, Transfer, Medication Errors, Response to Patient Errors, and Reportable Events, Biomedical Engineering, Biohazardous Waste,</p>	05/22/2014	

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S000156	<p>services of nursing, discharge, transfer and medication errors, response to patient errors, and reportable events.</p> <p>2. Review of the governing board minutes for calendar year 2013 indicated there were no reports of quality activities reviewed by the governing board for the contracted services of biomedical engineering, biohazardous waste, laboratory, laundry, maintenance, and security.</p> <p>3. In interview on 2-26-14 at 3:30 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to ensure that annual performance evaluations for each employee providing direct patient care or support services was completed for 10 of 10 personnel files reviewed (Staff #2, 3, 4, 5, 6, 7, P1, P3, P6 &amp; P7).</p>	S000156	<p>Laboratory, Laundry, Maintenance, and Security will all be reported specifically for each quarter to the Governing Board by the Center Manager. This information will also be used to annually evaluate contracted services. Refer to Attachment A for reporting reformat.</p> <p><b>Plan of Correction;</b> Self evaluations have been delivered to the staff with a required completion date of 3/7/2014. Since the current administrator (Deanna McAllister, RN) was not employed by the Center in 2013, she is unable to perform evaluations on the staff for that year</p>	03/07/2014

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S000166	<p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of staff #2, 3, 4, 5, 6, 7, P1, P3, P6 &amp; P7's personnel files lacked documentation of having an annual performance evaluation in 2013.</li> <li>On 02-25-14 at 0925 hours, staff #40 confirmed that a lot of annual performance evaluations were not done in 2013.</li> </ol> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to ensure that the Infection Control policy / procedures were reviewed at least triennially.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The Infection Control Policy / Procedure Manual was requested for review and staff</li> </ol>	S000166	<p>and there was no alternate for that period to conduct them retrospectively. Annual evaluations will be subsequently performed in June 2014 and every year thereafter. 90 day evaluations will continue to be performed on all new-hires, unless that review takes place at the same time the annual evaluations are due to be completed. The Center Manger is responsible for the administration and collection of all employee evaluations. These documents will be retained in each employee file for the duration of their employment.</p> <p><b>Plan of Correction;</b> It is the responsibility of the Center Manager to forward all policies to the Medical Staff, then to the Governing Board. On 3-18-2014 the infection policies were re-reviewed with the medical staff for final approval. Any edits concerns for change in process were discussed and an approval slip was</p>	05/22/2014

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S000172	<p>#41 presented a manual labeled Infection Control Policies. The Infection Control Policy / Procedure Manual lacked documentation that the manual was reviewed / approved at least triennially.</p> <p>2. On 02-24-14 at 1410 hours, staff #40 &amp; 41 confirmed the Infection Control Policy / Procedure Manual was being used by the facility and could not provide documentation that the Infection Control Policy / Procedure Manual had been reviewed / approved at least triennially.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review and interview, the facility failed to maintain and document personnel records for each employee for tuberculin tests for 5 of 16 personnel files reviewed (Staff #5, 8, 9, P3 &amp; P4).</p> <p>Findings include:</p>	S000172	<p>signed by the Medical Director. On May 22nd, 2014, final approval will be submitted to the Board of Managers and said policies will be reimplemented. Review and approval date will be documented on the table of contents for this section and approval slip will remain with the minutes of the 2nd quarter board meeting. The facility will then be in compliance with rule <u>410 AIC 15-2.4-1 (c)(5) (L)</u>.</p> <p><b>Plan of Correction;</b> A new 2-Step series initiated for staff #5, #8, #9, and p4 on 3/14/14. Initial read will took place at 72 hours and 2nd step will be initiated on 3/28/14 and read within 48 hours. Documentation of a chest x-ray for TB was acquired on p3 and a questionnaire has been</p>	03/31/2014

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	<p>1. Review of policy / procedure IC-14, Tuberculosis (TB) Plan, indicated the following: "Prospective Associates - Skin testing will employ the two step procedure. (If the reaction to the first test is less than 10 mm, a second test will be given 1 -3 weeks later). -If the prospective associate can provide documentation of a negative TST done in the past 12 months, only a one step will be done. Annual Personnel Screening -Associates with negative skin test history will have an annual TST (unless otherwise indicated by the facility's TB risk assessment). "</p> <p>2. On 02-24-14 at 1410 hours, staff #43 confirmed the Infection Control Policy / Procedure Manual was being used by the facility.</p> <p>3. Review of staff #5's personnel file indicated that he/she was hired on 12-19-12 and had documentation of a PPD being done on 11-2-12 and lacked documentation of a second step and documentation of an annual TST test.</p> <p>4. Review of staff #8's personnel file indicated that he/she was hired on 11-25-13 and lacked documentation of a 2 step tuberculin test being done.</p> <p>5. Review of staff #9's personnel file indicated that he/she was hired on 12-02-13 and lacked documentation of a 2 step tuberculin test being done.</p> <p>6. Review of staff #P3's personnel file indicated that he/she last annual tuberculin test was done on 06-01-12.</p>		<p>completed. All future employees will receive a 2-step PPD upon hire or a single TB test when providing documentation of an up to date PPD from another facility within that calendar year. Employees will receive annual TB testing in accordance with state guidelines and facility policy. It is the Center Managers responsibility to ensure that all new hires meet all human resources requirements, including but not limited to, communicable disease history, immunizations and required testing.</p> <p>1. Tag duplication</p> <p>2. A new 2-step series was initiated for staff #5 on 3/14/14</p> <p>3. A new 2-step series was initiated for staff #8 on 3/14/14</p> <p>4. A new 2-step series was initiated for staff #9 on 3/14/14</p> <p>5. Documentation was acquired on 3/14/14 for staff p3 regarding a chest x-ray, the required questionnaire has been completed and it has been verified this staff member has not been in an area of high risk for exposure, nor has exhibited any signs of TB. There is no need for a repeat x-ray</p> <p>6. A new 2-step series was initiated for staff p4 on 3/14/14</p>	

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S000176	<p>7. Review of staff #P4's personnel file indicated that he/she was hired on 03-11-13 and had documentation of a PPD being done on 09-17-12 and lacked documentation of a second step tuberculin test.</p> <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 ensure that all new personnel demonstrate and document competency in fulfilling assigned responsibilities for 2 of 16 personnel files reviewed (Staff #8 &amp; 10).</p> <p>Findings include:</p> <p>1. Review of policy / procedure LD-15, Staff Recruitment, Retention and Education, indicated the following: "Initial orientation courses and annual mandatory education is provided using Healthstream on line courses." This policy / procedure was last reviewed / revised on 03-26-13.</p> <p>2. Review of staff #8's personnel file indicated that he/she was hired on 11-25-13 as a medical assistant and the personnel file</p>	S000176	<p><i>1. TagDescription</i> <i>2. Staff #8, hired on 11/25/13 lackeddocumentation of orientation to position and responsibilities</i></p> <p><b>Plan of Correction;</b> Staff #8 began working December of 2013. Orientation paperwork was in process and was completed March 2014, with position specific orientation completed 01/2014. Competencies for her position, including medication administration, were completed 02/2014. Administrative orientation is complete as well as her 90 day evaluation. No staff will perform delegated responsibilities without completing their competencies for that task. The Center Manager</p>	03/31/2014

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S000228	<p>lacked documentation of an orientation to position responsibilities.</p> <p>3. Review of staff #10's personnel file indicated that he/she was hired on 08-13 as a housekeeper and the personnel file lacked documentation of an orientation to position responsibilities.</p> <p>4. On 02-25-14 at 1520 hours, it was requested the documentation of orientation for staff #8 &amp; 10 from staff #40 and none was provided by exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that</p>				<p>will remain responsible for documenting all staff orientations and competencies, which will remain available for review during the staff member's employment. This will satisfy <u>410 AIC 15-2.4-1 (c)(5)(M)</u>.</p> <p><i>1. Staff #10, hired on 08/2013 as a housekeeper and file lacked documentation of orientation</i></p> <p><b>Plan of Correction;</b> Documentation was obtained reflecting Center Specific orientation after the ISDH evaluation. Such documentation will remain with the contracted employee's file for the duration she is working for that service provider. All future housekeepers will be required to participate in a facility specific orientation, which will be documented and tracked by the Center Manager. This will satisfy <u>410 AIC 15-2.4-1 (c)(5)(M)</u>.</p>		

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	<p>all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that physicians and podiatrists performing surgery in the facility maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located, for 5 of 6 medical staff credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of 6 medical staff credential files indicated files of physicians MD#1, MD#2, MD#4 and MD#6 did not have documentation of admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located.</li> <li>In interview, on 2-26-14 at 2:00 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</li> <li>Review of 6 medical staff credential files indicated the file of podiatrist MD#5 did not have documentation of admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located.</li> <li>Further review of file MD#5, a podiatrist, indicated the practitioner did not have</li> </ol>	S000228	<p>s 228/ 410 ISV15-2.4-1 (e)(4) 1. MD files 1, 2, 4, and 6 had no documentation of admitting privileges at 1 or more hospitals in the same or adjacent county</p> <p><b>Plan of Correction;</b> On 5/8/2014 a newly transfer agreement began draft between Community North Hospital and SCP to reflect that all Physicians and Podiatrist could admit to a receiving Physician within that organization, maintaining the same stipulations as the old agreement. Said facility is less than one mile from SCP and meets the requirements of <u>410 ISV 15-2.4-1 (e)(4)</u>. Any Physician maintaining Surgical Privileges with Community North retains admitting privileges, which are not segregated in the DOP for each Physician at that hospital. The new transfer agreement and updated Surgical Privileges will remain with the Physicians' and Podiatrist's credentialing files and be maintained by the Center manager. This will satisfy the rule <u>410 ISV15-2.4-1 (e)(4)</u>.</p> <p>2. Repeat tag description</p>	05/16/2014			

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	<p>documentation of admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located. The review also indicated the practitioner did not have a written agreement, signed by both parties, with another facility-credentialed physician who did have admitting privileges at the same hospital with which the facility had a transfer agreement, that the physician would admit patients of MD#5 to the hospital, if needed.</p> <p>5. In interview, on 2-26-14 at 2:00 pm, employee #A1 confirmed the above regarding MD#5 and no other documentation was provided prior to exit.</p>		<p><i>3.MD file #5 (podiatrist) did not havedocumentation of admitting privileges at 1 or more hospitals in the same oradjacent county.</i></p> <p><b>Planof Correction;</b> According to a standing waiver from ISDH under 410-AIC15-2.3-1(e)(4), effective November 12th, 2012 no Center will berequired to submit a waiver request for the rule <u>410 ISV 15-2.4-1 (e)(4)</u>as long as the podiatrist is credentialed and privileged to perform surgicalprocedures at one or more hospitals in the same county or in an adjacent. Refer to attachment D forSurgical Priveleges. On 5/8/2014a newly transfer agreement began draft between Community North Hospital and SCPto reflect that all Physicians and Podiatrist could admit to a receivingPhysician within that organization, maintaining the same stipulations as theold agreement. Said facility is lessthan one mile from SCP and meets the requirements of <u>410 ISV 15-2.4-1 (e)(4)</u>. Any Physician maintaining SurgicalPrivileges with Community North retains admitting privileges, which our notsegregated in the DOP for each Physician at that hospital. The new transfer agreement and updatedSurgical Privileges will remain with the Physicians' and Podiatrist'scredentiaing files and be maintained by the Center manager. This will satisfy the rule</p>		

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S000230	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the facility failed to provide for a periodic review of the center and its operation by a utilization review committee composed of three (3) or more duly licensed physicians having no financial interest (ownership) in the facility in 1 instance.</p> <p>Findings: 1. Review of governing board minutes and other facility documents for calendar year 2013 indicated there were no minutes or documentation of a utilization review committee. 2. In interview, on 2-26-14 at 2:10 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	S000230	<p>410 ISV15-2.4-1 (e)(4).</p> <p><b>Plan of Correction;</b> Format of reporting structure has been changed to specifically outline the reporting of the Utilization review committee, thus named the peer review committee. Such information will be ascertained and reported from the QAPI subcommittee, chaired by Atteet Shah, MD. It is the responsibility of the Center Manager to forward the report to the Medical Staff then to the Governing Board. The QAPI committee has already reported to the Governing Board for the 4th quarter of 2013 in February of 2014. Refer to Attachment A for reporting reformat. Refer to Attachment E for the governing board meeting on February 5, 2014. The committee will report again on May 22nd, 2014 and every quarter thereafter.</p>	05/22/2014

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S000332	<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</p>			

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	<p>of a planned intervention.</p> <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>			

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	<p>(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.</p> <p>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</p>			

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	<p>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:</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 (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>			

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	<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's quality assessment performance improvement (QAPI) program failed to have a process for reportable events.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the facility's 2013 QAPI program did not indicate a dated and approved process for reportable events.</li> <li>In interview, on 2-26-14 at 1:50 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</li> </ol>	S000332	<p><b>S332/ 410-IAC15-2.4-2.2(a)(1)</b></p> <p><i>1. Review of the facility's 2013 QAPI program did not indicate a dated and approved process of reportable events</i></p> <p><b>Plan of Correction;</b> The Medical Staff has readopted the QAPI program as of 3/30/2014 and it will see final approval at the next quarterly Governing Board meeting on 5/22/2014. QAPI/Risk program does include a formal program for reportable events. QAPI-14 (Attachment F) describes the scope of policy and scope of adverse events and further designates standard, procedures and requirements as defined by the Indiana State Board of Health. Attachment G, QAPI-15 (A) in the QAPI/Risk manual outlines reported incidents involving infections and disease. Attachment H outlines all reportable events for the State of Indiana and is also in the QAPI/Risk manual (QAPI-15 (B)). Incident reporting as described to be combined with any reportable event is presented in IC-08 (B) as Attachment I in the Infection Control Policies. Attachments J, K and L are provided upon every hospital transfer and can be found in section RR in the Policy</p>	02/26/2014	

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S000400	<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, document review and interview, the facility failed to provide a safe and healthful environment that minimized infection exposure and risk to patients by following manufacturer's recommendations and policy &amp; procedure for 1 soiled work room.</p> <p>Findings include:</p> <p>1. Review of the manufacturer's recommendations for the Rapicide glutaraldehyde &amp; Metricide OPA glutaraldehyde solution testing strips indicated the containers were to be labeled when opened and discarded after 90 days of being opened or expiration date, whichever one happens first.</p>	S000400	<p>and Procedure manual. Respectively these documents are RR-12D, RR-12C and RR-12B. The Center Manager is responsible for annually updating such policy and procedures and will maintain the logs associated with reportable events. Then Center Manager is also responsible for the reporting of such events to those governing bodies outlined in the policies.</p> <p><b>Plan of Correction;</b> Staff was in-serviced 3-14-2014 on the manufacturer guidelines relative to labeling and discard for both chemicals. The process, however, was put into place as of 2-26-2014 upon ISDH exit. Both vials were discarded and the new vials were labeled with their 90 day expiration date. 1. <i>Tag Description</i> 2. <i>Tag Description</i> 3. <i>QC test was confirmed that it was not being performed on the testing strips when opened. Metricide OPA glutaraldehyde solution was being tested three times daily. Said chemical is to be tested prior to each use.</i> <b>Plan of Correction;</b> Staff was in-serviced 3-14-2014 on the manufacturer guidelines relative</p>	02/26/2014	

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	<p>2. On 02-25-14 at 1235 hours during the facility tour of the soiled work room, a Medivator with Rapicide glutaraldehyde solution for disinfecting scopes used for gastrointestinal procedures was observed. A container containing Metricide OPA glutaraldehyde solution was observed. The containers containing the Rapicide glutaraldehyde &amp; Metricide OPA glutaraldehyde solution testing strips were not labeled with the date opened.</p> <p>3. Review of policy / procedure IC-38, High Level Disinfection, indicated the following: "Policy Scope: High level disinfection (HLD) is performed according to manufacturer's instructions and nationally recognized guidelines. Procedure - The minimum effective concentration (MEC) is checked prior to each use. Quality Controls: -Test strips are to be dated with a 90 day expiration date when the bottle is opened. -A Quality Control test must be performed when a new bottle of strips is opened consisting of a dilute solution and non dilute solution of Metricide 14 day, strip test performed and results recorded. -Solution must be tested with the test strips prior to use."</p> <p>4. On 02-24-14 at 1410 hours, staff #43 confirmed the Infection Control Policy / Procedure Manual was being used by the facility.</p> <p>5. On 02-25-14 at 1235 hours, staff #44 confirmed that he/she does not perform the Quality Control test when a new bottle of testing strips are opened. Staff #44 also confirmed that he/she does not test the</p>		to performing the QC testing on new strips. Staff was also inserviced on testing and documenting testing of said chemical prior to each use, in accordance with facility policy and manufacturer guidelines. Logs were changed to match the policies and procedures currently approved for the facility, which did include performing the QC testing of new strips and the testing of the solution prior to each use. Refer to Attachment M and N. It is the responsibility of the Center Manager to ensure that all policies are followed and that staff receives the appropriate inservices for processes. This will be current and future process.	

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S000404	<p>Metricide OPA glutaraldehyde solution prior to each use, but rather tests the solution 3 times per day.</p> <p>-</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the facility failed to ensure that the Infection Control Plan was reviewed annually by the Infection Control Committee / Quality Management Committee and the Medical Staff Committee.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of policy procedure IC-01, Infection Control Program, indicated the following: "The Infection Control Plan is reviewed annually by the Infection Control Committee / Quality Management Committee and the Medical Staff Committee."</li> <li>On 02-24-14 at 1410 hours, staff #43 confirmed the Infection Control Policy / Procedure Manual was being used by the facility.</li> <li>On 02-24-14 at 1420 hours, staff #40</li> </ol>	S000404	<p><b>S404/ 410 IAC15-2.5-1(b)</b></p> <ol style="list-style-type: none"> <li>1. TagDescription</li> <li>2. TagDescription</li> <li>3. There wereno Infection Control Committee/Quality Management Committee minutes for 2013</li> </ol> <p><b>Plan of Correction;</b> The infection control plan was reviewed for implementation initially in October 2013 and approved by the Governing Board. The First subcommittee meeting occurred on 1/13/14 and fourth quarter reporting for 2013 was administered to the Governing Board on 2/5/2014. The next Quality/IC meeting is set for 3/18/2014 and will meet monthly. Reporting will continue quarterly through the QA meeting, chaired by Dr. Ateet Shah and subsequently delivered to Medical</p>	03/18/2014

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S000414	<p>confirmed there were no Infection Control Committee / Quality Management Committee minutes for 2013.</p> <p>4. Review of the Infection Control Committee / Quality Management Committee minutes for the first meeting in 2014 lacked documentation that the Infection Control Plan was reviewed.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a</p>		<p>Staff by the Center Manager, then reviewed by the Governing Board. The current process for review of the Infection Control Committee and Quality Management Committee minutes for 2014 will be in compliance with <u>410 IAC 15-2.5-1(b)</u>. The Center Manager will maintain documentation of all minutes for all committees and Governing Board meetings.</p> <p><i>1. Review of the first meeting in 2014 lacked documentation that the Infection Control Plan was reviewed.</i></p> <p><b>Plan of Correction;</b> The infection control plan is set to be reviewed on May 22nd, 2014 at 1200 by the Quality Assurance Committee and subsequently the Medical Staff and Governing Board. This plan will be reviewed annually, along with the infection control policy and procedures. The current process for review of the Infection Control Committee and Quality Management Committee minutes for 2014 will be in compliance with <u>410 IAC 15-2.5-1(b)</u>. The Center Manager will maintain documentation of all minutes for all committees and Governing Board meetings.</p>	

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	<p>committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on document review and interview, the facility failed to establish an infection control committee that meets at least quarterly, with membership that includes, but is not limited to the person directly responsible for management of the infection surveillance, prevention, and control program, a representative from the medical staff and a representative from the nursing staff.</p> <p>Findings include:</p> <p>1. On 02-24-14 at 1420 hours, staff #40 confirmed there were no Infection Control Committee / Quality Management Committee minutes for 2013.</p>	S000414	<p><b>Plan of Correction;</b> The template for the Quality and Infection Control Programs were devised in 10/2013. The First subcommittee meeting occurred on 1/13/14 and fourth quarter reporting for 2013 was administered to the Governing Board on 2/5/2014. The next Quality/IC meeting is set for 3/18/2014 and will meet monthly. Recommendation will be made at this time and reporting will continue quarterly through the QA meeting, chaired by Dr. Ateet Shah and subsequently delivered to Medical Staff by the Center Manager, then reviewed by the Governing Board.</p>	03/18/2014

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S000424	<p>4. Review of the Infection Control Committee / Quality Management Committee minutes for the first meeting in 2014 lacked documentation that a representative from the medical staff was at the Infection Control Committee / Quality Management Committee meeting.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.4-1(f)(2)(D)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(D) Written reports of quarterly meetings.</p> <p>Based on document review and interview, the facility failed to ensure that the infection control committee responsibilities include having written reports of quarterly meetings for 1 infection control committee.</p> <p>Findings include;</p> <p>1. Review of the Infection Control Committee / Quality Management Committee minutes for the last 4 quarters indicated there was only 1 meeting.</p>	S000424	<p><b>Plan of Correction;</b> The next Quality/IC meeting is set for 3/18/2014 and will meet monthly. Recommendation will be made at this time and reporting will continue quarterly through the QA meeting, chaired by Dr. Ateet Shah and subsequently delivered to Medical Staff by the Center Manager, then reviewed by the Governing Board. The next quarterly meeting is set to occur on May 22nd, 2014.</p>	03/18/2014
S000526	<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</p>			

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S000710	<p>testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on document review and interview, the facility failed to ensure that all nursing and other center personnel performing blood glucose and urine pregnancy laboratory testing have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed for 8 of 10 personnel files reviewed (Staff #4, 6, P1, P2, P3, P4, P6 &amp; P7).</p> <p>Findings include:</p> <p>1. On 02-24-14 at 1045 hours, staff #40 confirmed that registered nurses (RN) and medical assistants (MA) perform blood glucose and urine pregnancy tests.</p> <p>2. Review of staff #4, 6, P1, P2, P3, P4, P6 &amp; P7's personnel files lacked documentation of competency in performing the blood glucose and urine pregnancy tests in 2013.</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</p>	S000526	<p><b>S 526/ 410 IAC15-2.5-2(h)</b> <i>The facility failed to ensure that all nursing and other center personnel performing blood glucose and urine pregnancy tests annually with documentation maintained in the employee files for 9 of 10 personnel files reviewed.</i></p> <p><i>1. Tag Description</i> <i>2. Review of staff 4, 11, p1, p2, p3, p6 and p7's personnel files lacked said documentation.</i></p> <p><b>Plan of Correction;</b> All staff (those responsible for performing these tests) have received the annual pregnancy testing and blood glucose competency as of 3/17/2014. Competencies will be revisited annually to meet rule 410 IAC 15-2.5-2(h). The Center Manager will ensure that all job related competencies are completed within 90 days of employment then annually thereafter.</p>	03/17/2014

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	<p>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> <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>			

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	<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 documentation of hospital surgical privileges for 1 medical staff member who performed surgical procedures. Findings: 1. Review of 6 medical staff credential files indicated no documentation of hospital surgical privileges for medical staff member MD#5. 2. Review of a document with letterhead titled Indiana Podiatry Group, Inc., dated 2-26-14, confirmed medical staff member #MD5 does not have admitting privileges at any hospital. 3. In interview, on 2-26-14 at 2:00 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	S000710	<p><b>S 710/ 410 IAC15-2.5-4(a)(4)</b> <i>1. Review of 6 medical staff credential files indicated no documentation of hospital surgical privileges for medical staff #5 Plan of Correction; On 5/8/2014 a newly transfer agreement began draft between Community North Hospital and SCP to reflect that all Physicians and Podiatrist could admit to a receiving Physician within that organization, maintaining the same stipulations as the old agreement. Said facility is less than one mile from SCP and meets the requirements of 410 ISV 15-2.4-1 (e)(4). Any Physician maintaining Surgical Privileges with Community North retains admitting privileges, which are not segregated in the DOP for each Physician at that hospital. The new transfer agreement and updated Surgical Privileges will remain with the Physicians' and Podiatrist's credentialing files</i></p>	03/31/2014	

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			and be maintained by the Center manager. This will satisfy the rule <u>410 ISV15-2.4-1 (e)(4)</u> . <i>2.Review of a document with letterhead entitled Indiana Podiatry Group, Inc., dated 2/26/14 confirmed medical staff member #MD5 does not have admitting privileges at any hospital. Plan of Correction;</i> According to a standing waiver from ISDH under 410-AIC15-2.3-1(e)(4), effective November 12th, 2012 no Center will be required to submit a waiver request for the rule <u>410 ISV 15-2.4-1 (e)(4)</u> as long as the podiatrist is credentialed and privileged to perform surgical procedures at one or more hospitals in the same county or in an adjacent. Refer to attachment D for Surgical Privileges. On 5/8/2014 a newly transfer agreement began draft between Community North Hospital and SCP to reflect that all Physicians and Podiatrist could admit to a receiving Physician within that organization, maintaining the same stipulations as the old agreement. Said facility is less than one mile from SCP and meets the requirements of <u>410 ISV 15-2.4-1 (e)(4)</u> . Any Physician maintaining Surgical Privileges with Community North retains admitting privileges, which our not segregated in the DOP for each Physician at that hospital. The new transfer agreement and		

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S000732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially.</p> <p>Based on document review and interview, the medical staff failed to triennially review the medical staff rules. Findings: 1. Review of facility documents indicated there was no review of medical staff rules by the medical staff within the last 3 years. 2. In interview on 2-26-14 at 3:30 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	S000732	<p>updatedSurgical Privileges will remain with the Physicians' and Podiatrist's credentialing files and be maintained by the Center manager. This will satisfy the rule <u>410 ISV15-2.4-1 (e)(4).</u></p> <p><b>Plan of Correction;</b> Rules and regulations of the Medical Staff will be reintroduced at the Medical Staff meeting on May 22nd, 2014 to suit the language required by rule 410-AIC 15-2.5-4(b)(2). Approval will be documented and forwarded to the Governing Board, also on May 22nd, 2014 for final approval and reimplementation. The rules and regulation will thus be reviewed and approved at least triennially to satisfy the requirements of rule 410-AIC 15-2.5-4(b)(2). The Board of Managers will be responsible for reviewing the Rules and Regulations (Responsibilities) with the Medical Staff before board approval.</p>	05/22/2014
S000736	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p>			

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S000772	<p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based on document review and interview, the medical staff failed to have a medical staff meeting each quarter (4 meetings) in calendar year 2013. Findings: 1. Review of facility documents indicated there were no medical staff meetings at all in calendar year 2013. 2. In interview, on 2-26-14 at 2:10 pm, employee #A1 confirmed the above and no further documentation was provided.</p> <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</p>	S000736	<p><b>Plan of Correction;</b> SCP understands that the Governing Board Meetings must be held separately from the Medical Staff meetings to satisfy state requirements. We have reformatted our meeting structures to include the Medical Staff Meetings as a separate entity with specific topics designated for the Medical Staff. The first meeting occurred February 27th, 2014 in response to the ISDH walkthrough, has been documented and stored in a binder labeled Medical Staff Meeting minutes. Subsequent meetings are scheduled for May, August and November of 2014 and are coordinated by the Center Manager. Each calendar year SCP will hold at least 4 Medical Staff Meetings to meet the requirements of rule 410 IAC 15-2.5-4(b)(3)(B).</p>	02/27/2014	

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	<p>and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review and interview, the facility failed to ensure that the medical staff followed its rules and regulations on physicians performing history and physicals for 7 of 30 medical records (MR) reviewed (Patient #2, 18, 23, 25, 27, 28 and 29).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Rules &amp; Regulations indicated the following: "G. A history and physical examination shall be performed by a physician on all patients</p>	S000772	<p>1. Tag Description</p> <p>2. CRNA performed the history on patients numbered 18, 23, 25, 27, 28 and 29. Heart and breath sounds were left blank on 18, 23, 25, 27, 28 and 29.</p> <p><b>Plan of Correction;</b> Patient files for #s 18, 23, 25, 27, 28 and 29 were forwarded to the CRNA for correction. A meeting was held with him on 3/17/2014 to discuss</p>	05/22/2014

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	<p>no more than 30 days prior to the day of surgery and will be updated with a note on the day of surgery."</p> <p>2. Review of patient #18, 23, 25, 27, 28 and 29's MR indicated a certified registered nurse anesthetist (CRNA) performed the history and physical examination. The heart and breath sounds and abdomen examination was left blank for patient #18, 23, 25, 27, 28 and 29.</p> <p>3. Review of patient #2's MR indicated the patient had a procedure on 01-20-14 and the MR lacked documentation of a history and physical examination being completed.</p>		<p>complete documentation of the H&amp;P to satisfy State requirements. We will continue to do internal chart audits with some emphasis on H&amp;P completion. This happens on a quarterly basis and will work to satisfy rule <u>410 IAC 15-2.5-4(b)(3)(M)</u>.</p> <p>3. <i>Review of patient #2's medical record indicated the patient had a procedure on 1-20-2014 and lacked documentation of a history and physical being completed.</i></p> <p><b>Plan of Correction;</b> Rules and regulations of the Medical Staff will be reintroduced at the Medical Staff meeting on May 22nd, 2014 to suit the language required by rule 410-AIC 15-2.5-4(b)(2). Included in this meeting, language will reflect the CRNA to perform the Anesthesia Assessment but that a separate History and Physical must be performed by the Operating Physician no greater than 30 days from the procedure date and updated the day of surgery. It is the responsibility of the medical staff to ensure the policies approved are carried out in full. Approval will be documented and forwarded to the Governing Board, also on May 22nd, 2014 for final approval and reimplementation. The rules and regulation will thus be reviewed and approved at least triennially to satisfy the requirements of rule 410-AIC 15-2.5-4(b)(2) and adoption and implementation of the new rules and regulation will satisfy rule <u>410 IAC 15-2.5-4(b)(3)(M)</u>.</p>	

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S000826	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(E) Safety training required of personnel.</p> <p>Based on document review and interview, the facility failed to provide documentation of safety training in areas where anesthetics are used for 7 of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 7 medical staff credential files indicated files MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, and AH#1, did not contain any documentation of safety training in areas where anesthetics are used.</p> <p>2. In interview, on 2-26-14 at 2:00 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	S000826	<p><b>Plan of Correction;</b> Between February 27th and March 7th all Medical Staff participated in ESU and Fire Safety training for the operating room. All Medical Staff, currently operating at SCP received the in-service and demonstrated their knowledge through a competency. SCP plans to provide annual safety training to all staff and providers annual at a minimum, to satisfy rule <u>410 AIC 15-2.5-4(c)(1)(E)</u>. The Center Manager will ensure that all staff and physicians participate in annual electrical safety training, that it is documented and filed.</p>	03/07/2014
S001012	<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,</p>			

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	<p>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 interview, the facility failed to ensure that drugs were administered according to facility policy &amp; procedures and acceptable standards of practice for 5 of 29 medical records (MR) reviewed (Patient #3, 6, 7, 8 and 10).</p> <p>Findings include:</p> <p>1. Review of policy / procedure PH-15, Medication Administration, indicated the following: "Procedure: -All medications administered are recorded in the medication ribbon of Amkai Chart, and authenticated by the person licensed to administer the medication." This policy / procedure was last reviewed / revised on 03-26-13.</p> <p>2. Review of the following MRs indicated the following; Patient #3 was administered Bicitra with citric acid 334 mg / 500 mg in 5 ml of solution on 01-17-14 at 1229 hours by staff #P7, a medical assistant. Patient #6 was administered Bicitra with citric acid 334 mg / 500 mg in 5 ml of solution on 01-15-14 at 0913 hours by staff #8, a medical assistant. Patient #7 was administered Bicitra with citric acid 334 mg / 500 mg in 5 ml of solution on 01-20-14 at 0753 hours by staff #8, a medical</p>	S001012	<p><b>S 1012/ 410IAC 15-2.5-6(3)(B)</b> <i>The facility failed to ensure that drugs were administered according to facility policy and procedures and acceptable standards of practice for 5 of 29 medical records reviewed. (Patient 3, 6, 7, 8 and 10)</i></p> <p><i>1. Review of policy reflects medications are recorded in the medication ribbon of Amkai and authenticated by the person licensed to administer the medication.</i></p> <p><b>Plan of Correction;</b> PH-15 was corrected to reflect that personnel qualified to administer medications can record and administer medications under the supervision of a licensed personnel who authenticates the physician order. Changes to the policy were reviewed and signed by the Medical Staff Director on 3-18-2014 and implemented. Refer to attachment T</p> <p><i>1. Patients were administered Bicitra by staff #p7, a medical assistant.</i></p> <p><i>2. Tag Description</i></p> <p><i>3. Personnel file lacked documentation of being licensed and having competency to administer medications.</i></p>	03/18/2014

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S001146	<p>assistant. Patient #8 was administered Bicitra with citric acid 334 mg / 500 mg in 5 ml of solution on 01-22-14 at 1026 hours by staff #8, a medical assistant. Patient #10 was administered Bicitra with citric acid 334 mg / 500 mg in 5 ml of solution on 01-13-14 at 1214 hours by staff #8, a medical assistant.</p> <p>3. On 02-26-14 at 1010 hours, staff #43 verified that medical assistants administer the oral Bicitra with citric acid 334 mg / 500 mg in 5 ml of solution.</p> <p>4. Review of staff #8 and P7's personnel file lacked documentation of being licensed and having competency to administer medications.</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</p>		<p><b>Plan of Correction;</b> Documentation was obtained from legal counsel regarding scope of practice for medical assistants. Medication administration occurs with a written or verbal physician order and can be delegated to the MA by the RN with the direct supervision of the ordering physician or in the area where the physician is physically per facility policy. Our physicians are required to be on site as orders are implemented. To satisfy concerns for additional competencies, a new competency was completed on 3-19-2014 by all Medical Assistants and placed in employment files. All future new-hires will be required to complete the same competency before administering medications. This will be implemented and tracked by the Center Manager of SCP and will satisfy the rule <u>410 IAC 15-2.5-6(3)(B)</u>.</p>		

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S001164	<p>employees.</p> <p>Based on observation, the facility maintained a condition which may result in a hazard to patients, public, or employees in 3 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 2-25-14 at 2:30 pm in the presence of employee #A3, it was observed in the patient reception area and the patient reception office, a single smoke compartment, there was an alcohol-based hand sanitizer (ABHS) in each area, and each area was carpeted but was not sprinklered.</li> <li>On 2-25-14 at 2:45 pm in the presence of employee #A3, it was observed in the nurse education room, a single smoke compartment, there was an ABHS in the room and the room was carpeted but was not sprinklered.</li> <li>Placement of an ABHS in a single smoke compartment which is unsprinklered posed a fire hazard.</li> </ol> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</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>	S001146	<b>Plan of Correction;</b> All alcohol-based hand sanitizers were removed immediately upon mention. The facility will continue to provide alcohol-free hand sanitizers, under the direction of the Center Manager, to the public and staff in areas that are carpeted and non-sprinklered	02/26/2014

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	<p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the facility failed to conduct preventive maintenance (PM) on 1 piece of equipment in accordance with the manufacturer's recommended maintenance schedule.</p> <p>Findings:</p> <p>1. Review of a document by the manufacturer of a Sharplan 20 C Laser, entitled Table 7-1. Recommended Routine Inspection and Maintenance Schedule, indicated, the following Inspection/Service is recommended to be done every 6 months by a Laser Industries-authorized technical personnel:</p> <p>Check maximum power output Check power meter calibration Check coating of all mirrors and lenses Check cooling system for leaks and obstructions, and pressure in the expansion cylinder</p> <p>2. Review of a document entitled Surgery Center Plus Annual Electrical Safety Inspection, dated 05/29/2013, indicated the above checks were conducted annually.</p> <p>3. In interview, on 2-25-14 at 3:55 pm,</p>	S001164	<p><b>S1164/ 410 IAC15-2.5-7(b)(4)(B)(i)</b></p> <p><i>1. Recommended Routine Inspection and Maintenance Schedule, indicated, the following inspection/service is recommended to be done every 6 months by a Laser Industries-authorized technical personnel.</i></p> <p><i>2. Documentation at SCP indicated the laser was inspected annually</i></p> <p><b>Plan of Correction;</b> The final preventative maintenance of the laser was completed on 2/26/14. There will be no more cases performed with said laser and it has been listed for sale. There will be no future use of this equipment and no need for further preventative maintenance performed. Any future purchase of a laser will require performance of a biannual PM by a laser industries-authorized technician to satisfy <u>410 IAC 15-2.5-7(b)(4)(B)(i)</u>. All preventative maintenance will be scheduled and documented by the Center Manager of SCP. Refer to attachment W -1&amp;2.</p>	02/26/2014

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S001166	<p>employee #A3 confirmed the above and no further 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)(ii)</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>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on document review and interview, the facility failed to provide evidence of preventive maintenance (PM) on 2 of 11 pieces of patient care equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of a facility document titled Surgery Center Plus Annual Electrical Safety Inspection did not indicate PM for a suction machine nor for a wheelchair.</li> <li>In interview on 2-26-14 at 3:30 pm, employee #A1 confirmed the above and no further documentation was provided prior to</li> </ol>	S001166	<p><b>S1166/ 410 IAC15-2.5-7(b)(4)(B)(ii)</b> The facility failed to provide evidence of PM on 2 of 11 pieces of patient care equipment</p> <p>1. The facility document titled Surgery Center Plus Annual Electrical Safety inspection did not indicate PM for a suction machine nor a wheelchair.</p> <p><b>Plan of Correction;</b> Report from K&amp;R medical does include the pm of 1 wheelchair that is currently in service. The other wheelchair has not been in service for longer than 1 year and has been</p>	03/01/2014

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S001170	<p>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</p>		<p>removed from use. Both chairs did have stickers with PM dates that were not recognized during the inspection. Please refer to attachment X. The suction machines have no electrical wiring and function solely on the vacuum lines in wall mounts. The vacuum lines are inspected quarterly and that inspection occurred in March, 2014. The next quarterly inspections are set for June, September and December for 2014. All preventative maintenance will be scheduled and documented by the Center Manager of SCP. The facility is currently in compliance with <u>410 IAC 15-2.5-7(b)(4)(B)(ii).</u></p>		

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S001198	<p>manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to document defibrillator checks in accordance with the facility's policy for 1 of 1 defibrillator.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of facility Policy Number: AN-21, entitled Emergency Crash Carts, indicated monthly charge the defibrillator five times and verify that the charge is maintained. Further review of the document indicated record joules delivered ... and the watt setting reached in the log.</li> <li>Review of a document entitled DAILY OPERATING ROOM CHECK, for the month of January, 2014, indicated the above-stated checks were not conducted.</li> <li>In interview, on 2-26-14 at 3:55 pm, employee #A3 confirmed the above and no further documentation was provided prior to exit.</li> </ol> <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</p>			S001170	<p><b>Plan of Correction;</b> AN-15 in the Policy and Procedure Manual was adjusted to reflect the correct procedure for SCP, Indianapolis, regarding the number of times the defibrillator is charged and maintained. The Daily Operating Room Check is being revised to reflect this procedure and will include documentation of the watt setting and joules delivered. This will satisfy the rule <u>410 IAC 15-2.5-7(b)(4)(B)(iv)</u> as current and future processes match out policies. We confirmed there are no manufacturer recommendations on the number of times this procedure should be performed. It is the medical staff's responsibility to ensure that all SCP policies are in effect. Since it is a change in policy, the changes were forwarded to medical staff on 3-20-2014 for initial approval and final approval will be submitted to the governing board on 5-22-2014. All policies and procedures will be evaluated on an annual basis.</p>		03/20/2014

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	<p>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 disaster and preparedness with an appropriate governmental agency for year 2013, in 1 instance.</p> <p>Findings:</p> <p>1. Review of facility documents indicated there was no documentation of coordination of emergency disaster and preparedness with an appropriate governmental agency in calendar year 2013.</p> <p>2. In interview, on 2-26-14 at 10:30 am, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	S001198	<p><b>Plan of Correction;</b> SCP, Indianapolis has devised a letter of intent to submit to a local government agency. Current arrangements are in progress to obtain training for the new Center Manager, who will then educate staff of the new plan. Once the local agency for training is selected, the letter will be sent out for intent for participation and training will commence. It will be the Center Managers responsibility to coordinate all future Emergency and Disaster Preparedness training and/or communication with local governing agencies. The process will occur on an annual basis and remain documented in a binder labeled, "Disaster Preparedness." All documentation of the plan, necessary forms, organization charts and procedures will be available in this binder. This will satisfy the rule <u>410 IAC 15-2.5-7(c)(6)</u>.</p>	04/18/2014