

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001147	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2013
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NAME OF PROVIDER OR SUPPLIER INVERNESS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8004 CARNEGIE BOULEVARD FORT WAYNE, IN 46804
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 004581</p> <p>Survey Date: 2/20/13 through 2/21/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/28/13</p>	S000000		

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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S000010	<p>410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a)</p> <p>Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules.</p> <p>Based on document review and staff interview, the facility failed to comply with all applicable State laws for 1 of 1 unlicensed surgical technician's employee file reviewed.</p> <p>Findings include:</p> <p>1. IC 16-28-13-4: a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of employee #15's personnel file indicated that he/she</p>	S000010	<p>S 010 – 410 IAC 15-2.2-1 Compliance with Rules Response to 1-3 Effective 3/01/13 all Inverness Surgery Center existing and new hire, non-licensed employees with patient contact in his or her job description will be checked in the Indiana State Nurse's Aide Registry database. The check will be completed for all Center non-licensed endoscopy technicians and any other non-licensed individuals and will be added to the center's pre-employment checklist. The director will document the results of the search on the returned search form, sign and date the form and place it into the individual's personnel chart. The Center already conducts criminal background checks through the Indiana State Police Database on 100% of employees in the Center. The criminal background check is completed prior to the employees first day of work. The plan of correction was implemented by the Center director on 03/01/13. A copy of the Endo Technician's Indiana State Nurse's Aide Registry database search result is included in the</p>	03/01/2013	

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	<p>was hired on 2/16/2008 as an Endoscopy Technician and employee's file lacked documentation of a nurse aide registry report. The Endoscopy Technician was not certified.</p> <p>3. At 9:30 AM on 2/21/2013, staff member #1 indicated he/she was unaware that a state nurse aide registry report was to be run on all unlicensed and non-certified health care personnel that have direct patient contact. The staff member indicated staff member #15 assists the physicians during surgeries.</p>		uploads as Exhibit 1.		

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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 staff interview, the facility failed to ensure a peer review of physicians by three or more licensed physicians having no financial interest in the facility.</p> <p>Findings included:</p> <p>1. The Peer Review, Utilization Review and Medical policy ADM 14 (last updated 1/2012) section B, Composition, states, "Physicians, the Medical Records Reviewer, and clinical personnel will conduct review function. Review decisions are made only by the licensed</p>	S000230	S 230 410 IAC 15-2.4-1 Governing Body; Powers and Duties Response to 1-3 The Inverness Surgery Center Medical Executive Committee identified three non-partner physicians to immediately designate the Center's physician peer review committee. The group will audit physician charts and reports to ensure compliance with rules and guidelines. The physician Peer Review committee will meet minimally on an annual basis to conduct peer reviews, in compliance with Center policy: Admin-014: Peer Review, Utilization Review, and Medical Record Review Plan.exploring ways to improve procedures, maintaining committee records and promoting the most efficient use of available health services and facilities.	02/25/2013			

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	<p>physicians. The physicians shall not be employed by, nor have any financial interest in the Center, nor are they directly responsible for the care of the patients they are reviewing."</p> <p>2. The Peer Reviews for the previous 12 months revealed the nursing documentation was reviewed by a Registered Nurse. The Anesthesia documentation on the selected medical records was reviewed by physicians. However, the medical records physician documentation was reviewed by the Medical Records Consultant. Therefore, the physicians were not being peer reviewed by physicians.</p> <p>3. At 10:30 AM on 2/21/2013, staff member #1 confirmed the Medical Record Consultant did the peer review on the surgeons and the physicians conducted the peer review only on the anesthesiologists. The staff member indicated the surgeons were not peer reviewed by licensed</p>				

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	physicians.			

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S000310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to evaluate and monitor 5 services provided by contractors as part of its comprehensive quality assessment and improvement (QA&I) program: Housekeeping, Maintenance, Laundry, Pest Control, and Biomedical.</p> <p>Findings included:</p> <p>1. Medical Staff By-laws Article IX section 1-D, objective of the Quality Improvement Plan (last reviewed August 2011) states, " To continue current medical staff mechanisms for monitoring, evaluation and improving patient care with planned evaluation of efficiency and effectiveness."</p>	S000310	S 310 410 IAC 15-2.4-2 Quality Assessment and Improvement Response to 1-4 The Center director combined the general and more specific Quality Improvement Contractor Service Evaluation Report. The new document, attached as Exhibit Two, now includes the individual responsible for the monitoring, the specific performance requirements and measurements for all contracted services, including but not limited to: Pest Control, Housekeeping, Laundry, and Biomedical services. The quality indicators have been reviewed and adjusted to be specific and meaningful to the Inverness facility. The indicators are also tied to the Center's Quality Improvement, Infection Control, Safety Committees to improve the flow of communication about the services to the Medical Executive Committee and administration.	03/04/2013	

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	<p>2. The Quality Assessment program indicators were reviewed with staff member #1 at 11:00 AM on 2/21/2013. Contracted companies that provide Housekeeping, Maintenance, Laundry, Pest Control, and Biomedical services were not evaluated as described on the Inverness Surgery Center Quality Improvement Contractor Service Evaluation Report. The Quality Indicators For Contracted Services 2012 report identified different indicators than the Inverness Surgery Center evaluation report has identified. Laundry service on the contractor service evaluation report identified the promptness of laundry pickup and delivery compared to the Quality Indicator report which identified services provides monthly titration reports. The Quality Indicator for Contracted Services report did not identify the pest control contracted service; however, the contractor service evaluation report did</p>			
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	<p>identify the pest control contracted service.</p> <p>3. At 11:15 AM on 2/21/2013, staff member #2 indicated the contracted services are reported on a Quality Indicators For Contracted Service's report. The staff member indicated the contracted services are reviewed each quarter. The report notes if each contracted service met or did not meet the contractor's indicators. A check mark would be placed in either the 'yes' column or the 'no' column. A notation is at the bottom of the form stating all indicators must be met 95% of the time. However, the staff member confirmed the form does not give a good evaluation tool for each contracted service.</p> <p>4. At 11:30 AM on 2/21/2013, staff member #1 indicated he/she does not understand what the reason was on collecting the titration report from the laundry service or how the report was to be used on evaluating the laundry</p>			

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	contracted service.			

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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 and interview, the facility failed to provide a safe patient environment by ensuring areas were inspected and free of outdated supplies.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the surgical area with staff member #P1, beginning at 1:30 PM, the following observations were made: <ul style="list-style-type: none"> A. One of three Pediatric Medtronic pads with an expiration date of 10/28/12 on the OR crash cart. B Ten BD Insyte Autoguard intravenous catheters in the anesthesia cart in OR #4: four of four 24 gauge expired 02/2012, three of three 20 gauge expired 10/2012, three of three 22 gauge expired 09/2012. C. A container of Cidex OPA test strips, open, but not dated, with a manufacturer's expiration date of 10/2012. The label directions were to date when opening and discard after 90 days. During the tour of the pre/post areas at 2:10 PM on 02/20/13, accompanied by 	S000400	<p>S 400 410 IAC 15-2.5-1 Infection Control Program</p> <p>Response to 1-3 The Center director immediately replaced the expired supplies, testing implements, and medications. The director also re-educated staff regarding the responsibility of each staff member to check expiration dates as assigned and to correctly label the testing equipment, such as testing strips or liquid control with the correct expiration dates as required. The director also created new instructional signs for key areas of the center to reinforce compliance. The director also created checklists for testing equipment to serve as visual cues to remind staff to check for outdates of test equipment and testing supplies.</p>	02/28/2013			

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	<p>staff member #P10, four of four open, but not dated, vials of Accucheck Aviva control solution for the glucometer were observed at the nurses' station. Label directions were to date the solution upon opening and discard after 90 days.</p> <p>3. At 2:15 PM on 02/20/13, both staff members #P1 and P10 indicated all medications and supplies were to be checked monthly and staff had assignments for different areas. They indicated the test strips and control solutions should be dated when opened.</p>			

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S000780	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure their policies were followed regarding verbal and standing orders in 12 of 20 patient charts reviewed (#N2, N3, N4, N5, N7, N11, N12, N13, N15, N16, N17, and N18).</p> <p>Findings included:</p> <p>1. The facility policy "Guidelines for Maintaining the Medical Record as a Medical-legal Document", last reviewed 02/2012, indicated, "A. The medical record is maintained as a unit record. All entries in the medical record must be authenticated (name and professional status), timed and dated. ...N. Routine orders should be preprinted, completed,</p>	S000780	S 780 410 IAC 15-2.5-4 Medical Staff; Anesthesia and Surgical Response to 1 – 18 The Center director reviewed all documentation policies to ensure that each policy specified specific requirements for authentication, signage, dating and timing. The director amended policy Medical Records 04: Physician Standing and Routine Orders (Exhibit Three) to reflect the requirements for dating, authenticating, and timing of orders. The Center director met with each physician specified in the chart audit to explain the problems with his or her charting and provide guidance on the required aspects of charting. The director also increased the signage in the physician-charting areas of the Center to encourage attention to	02/28/2013			

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	<p>and signed by the responsible physician."</p> <p>2. The facility policy "Completeness and Legibility of the Medical Record", effective 02/27/12, indicated, "4. Physician and nursing staff will avoid the practice of 'writing over' on the medical record."</p> <p>3. The facility policy "Documentation: Charting and Charts", last reviewed 02/2012, indicated, "B. Timing and Dating of Documentation: 1. All H&Ps, physician order sheets, consents, dictation sheets, operative, and post-procedure reports must include the physician's signature, the date, and time the document is signed."</p> <p>4. The facility policy "Physician's Verbal and/or Telephone Orders", last reviewed 02/2012, indicated, "A. When a telephone order is received, the physician and/or nurse's name is documented after the order has been written. This documentation must include the first initial, last name, and credentials of the nurse leaving the order. The nurse receiving the order must also acknowledge and document that she/he read back and verified the order. This is documented by R/V at the end of the signature. C. The physician should sign the pre-operative verbal and telephone</p>		<p>documentation detail and compliance to the regulations and policies. The Medical Director sent a letter to all physician patrons of the Center (Exhibit Four) and their respective office managers to re-educate them on the specific requirements related to acceptable documentation in the Center, including but not limited to: the need for all orders, H&P's, and discharge summaries to be complete, accurately and appropriately dated and timed, written and signed by the correct individual physician. The Medical Director outlined the specific charting requirements needed for compliance in the Center. The Center director instructed the medical records clerk to remove all incoming instances of pre-dated orders received from physicians or their offices. The Center staff will contact the offices for replacement orders each time the pre-stamped orders are received. The Center staff were educated by the director to maintain the legibility of their charting and to avoid writing over in the medical record. The accuracy and appropriateness of physician charting will remain a focus of the peer review utilization group, the independent medical records auditor, and the improvement and compliance progress will be tracked by the Quality Improvement Committee.</p>				

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	<p>orders on the day of the patient's procedure. D. Post-operative verbal and telephone orders should be signed, timed, and dated prior to the physician leaving the facility or within 24 hours."</p> <p>5. The facility policy "Physician Standing/Routine Orders", last reviewed 01/2012, indicated, "A. Standing/routine orders will be placed on the patient's chart after the appropriateness for the individual patient has been assessed. These orders will be signed by the physician when the patient is: 1. Identified by the physician pre-operatively, and/or 2. Admitted to the RR/PACU area. ...C. Copies of standing/routine orders are maintained in the Pre-Op and RR/PACU areas and are filed under the physician or physician group name."</p> <p>6. The medical record for patient #N2 indicated standing orders that were signed by the physician, but not dated or timed. The record also indicated a verbal order from the physician on 11/30/12 that was not signed, dated, or timed by the physician.</p> <p>7. The medical record for patient #N3 indicated standing orders that were signed by the physician, but not dated or timed. The record also indicated a verbal order</p>			

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	<p>from the physician on 07/09/12 that was signed by the physician, but not dated or timed..</p> <p>8. The medical record for patient #N4 indicated standing orders that were electronically signed by the physician on 07/31/12, but the patient was not admitted for a procedure until 08/29/12.</p> <p>9. The medical record for patient #N5 indicated standing orders that were electronically signed by the physician on 08/07/12, but the patient was not admitted for a procedure until 08/31/12.</p> <p>10. The medical record for patient #N7 indicated pre-op standing orders that were signed by the physician, but not dated or timed. The record also indicated post-op standing orders that were not signed, dated, or timed by the physician.</p> <p>11. The medical record for patient #N11 indicated standing orders that were electronically signed by the physician on 03/27/12, but the patient was not admitted for a procedure until 05/03/12. The orders were signed again by the physician with the date written over/changed to 5/03/12.</p> <p>12. The medical record for patient #12 indicated pre-op standing orders that were</p>						

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	<p>signed by a nurse for the physician and dated 12/06/12, but the patient was not admitted for a procedure until 12/18/12. The orders lacked a physician signature.</p> <p>13. The medical record for patient #N13 indicated standing orders that were signed by the physician, but not timed.</p> <p>14. The medical record for patient #N15 indicated pre-op standing orders that had a physician name written by the nurse as a telephone order from 07/05/12, but the patient was not admitted for a procedure until 07/23/12. The physician signed, but did not date or time the orders. The post-op standing orders lacked a physician signature and were noted by the nurse on 09/17/12, almost two months later.</p> <p>15. The medical record for patient #N16 indicated standing orders that were electronically signed by the physician on 08/22/12, but the patient was not admitted for a procedure until 08/29/12.</p> <p>16. The medical record for patient #N17 indicated standing orders that were signed by the physician, but not dated or timed.</p> <p>17. The medical record for patient #N18 indicated pre-op standing orders that had a physician name written by the nurse as a</p>						

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	<p>telephone order from 11/05/12, but the patient was not admitted for a procedure until 11/08/12. The record lacked a physician signature for the orders.</p> <p>18. At 1:15 PM on 02/21/13, staff member #P1 confirmed the medical record findings were not according to policy.</p>				

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S000888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on policy and procedure review, medical record review, and interview, the facility failed to ensure the operative report was authenticated according to policy for 9 of 20 patient records reviewed (#N3, N6, N7, N10, N15, N16, N17, N18, and N20).</p> <p>Findings included:</p> <p>1. The facility policy "Documentation: Charting and Charts", last reviewed 02/2012, indicated, "B. Timing and Dating of Documentation: 1. All H&Ps, physician order sheets, consents, dictation</p>	S000888	S 888 410 IAC 15-2.5-4 Medical Staff; Anesthesia and Surgical Response to 1 - 11 The Center director met with each physician specified in the chart audit to explain the problems with his or her charting and provide guidance on the required aspects of charting. The director also increased the signage in the physician-charting areas of the Center to encourage attention to documentation detail and compliance to the regulations and policies. The Medical Director sent a letter to all physician patrons of the Center (Exhibit Four). The Medical Director outlined the specific charting	02/28/2013			

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	<p>sheets, operative, and post-procedure reports must include the physician's signature, the date, and time the document is signed. ...4. All chart orders and sections must be completed and signed-off within thirty days of service."</p> <p>2. The operative report for patient #N3 was dictated on 07/09/12, the day of the procedure, but lacked a date and time for the physician's signature.</p> <p>3. The operative report for patient #N6 was dictated on 02/23/12, the day of the procedure, but lacked a date and time for the physician's signature.</p> <p>4. The operative report for patient #N7 was dictated on 10/23/12, the day of the procedure, but was not electronically signed by the physician until 12/06/12, greater than 30 days later.</p> <p>5. The operative report for patient #N10 was dictated on 07/12/12, the day of the procedure, but lacked a date and time for the physician's signature.</p> <p>6. The operative report for patient #N15 was dictated on 07/23/12, the day of the procedure, but lacked a date and time for the physician's signature.</p> <p>7. The operative report for patient #N16</p>		<p>requirements needed for compliance to policies, state and federal regulations in the Center to re-educate them on the specific requirements related to acceptable documentation in the Center, including but not limited to: the need for all orders, H&P's, operative reports, post-procedure reports, and discharge summaries to be complete, accurately and appropriately dated and timed, written and signed by the correct individual physician. The accuracy and appropriateness of physician charting will remain a focus of the peer review utilization group, the independent medical records auditor, and the improvement and compliance progress will be tracked by the Quality Improvement Committee.</p>		

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	<p>was dictated on 08/29/12, the day of the procedure, but was not signed by the physician until 01/30/13, greater than five months later.</p> <p>8. The operative report for patient #N17 was dictated on 10/02/12, the day of the procedure, but lacked a date and time for the physician's signature.</p> <p>9. The operative report for patient #N18 was dictated on 11/08/12, the day of the procedure, but was not signed by the physician until 12/13/12, greater than 30 days later.</p> <p>10. The operative report for patient #N20 was dictated on 11/30/12, the day of the procedure, but lacked a date and time for the physician's signature.</p> <p>11. At 1:15 PM on 02/21/13, staff member #P1 confirmed the medical record findings</p>			

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S001010	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, policy review, and interview, the facility failed to follow their policies regarding multi-dose vials for 3 of 3 open vials observed.</p> <p>Findings included:</p> <p>1. During the case observation in operating room #2 at 11:25 AM on 02/20/13, an open, but not dated, 30 milliliter (ml) vial of Marcaine 0.25% with epinephrine was observed sitting on an open counter.</p> <p>2. During the tour of the facility at 1:50 PM on 02/20/13, accompanied by staff member #P1, two open vials of insulin were observed in the medication refrigerator. The vial of Humulin R had an open date of 01/09/13 and the vial of Humalog was dated 05/24/12. Staff member #P1 indicated these were the only</p>	S001010	<p>S 1010 410 IAC 15-2.5-6 Pharmaceutical Services Response to 1 -4 The Director re-educated the Center staff, using the existing policy PC 102: Administration of Medications (Exhibit Five), to re-educate the staff regarding the correct distribution, administration, and storage of medications. The staff was re-educated regarding the necessity to check the medication expiration dates as routinely assigned by the director, and to employ correct labeling of multi-dose medications when opened, per policy ADM 029: Medication Ordering and Distribution (Exhibit Six). The Center's Medical Executive Committee reviewed both policies on 2/25/13 and verified that the policies were clear and met the standards required for properly dating, handling, and labeling medications in the Center.</p>	03/01/2013	

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	<p>vials of insulin in the facility.</p> <p>3. The facility policy "Medication Ordering and Distribution", last reviewed 02/2012, indicated, "Weekly inventory is taken on all medications. Particular attention is given to expiration dates. ...All opened vials will be marked with an expiration date of 28 days from the time of opening, unless drug expires in less than 28 days."</p> <p>4. At 3:00 PM on 02/20/13, staff member #P1 confirmed the medications weren't dated and discarded according to policy.</p>			

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S001146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, manufacturer's literature, and interview, the facility failed to maintain a safe environment for patients and staff in the operative areas and adjoining rooms.</p> <p>Findings included:</p> <p>1. During the tour of the facility on 02/20/13, beginning at 1:15 PM and accompanied by staff member #P1, the following observations were made:</p> <p>A. A container of antiseptic handrub in a wall mounted holder without a spill tray, installed approximately 2 inches above an electrical switch in the Pathology Room.</p> <p>B. A container of antiseptic handrub in a wall mounted holder without a spill tray, installed approximately 7-8 inches above an electrical switch in the clean utility room.</p>	S001146	<p>S 1146 410I AC 12-2.5-7 Physical Plant, Equipment Maintenance Response to 1 a – c, 2 The director placed an immediate work order and had the antiseptic hand-rub dispensers relocated in each of the three specified areas to ensure compliance with environmental safety regulations. As of 3/1/13, the dispenser relocation was complete.</p> <p>Response to 1D, 3-6 The Center director created a policy to ensure the staff maintains the standards of fluid storage in warming units. The policy (Exhibit 7), EC 052 Fluid Storage and Blanket Warmers outlines the need to label fluids being placed into warming units with the fluid manufacturer's expiration date on each bag. The policy also outlines the need to check the temperature of the warmers and the expiration dates of all fluids,</p>	03/01/2013			

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	<p>C. A container of antiseptic handrub in a wall mounted holder without a spill tray, installed approximately 7-8 inches above an electrical switch in the decontamination room.</p> <p>D. A MAC warming cabinet containing six 1000 milliliter (ml) intravenous bags of Lactated Ringers solution and four 1000 ml. intravenous bags of 0.9 % Normal Saline solution in the top cabinet. None of the bags were date marked and the temperature of the top portion of the cabinet registered 104 degrees Fahrenheit.</p> <p>2. The label on the antiseptic handrub indicated it contained 62.5% ethyl alcohol and a warning that the product was flammable, keep away from fire or flame.</p> <p>3. Review of the user manual for the warming cabinet indicated, "MAC Medical does not recommend chamber set points. For appropriate heating temperatures, please contact the manufacturer of the goods being heated."</p> <p>4. An Internet search indicated recommendations from the Baxter Health Care Corporation, manufacturer of some of the fluids, "IV bags in plastic over-pouches may be warmed for no longer than 14 days at a temperature not to exceed 40 degrees Celsius (104 degrees Fahrenheit)."</p>		<p>daily and record them in the temperatures in the daily OR Log. The director educated the staff regarding the new policy and fluid labeling/handling requirements.</p>				

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	<p>5. During the tour at 1:30 PM on 02/20/13, some of the staff indicated the fluids in the warming cabinet should be marked and others indicated they were told date marking was no longer necessary. The temperature of the cabinet was being monitored and was kept at 104 degrees Fahrenheit.</p> <p>6. At 9:20 AM on 02/21/13, staff member #P1 indicated there was no facility policy for the warming cabinet and they had not obtained information from the fluid manufacturer regarding the specifics of warming the fluids.</p>			

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S001300	<p>410 IAC 15-2.6-1 DIETARY SERVICES 410 IAC 15-2.6-1(a)</p> <p>(a) If nourishments and other dietary needs of the patients are provided in the center, the center shall comply with 410 IAC 7-24.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to ensure food was not stored with employee medication that was located in the employee break room.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Extended Stay - Dietary policy #PC 036 (last reviewed 1/2012) states, "Dietary supplements will be kept in the refrigerator/freezer located in the recovery room and the cabinets located in the break room." 2. Retail Food Establishment Sanitation Requirements, 410 IAC 7-24-419 (effective November 13, 2004) states, "Medicines for the employees' use shall be located to prevent the contamination of food, 	S001300	S 1300 410 IAC 15-2.6-1 Dietary Services Response to 1 – 4 The bottle of Hi-Tech laxative was removed and discarded from the employee kitchen cabinet by the director immediately upon being informed of its presence by the surveyor. The director posted a sign in the employee kitchen forbidding the storage of medications in the food storage area. The Center staff and physicians informed of the finding and re-educated by the director regarding the correct storage location for medications, and the expectations and limitations of food storage areas. The director added the task of checking the food storage areas for correct, permissible contents to the existing Inverness Kitchen Duties Schedule on 02/25/2013.	02/25/2013	

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	<p>equipment, utensils, linens, and single-service and single-use articles."</p> <p>3. At 9:45 AM on 2/20/2013, the employee break room was inspected. The enclosed cabinets located above the counter were observed storing 30 assorted canned soups and 6 containers of peanut butter. On the same shelf with the assorted canned soups was a brown bottle with a white label, Hi-Tech Pharmacal Docu Liquid Stool Softener Laxative.</p> <p>4. At 10:50 AM on 2/20/2013, staff member #1 indicated the medication belonged to the physicians.</p>			