

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001073	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/03/2013
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NAME OF PROVIDER OR SUPPLIER  RIVERPOINTE SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 500 ARCADE AVE STE 100 ELKHART, IN 46514
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S000000	The visit was for a licensure survey.  Facility Number: 009967  Survey Date: 7-01-13 to 7-03-13  Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor  Linda Plummer, RN Public Health Nurse Surveyor  QA: claughlin 07/17/13	S000000		
S000156	10/17/13 revised due to IDR 410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)  Require that the chief executive officer develop and implement policies and programs for the following:  (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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Based on policy and procedure review, personnel file review, and staff interview, the facility failed to ensure that an annual performance evaluation was conducted for 1 of 2 scrub/surgical technicians (staff member N8).</p> <p>Findings:</p> <p>1. at 9:20 AM on 7/2/13, review of the policy and procedure "Performance Reviews", policy number AP-02, with a signed date of 5/8/13, indicated:</p> <p>a. under "Guidelines", it reads: "...River Pointe Surgery center must conduct a performance review of your job performance, on an annual basis, or more or less frequently as River Pointe Surgery center shall determine..."</p> <p>2. review of 2 surgical/scrub tech personnel files indicated:</p> <p>a. staff member N8 was hired 1/5/09 and had a last dated performance evaluation of 11/2/11</p> <p>3. interview with staff member #52, the executive assistant/human resources manager, at 9:15 AM on 7/2/13, indicated:</p> <p>a. the facility can, by policy statement, determine to not perform an annual evaluation of staff performance</p> <p>b. the facility determination to not perform annual evaluations is not per</p>	S000156	<p>Policy AP-02 has been amended to require annual performance reviews for all personnel. Staff Member N8 was given a performance evaluation and such evaluation was included in his personnel file. Administrator and Executive Assistant/HR Manager are responsible for monitoring and enforcing annual performance evaluations. They will review personnel files regularly to determine date(s) of annual performance evaluations and ensure they are completed. Findings: 1. Policy AP-02 was amended to require annual performance evaluations. A copy is attached. 2. Staff Member N8 was given an annual performance evaluation. 3. Policy AP-02 was amended to require annual performance evaluations. 4. Policy AP-02 was amended to require annual performance evaluations.</p>	07/29/2013			

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S000226	<p>surgery center licensure rules</p> <p>4. interview with staff member #50, the surgery nurse manager, at 9:20 AM on 7/2/13 indicated:</p> <p>a. staff member N8 is a PRN (as needed) employee and evaluations for PRN staff are not necessarily done on an annual basis</p> <p>b. the facility determination to not perform annual evaluations, even for PRN staff, is not per surgery center licensure rule requirements</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</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>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the center failed to maintain a list of all contracted services, including the scope and nature of services provided.</p>	S000226	IDR410 IAC 15-2.4-1(e) (3)The Facility provided the surveyor with a list of contracted services. A copy of the list provided is attached here as Exhibit "A". Findings Nos. 1-3 are incorrect. The surveyor told the	07/29/2013

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S000300	<p>Findings:</p> <ol style="list-style-type: none"> <li>On 7-01-13 at 1145 hours, staff A2 and A3 were requested to provide a list of contracted services including the scope and nature of services provided and none was provided prior to exit.</li> <li>The document Vendor List failed to indicate the scope and nature of services provided for listed providers.</li> <li>On 7-02-13 at 1545 hours, staff A2 and A3 confirmed that the center failed to maintain a list of contracted services.</li> </ol> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the center failed to assure</p>	S000300	<p>Facility staff he did not like the format of the list. The Facility requests the tag be deleted.POC A list of contracted services will be maintained by the Facility and will contain the scope and nature of services for each vendor. A copy of the updated list has been attached to this response. The list is updated as needed and quarterly by the Materials Manager and Nurse Manager. The Materials Manager and the Nurse Manager shall check the list monthly to verify all services are included and take appropriate steps to ensure completeness. Findings: 1, 2 and 3: A list of contractors will be maintained by the Facility and will be updated when needed and quarterly by the Materials Manager and the Nurse Manager. It contains the scope of services provided by each contractor.</p>				

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	<p>participation of committee members as required by policy for the Medical Quality Improvement Committee.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The policy/procedures Quality Improvement Program (approved 4-12) and Medical Quality Improvement Committee Standards (approved 5-13) indicated that the administrator/executive director was a QI or MQIC member and documentation of 2012 and 2013 MQIC meetings failed to indicate attendance by the administrator/executive director.</li> <li>2. During an interview on 7-03-13 at 0925 hours, staff A2 confirmed that the administrator was not attending the MQIC meetings.</li> </ol>			

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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. Based on document review and interview, the center failed to ensure that all contracted services were evaluated through its quality assessment and improvement (QA) program for 8 of 20 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedures Quality Improvement Overview (approved 4-12), Quality Improvement Program (approved 4-12), Quality Improvement Activities (approved 5-13) and Medical Quality Improvement Committee Standards (approved 5-13) failed to indicate a process for evaluating all contracted services through the QA program.</p> <p>2. The document 2013 Annual QI Criteria Log observed in the Medical Quality Improvement Committee minutes dated 4-08-13 failed to indicate</p>	S000310	IDR410 IAC 15-2.4-2(a)(1)The tag states that the contracted sevicees were not reiveiwed. That is incorrect. A copy of the Contracted Services Annual Report done most recently is attached as Exhibit C. The Facility requests that the tag be deleted. POC Facility has amended the Quality Improvement Program Policy to address evaluating its contracted services. The contracted services list will reflect the month of the annual review. The Medical Director as Chair of the MQIC is responsible for ensuring the contracted services are evaluated as part of the QI program. The agenda template established by the Facility reflects consideration of the contracted services. Nurse Manager shall monitor compliance with updating contractor list and notify administrator of any further action required. Findings: 1. The QI Policy has been amended to address the process for reviews of contractors. 2. The QI Policy	07/31/2013			

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S000404	<p>the name of a service provider for 10 of 12 listed contracted services and failed to indicate which one of two laundry providers was evaluated. The documentation failed to indicate that 3 fire service providers (fire extinguisher service CS1, fire alarm system certification CS2, and fire sprinkler service CS3), 3 radiology service providers (factory equipment service by CS4, medical physics consulting by CS5, and radiation badge monitoring by CS6) and a sterilizer service provider CS7 identified through document review were currently evaluated through the QA program.</p> <p>3. On 7-02-13 at 1635 hours, staff A2 and A3 confirmed that the center failed to evaluate all contracted services through its QA program.</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>	S000404	has been amended to address the process for reviews of contractors and the contracted services list will reflect annual review date. A template for the agenda of the MQIC meetings will include contracted services. All contracted vendors will be reviewed in the future. The Medial Director as Chair of the MQIC is responsible for ensuring that contracted services are assessed. The Materials Manager and the Nurse Manager are responsible for updating the contracted services list and keeping it current. The contract services are included on the agenda template for the MQIC meetings.				

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	<p>Based on policy and procedure review, personnel file review, and interview, the facility failed to implement its policy related to an annual TB (tuberculosis) risk assessment.</p> <p>Findings:</p> <p>1. at 3:10 PM on 7/2/13, review of the policy and procedure "Tuberculosis Controls", with a policy number IT-02, and signed on 5/8/13, indicated:</p> <p>a. under "Procedure", on page two, it reads in section 6. "River Pointe Surgery center will perform a yearly TB risk assessment. Based on the yearly assessment it will be decided by the Medical Director whether or not our staff need TB testing for that year. If it is decided that we are at low risk, then annual Mantoux TB testing will not be performed..."</p> <p>2. at 2:35 PM on 7/1/13, review of staff personnel files indicated staff are completing an annual TB questionnaire in place of receiving an annual TB test</p> <p>3. interview with staff member #51, the infection preventionist, at 2:45 PM on 7/2/13 indicated:</p> <p>a. it has been determined that the facility is at a low risk for TB based on the assessment done at the neighboring acute care hospital and a call to the local</p>				

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S000640	<p>health department who agreed that this is a low risk community</p> <p>b. a TB risk assessment, required by facility policy as stated in 1. above, has not been completed by this facility</p> <p>c. it was unknown that the CDC (centers for disease control) provides a risk assessment for risk determination related to TB</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on policy and procedure review, medical staff rules and regulations review, patient medical record review, and staff interview, the facility failed to ensure the completion of medical records per facility policies for 5 of 24 patient records reviewed (pts. #2, #3, #4, #8 and #16).</p> <p>Findings: 1. at 4:20 PM on 7/2/13, review of the policy and procedure "Medical Records and Documentation", with a policy number of AM-03, and a signed date of 5/8/13, indicated:</p>	S000640	The medical records identified have all been completed. All physicians and medical staff are being notified in writing of their respective obligations to complete medical records in a timely manner and could be subject to sanctions for the failure to do so. The physicians and medical staff have also been notified that only accepted abbreviations may be used. The Medical Director shall be apprised of non-compliance, take additional actions as necessary and report non-compliance to the Governing Body as necessary. Findings: 1-4 Physicians and medical staff are being notified of the	07/31/2013			

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	<p>a. under "Procedure" in section A., it reads: "...This record shall be reviewed periodically to ensure completeness..."</p> <p>b. under "Documentation", in section A. Nursing Entries, it reads: "...4. Forms are to be completed in their entirety...7. Only approved abbreviations may be used on the medical record..."</p> <p>2. at 3:45 PM on 7/2/13, review of the "River Pointe Surgery Center Medical Staff Approved Abbreviation List April 2013 Revision", with a signature date of 4/22/13, indicated:</p> <p>a. s/o is not on the approved abbreviation list</p> <p>3. at 12:15 PM on 7/2/13, review of the medical staff rules and regulations, last signed 7/27/10, indicated:</p> <p>a. in Section 2. "Orders", it reads: "...Verbal, including telephone, orders may be accepted by...Signatures are required on the medical record by the physician...and on all orders within 24 hours..."</p> <p>4. Review of medical records indicated:</p> <p>a. on 5/30/13, pt. #2 had orders written by nursing that read: "s/o Dr.../S....RN" (s/o = standing order)</p> <p>b. pt. #3 lacked documentation of the time of anesthesia's post op note at the</p>		<p>requirement to comply with records policies. At the end of each day, the medical records will be reviewed and flagged for incomplete areas and the medical staff notified. The Nurse Manger or QIC will conduct monthly audits to verify the medical records are being completed and report the results to the Medical Director.</p>				

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	<p>bottom of the "Anesthesia Record" page</p> <p>c. pt. #4 lacked documentation of the type of anesthesia to be administered at the top of the "Anesthesia Record" page (general anesthesia was noted by nursing on the "Operating Room Record" form)</p> <p>d. pt. #8 had a verbal order written by nursing at 1345 hours on 12/21/12 that lacked authentication by the practitioner</p> <p>e. on 6/17/13, pt. #16 had orders written by nursing that read: "s/o Dr.../S...RN"</p> <p>5. interview with staff member #50, the operating room nurse manager, and #51, the infection preventionist/quality nurse, at 3:45 PM on 7/2/13, indicated:</p> <p>a. s/o is not to be used to represent standing orders as this is not on the approved abbreviation list</p> <p>b. the anesthesia record forms for pts. #3 and #4 are lacking completion as indicated in 3. above</p> <p>c. the medical record for patient #8 is lacking completeness by the absence of authentication per the provider for the verbal order given at 1345 hours on 12/21/12</p>				

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S000646	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(3)</p> <p>All entries in the medical record must be as follows:</p> <p>(3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule.</p> <p>Based upon document review and interview, the center lacked a policy/procedure to ensure all entries in the medical record (MR) were dated when authenticated.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The policy/procedure Medical Records and Documentation (approved 5-13) lacked a requirement indicating that all MR entries must be dated when authenticated</li> <li>During an interview on 7-02-13 at 1530 hours, staff A2 and A3 confirmed that the policy/procedure lacked a requirement to date each entry when authenticated.</li> </ol>	S000646	<p>The Medical Records Policy (AMO 03) was amended to require all entries are dated when authenticated not to exceed 30 days from date of procedure. The Business Manager shall monitor compliance with this requirement and notify the Administrator of compliance and whether further action is required. Findings: 1- The Policy was amended to require the date of authentication and the medical staff was notified of the requirement.</p>	07/30/2013			

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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. Based upon document review and interview, the medical staff failed to review its bylaws, rules and regulations at least triennially.</p> <p>Findings:</p> <p>1. On 7-01-13 at 1130 hours, staff A2 and A3 were requested to provide documentation indicating that the medical staff had reviewed its medical staff bylaws, rules and regulations within the past 3 years and none was provided prior to exit.</p> <p>2. Review of the Medical Staff Bylaws, Rules and Regulations (approved 7-12) failed to indicate a provision ensuring that the medical staff bylaws would be periodically reviewed by its medical staff at least triennially. The medical staff bylaws indicated approval by the governing board on 7-30-12.</p> <p>3. The medical executive committee (MEC) meeting minutes for 4-23-12 and 7-30-12 failed to indicate that the</p>	S000732	<p>The Medical Staff Bylaws are being amended to reflect that the medical staff bylaws are to be reviewed triennially. The Medical Director is responsible for ensuring that the bylaws are reviewed as Chairman of the Medical Staff. The Medical Director will monitor compliance. Findings: 1. The Board of Managers has placed the bylaws review on the agenda at the next medical staff meeting. 2. The Medical Staff bylaws are being amended to reflect that they should be reviewed every three years. 3. The Board of Managers and medical staff have placed the review of the bylaws on the agenda of the next medical staff meeting. 4. The bylaws are being amended to include a triennial review of the bylaws.</p>	08/02/2013			

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S000742	<p>medical staff bylaws had been reviewed and approved by the medical staff prior to the governing board approval on 7-30-12.</p> <p>4. During an interview on 7-02-13 at 1240 hours, staff A7 confirmed that the medical staff bylaws, rules and regulations lacked a provision for periodic (or at least triennial) medical staff review and approval and confirmed that no documentation indicating that the medical staff bylaws, rules and regulations had been reviewed by the medical staff or MEC was available.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(C)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(C) A provision for maintaining records of all meetings of the medical staff and its committees.</p> <p>Based upon document review and interview, the medical staff failed to document quarterly medical staff meetings.</p> <p>Findings:</p>	S000742	A medical staff meeting has been scheduled. The Medical Director as Chairman of the medical staff is responsible for calling the medical staff meetings at least quarterly and ensuring that minutes are taken. The Chair shall report to the Governing Body compliance with medical	08/02/2013			

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	<p>1. On 7-01-13 at 1130 hours, staff A2 and A4 was requested to provide documentation of medical staff meetings and none was provided prior to exit.</p> <p>2. The document RPSC 2013 Meeting Schedules indicated the following: " Medical Staff Meeting Quarterly - Prior to EGH ' s Med Staff Business Meeting ...February 19, 2013 ...May 21, 2013 ... "</p> <p>3. During an interview on 7-02-13 at 1225 hours, staff A indicated that no minutes of medical staff meetings are maintained at the center.</p> <p>4. During an interview on 7-03-13 at 0845 hours, the chief financial officer A7 confirmed that no documentation of medical staff meetings was available.</p>		<p>staff participation. Findings: 1-4: Meetings of the medical staff will be properly documented with minutes. The Medical Director as Chairman of the Staff shall ensure minutes are taken and properly filed. The Chair shall monitor participation in the medical staff meetings and report to the Governing Body as necessary.</p>		

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S000772	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on policy and procedure review, medical staff rules and regulations review, patient medical record review, and staff interview, the medical staff failed to ensure the implementation of the facility policy for H &amp; Ps (history and physicals) for 1 of 2 records for Dr.</p>	S000772	The Facility has notified the physicians that they are required to comply with the Facilities bylaws, rules and regulations and policies regarding History and Physicals ("H &P") for all patients. The medical record is to be checked by the pre-op nurse for completion of the H&P.	07/31/2013			

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	<p>#55; 1 of 1 record for Dr. #56; and 1 of 2 patients for Dr. #57 (patient medical records #5, #8, and #13) and failed to assure the medical staff bylaws ensured all preoperative History and Physical (H&amp;P) examinations done prior to the date of the procedure were performed within the timeframe specified by the medical staff and updated on the day of surgery.</p> <p>Findings:</p> <p>1. at 1:00 PM on 7/2/13, review of the policy and procedure "History and Physical", policy number CH-02, with a signed date of 5/8/13, indicated:</p> <p>a. under "Procedure", it reads: "...The content of the H &amp; P will include but is not limited to the following information: Pertinent history and indications for the planned procedure; Significant medical and surgical history; Allergies; Current medications; Assessment of the patient's current condition including vital signs; Cardiac and respiratory status and relevant lab work or other diagnostic test results. History and Physicals will be valid for 30 days. An H &amp; P completed greater than 30 days prior to an admission does not meet the requirement for a current H &amp; P and cannot be updated. A new H &amp; P is required. History and physical examinations, such as those performed</p>		<p>Compliance with this requirement to be monitored by Nurse Manager and notify Administrator of non-compliance. Findings: 1. All policies are incorporated into the Rules and Regulations of the Medical Staff including CH-02. 2. The Rules and Regulations incorporate the policies including Policy CH-02; 3. Physicians are being notified to comply with all requirements for admission and H&amp;P documentation. The Medical Director is responsible for monitoring adherence by the medical staff. 4. Physicians are being notified to comply with all requirements for admission and H&amp;P documentation. The Medical Director is responsible for monitoring adherence by the medical staff. 5. The Rules and Regulations are incorporating the policies of the Facility. 6. The Rules and Regulations which are authorized by the medical staff bylaws are being amended to require compliance with the requirements for H&amp;P and documentation of such.</p>				

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	<p>in the office of a member of the Medical Staff within 30 days prior to the patient's admission, is acceptable in a format approved by the Surgery Center. An H &amp; P Update/Review form is a document entered into the medical record...and signed prior to the procedure..."</p> <p>2. at 12:15 PM on 7/2/13, review of the medical staff rules and regulations, last signed 7/27/10, indicated:</p> <p>a. the document lacked specifics related to history and physical exams from the practitioner's office and the form for accepting an H &amp; P written within 30 days of the procedure (only the immediate pre operative evaluation is noted in this document in Section 6. "Admitting", item c.)</p> <p>3. review of patient medical records indicated:</p> <p>a. pt. #5:</p> <p>A. had a second surgery on 7/20/12 (after a first surgery on 7/13/12)</p> <p>B. had a history and physical dated 6/14/12 that was beyond the 30 days prior to the surgery of 7/20/12</p> <p>C. had an office note of 7/19/12 that lacked all of the components required by the History &amp; Physical policy (listed in 1. above) to be used for the H &amp; P prior to the 7/20/12 surgery</p>				

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	<p>b. pt. #8:</p> <p>A. had an office visit note on 12/20/12 that qualifies as an H &amp; P</p> <p>B. lacked an "update" to the 12/20/12 office note on the day of surgery, 12/21/12, as required by policy</p> <p>c. pt. #13:</p> <p>A. had surgery on 6/25/13 and had a dictated H &amp; P dated 6/26/13</p> <p>4. interview with staff member #50, the operating room nurse manager, and #51, the infection preventionist/quality nurse, at 3:45 PM on 7/2/13, indicated:</p> <p>a. the office note of 7/19/12 for pt. #5 does not comply with the requirements of the History and Physical policy and the 6/14/12 H &amp; P was outside the 30 day requirement</p> <p>b. the physician failed to check the appropriate form to "update" the 12/20/12 H &amp; P for the 12/21/12 surgery for pt. #8</p> <p>c. the medical staff rules and regulations do not address the history and physical requirements for physicians, only the history and physical policy is specific to this</p> <p>5. The Medical Staff Bylaws, Rules and Regulations (approved 7-30-12) failed to indicate that a medical H&amp;P exam performed prior to the date of surgery shall be performed within 30 days of the</p>				

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S000888	<p>surgical procedure with an update on the day of admission and failed to indicate that a policy/procedure History and Physical (approved 5-13) or other center policy/procedures were incorporated by the medical staff rules and regulations.</p> <p>6. During an interview on 7-03-13 at 0910 hours, the chief financial officer A7 confirmed that the medical staff bylaws, rules and regulations lacked the indicated provisions.</p> <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 staff rules and regulations</p>	S000888	Policy AM-03 is being amended to be consistent with the Rules and Regulations regarding	07/31/2013

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	<p>review, patient medical record review, and staff interview, the medical staff failed to ensure that operative reports were written or dictated immediately following the operative procedure for 5 of 24 medical records. (pts. #10, 18, 20, 22, and 23)</p> <p>Findings:</p> <p>1. at 4:20 PM on 7/2/13, review of the policy and procedure "Medical Records and Documentation", with a policy number of AM-03, and a signed date of 5/8/13, indicated:</p> <p>a. on page two, under "Procedure", it reads in section G.: "Operative Diagnosis and Reports - Preoperative and postoperative diagnoses shall be written on attendance procedure records and dictated by the operating surgeon. Operative reports shall include a detailed account of the findings at surgery for patients, as well as the details of the surgical technique. Operative reports shall be written (or dictated) within 24 hours following surgery..."</p> <p>2. at 12:15 PM on 7/2/13, review of the medical staff rules and regulations, last signed 7/27/10, indicated:</p> <p>a. in section 6., "Admitting", it reads in item c.: "...A standard operative note by the operating physician (or his assistant) is to be written or dictated</p>		<p>completion of operative reports immediately after the operative procedure. The Biller/Coder is required to monitor compliance with this requirement and notify the Business Manager of non-compliance. Findings: 1. Policy AM-03 is being amended to reflect the same requirement as the Rules and Regulations (i.e. immediately after). 2. The Rules and Regulations requirements have been expressed to the physician staff. 3. The physicians have been notified of the policy requirements and will be monitored by Surgical Scheduler and Business Manager. 4. Policy AM-03 is being amended to be consistent with the Rules and Regulations. The requirement is being monitored by Surgical Scheduler and Business Manager. The failure to comply will be reported to the administrator.5. The physicians have been notified that they must comply with the requirement for Post-Operative Progress Notes</p>				

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	<p>immediately after the procedure..."</p> <p>3. review of patient medical records indicated:</p> <p>a. pt. #10 had a dictated operative note dated 8/11/12, when the surgery was 8/10/12 (there was also no one page hand written operative note)</p> <p>b. pt. #18 had no dictated operative note, and no hand written operative note, for surgery on 6/21/13</p> <p>c. pt. #20 had surgery on 6/25/13 and lacked both a hand written operative note and a dictated note</p> <p>d. pts. #22 and #23 had surgery on 6/26/13 and lacked both a hand written operative note and a dictated note</p> <p>4. interview with staff member #51, the quality nurse, at 10:40 AM on 7/3/13, indicated:</p> <p>a. after the accreditation survey of 12/12, the facility began utilizing a form titled "Post-Operative Progress Note" that physicians complete by hand on the day of surgery--this form has all of the required components of an operative note</p> <p>b. there is a discrepancy between the medical staff rules and regulations which indicate the operative note must be completed immediately after a surgical procedure, and the policy which gives the physician 24 hours to complete</p>						

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S001146	<p>this</p> <p>c. patients #18, 20, 22, and 23 are lacking the "Post-Operative Progress Note" that physicians are to complete by hand on the day of surgery</p> <p>d. after calling the contracted transcriptionist, it was determined that there has been no dictation submitted for the operative notes for patients #18, 20, 22 or 23</p> <p>5. at 12:45 PM on 7/3/13, interview with staff member #54, the administrator on call and the chief financial officer, indicated the physician for patients #22 and #23 had dictated their operative notes, but not on the day of surgery, or within the 24 hour requirement in the facility policy</p> <p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review and</p>	S001146	The air handling and ventilation	07/08/2013			

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	<p>interview, the center failed ensure its air handling equipment was serviced and maintained to ensure proper operating room (OR) ventilation for 1 (room 3) of 5 OR rooms in use at the center.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The American Institute of Architects (2001edition) Guidelines for Design and Construction of Hospital and Health Care Facilities indicated the following: " Table 7.2 Operating Room (OR) Minimum total air exchanges per hour : 15. "</li> <li>2. The policy/procedure Infection Prevention and Control indicated the following: " Ventilation and Environmental Conditions ...ensure that appropriate ventilation controls are in place in the ORs to achieve optimal ventilation conditions ...minimum of 15 air exchanges per hour ... "</li> <li>3. Center documentation dated 12-10-12 indicated 14.5 air exchanges per hour for OR 3 and indicated that the AIA Minimum Total Air Exchange per hour for room [OR 3] was 15.</li> <li>4. On 7-02-13 at 1320 hours, staff A2 was requested to provide documentation of a corrective action in response to the identified deficiency and none was provided prior to exit.</li> <li>5. During an interview on 7-02-13 at 1335 hours, staff A8 confirmed that no documentation of a corrective action</li> </ol>		<p>issue was corrected. The OR Nurse Manager and QIC monitors the condition of the Facility on a monthly basis using the Environmental/Safety Rounds worksheet checklist worksheet has been amended to include "The Ceiling". (See Attached). The OR Manager notifies the Materials Manager as items are identified for correction. Findings 1-5: See above.</p>				

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S001172	<p>was available.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)</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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: Based on document review, observation and interview, the center failed to assure the operating room (OR) ceilings were free of dust and particulate matter and failed to assure OR ceiling surfaces did not have gaps open to the area above for 1 (room 4) of 5 OR rooms in use at the center.</p> <p>Findings:</p> <p>1. The policy/procedure Housekeeping / Sanitation (approved 5-13) indicated the following: " Air vents in OR rooms need to be checked monthly for possible vacuuming ...monthly cleaning in OR rooms include: walls, ceiling ... "</p>	S001172	The gaps and dust have been corrected. The OR Nurse Manager checks these items monthly and will notify the Materials Manager as items are needed for correction. An Environmental/Safety rounds worksheet is attached, which has been amdnded to include the OR Ceiling.Findings 1-3: See above.	07/08/2013			

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S001180	<p>2. During an observation on 7-01-13 at 1410 hours, the following condition was observed in OR room 4: three (3) 3/16 inch by 24 inch gaps in the OR ceiling between the ends of the flush-mount 24 inch by 48 inch ceiling light fixtures and the metal grid supporting the light fixtures. A heavy accumulation of dark dust and particulate material was observed in the gaps between the light fixtures and the supporting grid.</p> <p>3. During an interview on 7-01-13 at 1410 hours, staff A2 confirmed the OR room 4 observation of ceiling gaps and accumulated dust.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on document review and interview, the center lacked documentation of an organized safety management program that included a review of safety functions by a</p>	S001180	IDR410 IAC 15-2.5-7(c)(1)The Facility conducts its safety function through the MQIC which meets the requirements of a safety committee. The QI program addresses all aspects of	07/30/2013

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	<p>committee appointed by the chief executive officer and included representatives from administration and patient care services.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 7-01-13 at 1130 hours, staff A2 and A3 were requested to provide documentation of a safety management program including committee responsibilities, membership and meeting minutes and none was provided prior to exit.</li> <li>The policy/procedures Safety Surveillance policy (approved 4-12), Quality Improvement Overview (approved 4-12), Quality Improvement Program (approved 4-12), Quality Improvement Activities (approved 5-13) and Medical Quality Improvement Committee Standards (approved 5-13) failed to indicate or incorporate the scope of safety program functions, committee membership or meeting requirements.</li> <li>During an interview on 7-03-13 at 0945 hours, staff A2 and A3 indicated that the safety committee functions were conducted during the MQIC meetings and confirmed that the QI and safety surveillance policy/procedures failed to</li> </ol>		<p>the safety function and is addressed by the MQIC at its meetings. A copy of the materials have been attached as Exhibit B. The Facility requests that the tag be deleted. POC Policy for Quality Improvement Program has been amended to state that the QI program functions will be performed through the Medical Quality Improvement Committee and require the attendance of the safety officer at the meetings. The Medical Quality Improvement Standards has been amended to include safety program. The Medical Director as Chair of the MQIC will be responsible for ensuring that all items required to be addressed at the meeting will be addressed and included in the minutes. A template agenda has been established which includes the safety program. Findings: 1. The MQIC will include safety program review and the Quality Improvement Program has been amended to include that function. 2. The MQIC will perform the function of the safety committee and the policies have been amended to address that function. 3. The MQIC will perform the function of the safety committee and the policies have been amended to address that function. 4. An agenda template has been established for MQIC meetings which includes the safety program. 5. An agenda template has been established for MQIC meetings which includes</p>		

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S001182	<p>indicate the safety program scope and committee requirements.</p> <p>4. The MQIC meeting minutes dated 1-14-13 and 4-08-13 failed to indicate a section heading for the safety program to document committee activity with participation of committee members during the MQIC meeting.</p> <p>5. During an interview on 7-03-13 at 0955 hours, staff A2 confirmed that the MQIC minutes lacked documentation of safety committee activity or an organized safety management program.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based upon document review and interview, the center failed to document an organized, center-wide program which collected and evaluated information about hazards and safety practices.</p>	S001182	<p>the safety program.</p> <p>IDR410 IAC 15-2.5-7(c)(2)The cited Rule requires only that the Facility have a process that evaluates hazards and safety practices to be reveiwed by the committee. The surveyor was provided with the evaluation tool used by the Facility to monitor and identify hazards and safety</p>	07/31/2013			

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>On 7-01-13 at 1130 hours, staff A2 and A3 were requested to provide documentation of a safety management program including committee responsibilities, membership and meeting minutes and none was provided prior to exit.</li> <li>Review of the MQIC meeting minutes for 2012 and 2013 failed to indicate a report by the Safety Committee for 4 of 4 meetings and failed to document any safety committee participation including discussion and recommendations (if indicated) regarding review of Incident Reports (Quality Monitor Reports), periodic center safety inspections or quarterly fire drills for 4 of 4 meetings.</li> <li>During an interview on 7-03-13 at 0955 hours, staff A2 confirmed that the MQIC minutes lacked documentation of safety committee activity and lacked documentation indicating an organized process to evaluate and review hazards and safety practices by a safety committee.</li> </ol>		<p>practices and those items are provided to the MQIC which covers the safety program. The minutes of the MQIC and the report attached to them show that the hazards and safety issues were addressed. They are attached as Exhibit B hereto. The Facility requests that the tag be deleted. POCThe safety program is addressed by the MQIC as part of its meetings. The policies will be amended to reflect that the safety program is addressed by the MQIC and the minutes will reflect that function including the safety committee participation. A template agenda has been adopted and includes all items to be addressed in the minuets including the safety program. The template will ensure that the safety program is addressed in the future as a specific item. Findings 1-3: See above</p>				