

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001077	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/04/2012
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NAME OF PROVIDER OR SUPPLIER  RIVER VIEW SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 330 N WABASH AVE STE 200 MARION, IN 46952
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 010383</p> <p>Survey Date: 1/3/2012 through 1/4/2012</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: 02/14/12</p>	S0000		

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

TITLE

(X6) DATE

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

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S0110	<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 staff interview, the facility failed to incorporate the functions of a Medical Records Committee, Tissue Committee, Infection Control Committee, surgical review committee, pharmacy and therapeutics committees, patient care evaluation committee, and Safety Committee in the Medical Quality Improvement Committee (MQIC).</p> <p>Findings included:</p> <p>1. Medical Staff By-laws Article X Section 3-C-7 states, "The MQIC shall also incorporate the functions of a Medical Records Committee, Tissue Committee, Infection Control Committee, surgical review committee, pharmacy and therapeutics committees, patient care evaluation committee, and Safety</p>	S0110	<p>January 16, 2012 Instituted a new form to incorporate the functions of Medical Records Committee, Tissue Committee, Infection Control Committee, Surgical Review Committee, Pharmacy and Therapeutics Committees, Patient Care Evaluation Committee, and Safety Committee. Topics discussed; results attained and recommendations will be reviewed and discussed in quarterly Medical Quality Improvement Committee of April 12, 2012. Minutes of quarterly medical Quality Improvement Committee will be reviewed in Board of Managers quarterly meeting of April 24, 2012. Responsible person Clinical Coordinator and Business Office Manager</p>	02/03/2012			

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	<p>Committee. These functions shall include, but not limited to: meet not less than once per quarter and maintain a permanent written record of its proceedings and actions."</p> <p>2. Review of the MQIC committee meetings held in 2011 indicated the 9 committees identified in the Medical Staff By-law were not incorporated into the MQIC quarterly meetings.</p> <p>3. At 3:05 PM on 1/3/2012, staff member #1 confirmed the MQIC minutes held in 2011 did not identify the required meetings as defined in the Medical Staff By-laws.</p>				

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S0144	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c) (2)</p> <p>(c) The governing body shall do the following:</p> <p>(2) Delineate in writing the responsibility and authority of the chief executive officer.</p> <p>Based on document review and staff interview, the facility failed to ensure a CEO/Executive Director was appointed by the Governing Board.</p> <p>Findings included:</p> <p>1. Board of Managers Meeting Minutes dates February 1, 2010 states, "(Medical Director) opened the meeting with how to proceed hiring someone for the Executive Director position. Resumes were reviewed by some board members. (Board member) suggested hiring a consultant for a period of time since the current issue of a possible merger has not been finalized and pending due diligence. A suggestion was made to maybe consider hiring someone on a part-time basis. (Medical Director) asked (Clinical Coordinator &amp; Business Office Manager) what each of their responsibilities are and (Clinical Coordinator) said he/she handled all clinical issues and (Business Office Manager) said he/she handles the</p>	S0144	<p>January 5, 2012 Revised job description of Medical - Executive Director and combined the responsibilities. January 5, 2012 added review of revised job description to Board of Managers Agenda to be presented; reviewed and approved in meeting of January 10, 2012.. January 10, 2012. Revised Medical-Executive Director job description and revised Organization chart approved in Board of Managers meeting. February 20, 2012 organizational chart revised to show Medical/Executive Director will be same person with daily operations handled by Clinical Coordinator and Business Office Manager. Responsible person Clinical Coordinator and Business Office Manager</p>	02/03/2012			

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	<p>business side.(Clinical Coordinator) said he/she would need the Medical Director's assistance on certain issues."</p> <p>2. At 2:46 PM on 1/3/12, staff member #3 indicated the administrator quit a couple of years ago and the Governing Board decided not to rehire that person; however, the minutes of the meeting held in February 2010 reflects the facility kept taking resumes and failed to vote or mention directly in the meeting that the ASC was not going to rehire the Executive Director. The staff member indicated the Clinical Coordinator, Business Office Manager, and the Medical Director have split the responsibilities of the CEO/Executive Director.</p> <p>3. At 12:15 PM on 1/4/2012, staff member #1 indicated the facility does not have an Executive Director and the Medical Director has been answering any concerns the Clinical Coordinator and the Business Office Manager could not handle. The reason the looking for a new CEO/Executive Director has been terminated was due to the possible merger with Marion General Hospital.</p> <p>4. After reviewing the Governing Board minutes and interviewing the staff, the ASC does not have in writing a</p>						

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	<p>CEO/Executive Director to oversee the operation of the ASC for the Governing Board since February 2010.</p> <p>5. River View Surgery Center Organizational Chart was arranged as follows: Shareholders on top followed by Board of Manager. Then the two positions are listed under the Board of Managers; Executive Director and the Medical Director. The positions listed under the Executive Director are: Clinical Coordinator; OR, ENDO; PACU/Adm. The positions listed under the Medical Director were the Business Office Manager and Clerks. The Job Summary for the Executive Director states, "Provides leadership, guidance and administration of all center activities to assure accomplishment of goals and objectives." Since February 2010, the ASC has not hired or currently in the process of filling the position of the CEO/Executive Director.</p>				

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S0162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on documentation review and staff interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence was current as defined by the center's policies and procedures for 9 of 13 credentialed medical staff members (#7, 10, 11, 12, 13, 14, 15, 18, and 19).</p> <p>Findings included:</p> <p>1. Policy CPR for Medical Staff Physicians Article II section A states, "All current physicians with privileges are encouraged to maintain ongoing CPR competency." Article II section 3 A states, "A copy of the card (front and back) will be made and placed in their file. The card will be accepted as evidence of competency for CPR."</p>	S0162	<p>February 22, 2012 Contacted Nurse Practitioner to confirm she had CPR certification or not. February 22, 2012 One Surgical Technician without current CPR certification is current and copy of her certification obtained and placed in file. February 22, 2012 Second Surgical Technician scheduled for CPR class once completed copy of certification to be sent to Center for allied Staff file. February 24, 2012 follow up phone call to Nurse Practitioner. She is to be scheduled for CPR class and upon completion copy of certification to be sent to Center for Allied Staff file. March 1, 2012 Nurse Practitioner and second Surgical Technician to provide certification by April 30, 2012 to be in compliance of the Allied Medical Staff. Responsible person Business Office Manager February 24, 2012 Reviewed Article II with</p>	02/03/2012			

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	<p>2. Six of 8 physician credential files were reviewed. Physician staff members #7, 11, and #14 files did not have copies of their CPR competency attached, even though the staff member's signed Request For Privileges forms notes a photo copy of CPR was provided.</p> <p>3. Credentialed staff member #10 signed Request for Privileges documentation noted the staff member signed the documentation stating his/her CPR competency was not current.</p> <p>4. Credentialed staff member's file #12 and #13 were reviewed. Staff member #13 ACLS certification copy noted it expired 9/2011. Staff member #13 CPR certification copy noted it expired 9/2009.</p> <p>5. CPR for Direct Patient Care Providers Article II section A states, "All current employees with patient care responsibilities are required to maintain ongoing CPR competency." Article II section 3 A states, "A copy of the card (front and back) will be made and placed in their employee file. This card will be accepted as evidence of competency for CPR."</p> <p>6. Three of 5 Allied Health professionals did not have a copy of their CPR competency attached to their credentialed</p>		<p>Clinical Coordinator and Medical Director regarding CPR competency. February 24, 2012 All current physicians with privileges will be encouraged to maintain ongoing CPR competency. Proof of CPR competency was removed from the Request for Privileges form. Responsible persons Business Office Manager and Clinical Coordinator</p>				

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	<p>files: #15 (Nurse Practitioner); #18 and #19 (Surgical Technicians).</p> <p>7. The Surgical Technicians job descriptions state, "He/she will maintain CPR certification."</p> <p>8. At 3:25 PM on 1/4/2012, staff member #3 indicated he/she could not locate the CPR certifications; therefore, the staff member could not provide evidence of CPR competency for 9 of the 13 credentialed staff members.</p>				

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S0166	<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 policy and procedure review and interview, the facility failed to ensure there were written, approved policies and procedures for the out-of-lab testing conducted at the center.</p> <p>Findings included:</p> <p>1. Review of the Policy and Procedure binders provided on 01/13/12 by staff member #1 failed to indicate any policies or procedures for out-of-lab testing by staff in the facility.</p> <p>2. At 4:50 PM on 01/04/12, staff member #1 indicated urine pregnancy testing and blood sugar testing using a glucometer were performed by staff on patients of the center. He/she indicated there were no written policies or procedures for these tests, but staff followed manufacturer's instructions. He/she also indicated some changes in the record keeping of the urine</p>	S0166	<p>The annual policy and procedure review and prn updates that have been done will include two additional reviews/updates current policy to be in compliance. The annual policy and procedure review with prn updates was completed January 2012. Second review to be completed April 2012. Third review to be completed August 2012. Responsible person Clinical Supervision Instituted a new policy. The absence of hCG urine pregnancy testing policy and procedure has been corrected as of January 9, 2012. Responsible person Clinical Supervision Instituted policy placed in facility policy and procedure manual January 9, 2012 Revised policy and procedure Blook Glucose Monitor Quality Control Check Guideline and Blood Glucose Monitoring and Infection Control. Revised policy placed in policy and procedure manual January 11, 2012. Responsible person</p>	02/03/2012			

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	pregnancy testing were discussed in staff meetings in May and November of 2011, but no specific policy or procedure was in effect.		Clinical Supervision		

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S0310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure 14 services provided by contractors and quality indicator for safety was evaluated as part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <p>1. The Quality Improvement Program last reviewed September 2011 states, "This interdisciplinary program will be organized and maintained by an active peer based committee which functions to evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, correct identified problems and evaluate the effectiveness of improvement strategies." The Quality Improvement Program has attachments including the indicators the Center will evaluate. The ASC Quality Indicator</p>	S0310	<p>February 27, 2012 Safety training meeting held with management staff and Safety Officer Consultant for initial training. March 27, 2012 - next safety training meeting scheduled with Safety Officer Consultant to review fire safety and emergency management. In April 2012 meeting to be scheduled with Safety Officer Consultant to review Safety inspection of environment using the safety inspection tool; May 2012 next meeting to be scheduled with Safety Officer Consultant to develop a Safety Performance Dashboard; update monthly. June 2012 next meeting to be scheduled with Safety Officer Consultant to develop a Chemical Listing and ensure an MSDS for all chemicals. On going safety training will continue through December 31, 2012 to complete safety training.before scheduling periodic instruction in the proper use of safety, emergency, and fire-extinguishing equipment to staff. Quarterly review of the</p>	02/03/2012			

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	<p>Report Form 2011 list the following indicators to be reviewed in the MQIC: Patient Falls in the ASC; Patient Burn; Hospital Transfer/Admission; Wrong Site,Side, Patient, Procedure, Implant; Prophylactic IV Antibiotic Timing; and Appropriate Surgical Site Hair Removal.</p> <p>2. Medical Staff By-laws Article X Section 3 subsection e states, "The MQIC shall also incorporate the functions of a Safety Committee. These functions shall include, but not limited to: 1. Assuring that the Center has the necessary personnel, equipment, and procedures to handle medical and other emergencies that may arise in connection with the services sought or provided, 2. Providing periodic instruction to all personnel in the proper use of safety, emergency, and fire-extinguishing equipment;..." This section shall evaluate at least 16 functions of safety committee in the MIQC. The MQIC 4 meetings held in 2011 only evaluated the quality control indicators as listed on the ASC Quality Indicator Report Form 2011.</p> <p>3. Review of the Medical Quality Improvement Committee (MQIC) minutes for 2011 the following contracted services were not evaluated by the MQIC committee: Hazardous Waste, Respiratory Therapy, Sterization, EKG, Radiology,</p>		<p>Safety Committee meetings will be presented and reviewed in the quarterly MQIC meetings. The first Safety Committee minutes of February 27, 2012 will be evaluated in the April 12, 2012 quarterly Medical Quality Improvement Committee meetings. Responsible person Clinical Coordinator February 27, 2012 Instituted new form listing all contracted services April 12, 2012 Listing of contracted services will be included in the quarterly Medical Quality Improvement Committee meetings on a quarterly basis for evaluation. Responsible person Clinical Coordinator</p>				

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	<p>Laboratory, Pathology, Blood Bank, Pharmacy, Bio-medical Maintenance, General Maintenance, Laundry/Linen, Endoscopic, and Housekeeping. The quality indicator Safety was not evaluated in the 4 MQIC committees that were held in 2011 as stated in the Medical Staff By-laws.</p> <p>4. At 12:30 PM on 1/4/2012, staff members #1 and #2 indicated that they did not realize that contracted services provided to the ASC shall be evaluated by the MQIC. Staff member #1 confirmed that all contracted services provided to the ASC are not evaluated in the MQIC.</p>				

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S0420	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(B)</p> <p>The infection control committee responsibilities must include, but are not limited to, the following:</p> <p>(B) Recommending corrective action plans, reviewing outcomes, and assuring resolution of identified problems.</p> <p>Based on facility document review, meeting minutes, and interview, the facility failed to ensure the Infection Control Committee functioned according to the bylaws.</p> <p>Findings included:</p> <p>1. Review of the facility's medical bylaws, originally approved on November 12, 1997, indicated under "Article X. Medical Staff Committees, ...Section 3. Medical Quality Improvement Committee, a. The Medical Quality Improvement Committee (MQIC) shall consist of the following: (1) Medical Director as Chairman, (2) Executive Director, (3) Clinical Coordinator, and three (3) Physicians. ...c. The MQIC shall also incorporate the functions of a medical records committee, tissue committee, surgical review committee, pharmacy and therapeutics committee, infection control committee, and patient</p>	S0420	February 22, 2012 Instituted a new form to incorporate the function of Infection Control Committee. April 12, 2012 New form will be reported in quarterly Medical Quality Improvement Committee to evaluate the topic discussed; retained results; and recommendations. Responsible Person Clinical Coordinator	02/03/2012			

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	<p>care evaluation committee. These functions shall include, but not be limited to:</p> <p>...2. Surveillance of inadvertent Center infection potential, review and analysis of actual infections, promotion of a prevention and correction program designed to minimize infection, and supervision of infection control in all phases of the Center activities, including: pre-operative and post-operative areas, operating rooms, etc. isolation procedures, prevention of cross infection by anesthesia apparatus, testing of Center personnel for carrier status as needed, disposal of infectious material, and other situations as requested."</p> <p>2. Review of the Medical Quality Improvement Committee Meeting Minutes from Tuesday, January 18, 2011 indicated the only reference to infection control was under Quality Improvement Activity, "...c. Complications/Infections: [Staff member #1] stated that there have been 5 post-op infections reported through November for 2010. Follow-up on the reported infections show that the infections were resolved after treatment and antibiotics."</p> <p>3. Review of the Medical Quality Improvement Committee Meeting</p>						

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	<p>Minutes from Tuesday, April 5, 2011 indicated the only reference to infection control was under Quality Improvement Activity, "...c. Complications/Infections: [Staff member #7] stated that there have been no post-op infections or complications reported for January and February." Also included under Quality Improvements was, "i. Quality Monitoring and Infection Control Surveillance- Cleanliness of OR Rooms- results show 98%. This is an improvement over previous QI of September 2010.</p> <p>4. Review of the Medical Quality Improvement Committee Meeting Minutes from Tuesday, July 12, 2011 indicated the only reference to infection control was under Quality Improvement Activity, "...c. Complications/Infections: [Staff member #7] reported that there was one post-op infection in March for an Excision Sebaceous Cyst on Back which was resolved with I&amp;D. Two complications were reported: in April a Closure Left Oral Antral Communication patient was transferred with a post-op bleed (resolved after return to surgery); and a Right Carpal Tunnel with mild dehiscence (resolved)."</p> <p>5. Review of the Medical Quality Improvement Committee Meeting</p>			

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	<p>Minutes from Tuesday, October 11, 2011 indicated the only reference to infection control was under Quality Improvement Activity, "...c. Complications/Infections: [Staff member #7] reported that: May- 0 infections and 1 complication, June- 0 infections and 1 complication, July- 2 infections and 1 complication, and August- 0 infections and 1 complication. All infections and complications were resolved." Also reported under "e. Quality Improvements: i. Quality Monitoring and Infection Control Surveillance- Ancillary Cleaning Service Compliance Rounds- proper cleaning of environment and handling of waste."</p> <p>6. Review of the Medical Quality Improvement Committee Meeting Minutes from Tuesday, December 13, 2011 indicated the only reference to infection control was under Quality Improvement Activity, "...c. Complications/Infections: [Staff member #7] reported that: September- 0 infections and complications, October- 1 infections (Carpal Tunnel which required a return to OR after 1 week) and 1 complication (Excision of an Olecranon Bursa with a stitch abscess which was resolved after suture piece was removed." Also reported under "e. Quality Improvements: i. Quality Monitoring and Infection Control Surveillance- Flash Sterilization-</p>			

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	<p>logs maintained appropriately 100%."</p> <p>7. At 4:30 PM on 01/04/12, staff member #1, the person designated as the Infection Control person, indicated the MEC also functioned as the Infection Control Committee. He/she indicated the various items were discussed at staff meetings, but confirmed the attendance at those meetings did not meet the criteria for attendance at an Infection Control Committee. He/she confirmed the infection control items listed in the MQIC meeting minutes were more of a report under QI rather than an activity of an infection control committee.</p>				

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S0526	<p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on review of employee files, facility document review, and interview, the facility failed to ensure 4 of 4 nurses (#20, 21, 22, and 23) who performed out-of-lab testing on patients of the center, had training and annual competency for the testing.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of the training records for nurses #20, 21, 22, and 23 failed to indicated any training or annual competency for performing out-of-lab testing.</li> <li>2. Review of the minutes from the Clinical Staff Meeting for May 2011 indicated, "...7. Urine hcg Test Log Book- New log book will be kept in the PACU dirty utility. Place patient label in log book for each test completed with results and also document on the attached label on the Pre-Admission form on the patient chart. When forms are reprinted, this notation will be added."</li> </ol>	S0526	<p>Instituted new policy Glucometer/Patient Glucose Annual Training, Assessment, and Competency Record January 9, 2012 Revised Education Program policy and procedure January 9, 2012 for hCG urine testing and blood glucose monitoring, employees will receive Annual Training and Competency evaluations with documentation placed in personnel files. February 22 and 23, 2012 Competency evaluations for hCG urine testing and blood sugar monitoring were conducted. The Training &amp; Competency evaluations have been placed in personnel files. Responsible Person Clinical Supervision</p>	02/03/2012			

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	<p>3. Review of the minutes from the Clinical Staff Meeting for November 2011 indicated, "...6. Add lot # and expiration date to hCG urine test log for each patient, Addresses quality monitoring (not using expired product), Have lot # recorded in case there is a recall/manufacture defect, See new form to facilitate this."</p> <p>4. At 4:50 PM on 01/04/12, staff member #1 indicated urine pregnancy testing and blood sugar testing using a glucometer were performed by nurses on patients of the center. He/she indicated there were no written policies or procedures for these tests, but staff followed manufacturer's instructions. He/she also indicated some changes in the record keeping of the urine pregnancy testing were discussed in staff meetings in May and November of 2011, but no specific policy or procedure was in effect. He/she indicated no annual competency was demonstrated by staff.</p>				

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S0676	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or legally reproduced medical records must be maintained by the center for a period of seven (7) years in accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure.</p> <p>Based on staff interview, the facility failed to provide a waiver for storing medical records offsite.</p> <p>Findings included:</p> <p>1. At 11:30 AM on 1/4/2012, staff member #3 indicated in '330 Building' on the 4th floor, the Center stores medical records in a storage room. The staff member indicated the storage room was not part of the ASC but was owned by Marion General Hospital. The staff member indicated at the end of each physical year, medical records would be placed in the storage room on the 4th floor. The Center only maintains medical records for the current year onsite. The staff member indicated the ASC does not have a waiver for storing medical records offsite.</p>	S0676	<p>February 22, 2012 Allied Health worker privileged to prescribe medication DEA obtained and place in file. Responsible person Business Office Manager February 23, 2012 Letter requesting Departmental Waiver sent to ISHD. Responsible person Business Office Manager</p>	02/03/2012	

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S0710	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p>				

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	<p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on document review and staff interview, the facility failed to ensure a credentialed allied Health worker who was privileged by the medical staff to prescribe medication has a DEA for 1 of 1 Nurse Practitioner (#15).</p> <p>Findings included:</p> <p>1. Medical Staff By-laws Article II Section 2 subsection A 1 states, "The applicant shall perform all of the obligations of a member of the Medical</p>	S0710	February 22, 2012 Nurse Practitioner credentialed to prescribe medication - current DEA obtained and placed in file. Responsible person Business Office Manager	02/03/2012			

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	<p>Staff and agree to be bound by the terms and conditions of the Bylaws and Rules and regulations." Article IV section B states, "The following documents are required for applications to be appointed to the medical staff; Copy of DEA and CSR certificates." Article V Section 3 states, "An AHP practicing at the Center shall be entitled to exercise only those clinical privileges specifically granted to him/her by the MEC."</p> <p>2. Allied Health Professional (AHP) Staff member #15 was credentialed by the medical staff and approved by the Governing Board on October 28, 2011. The AHP (Nurse Practitioner) privileges indicated the staff member was approved to prescribe medication. The staff member's file lacked a copy or any other evidence noting the staff member has a current DEA.</p> <p>3. At 3:00 PM on 1/4/2012, staff member #3 indicated he/she does not have documentation that staff member #15 has a DEA registration. The staff member confirmed that staff member #15 credentialed file does not have a copy of a DEA within the file.</p>				

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S1010	<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 policy regarding multi-dose vials in 3 different areas of the surgical department.</p> <p>Findings included:</p> <p>1. During the tour of the Recovery Room at 10:00 AM on 01/04/12, accompanied by staff member #1, the following observations were made in the medication cabinet:</p> <p>A. An open, 20 milliliter, multidose vial of Labetalol Hydrochloride with a written, opened date of 11/21/11. B. An open, but not dated, 20 milliliter, multidose vial of Ondansetron.</p> <p>2. During the tour of the Recovery Room at 10:00 AM on 01/04/12, accompanied</p>	S1010	<p>January 9 - 11, 2012 The Multiple-Dose Vial policy was reviewed per annual policy review with amendments made for clarity. New policy was distributed for employees to review as part of continuing education with signature documentation that they have reviewed the revised policy and procedure; and placed in the Conintuing Education/In-service Binder Vol. 1. The importance of following facility policy also stressed at January/February clinical meeting with staff. Handling of milti-dose vials was also added to the Education Program Policy as a required topic at the annual manadatory review. Handling Multi-dose Vial "Signage" was also placed throughout Center. Clinical Coordinator met with Director of Anesthesia and Marion General Hospital pharmacy representative for discussion/prevention of mishandling/improper dating of</p>	02/03/2012	

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	<p>by staff member #1, an open, 10 milliliter vial of Novolog Insulin was observed in the medication refrigerator. A written, opened date of 06/16/11 was observed on the vial.</p> <p>3. During the tour of the Operating Room (OR) medication room at 10:45 AM on 01/04/12, accompanied by staff member #1, an open, 20 milliliter, multidose vial of Labetalol Hydrochloride with a written, opened date of 11/13/11 was observed in the anesthesia box #3.</p> <p>4. During the case observation in the OR at 11:00 AM on 01/04/12, the following observations were made on the anesthesia cart:</p> <p>A. An open, 10 milliliter, multidose vial of Rocuronium with a written expiration date of 12/27/11.</p> <p>B. An open, but not dated, 10 milliliter, multidose vial of Neostigmine.</p> <p>5. The facility policy titled "Infection Control General Guidelines", last reviewed January 2011, indicated, "...IV. Sterile Supplies ...b. Multi-dose medication will be dated when opened. All opened medication will be discarded 28 days after opening or per product information."</p>		<p>medication vials. A bi-weekly schedule has also been developed for licensed staff to check and document that multi-dose medications are dated correctly with appropriate expiration date and that there are not any expired medications in stock. Medication inspection process began 2/27/2012. A training and competency has been developed to be included at the annual mandatory. Responsible person Clinical Supervision Deficiencies for failure to follow Multiple-Dose Vials policy corrected January 9-11, 2012 per policy revision and with posting of signange. Bi-weekly medication/expiration check list was implemented 2/27/12.</p>				

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	6. At 11:00 AM on 01/04/12, staff member #1 indicated all multidose vials should be dated when opened and discarded after 28 days and confirmed the findings.			

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S1162	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)</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>Based on observation, documentation review, and staff interview, the facility failed to maintain their required 12 month preventive maintenance on 133 pieces of patient care equipment.</p> <p>Findings included:</p> <p>1. At 9:45 AM on 1/4/2012, the Recovery Area was toured. A Lifepak 12 Defibrillator was observed with a required PM tag on it indicating the next due date for preventive maintenance (PM) was 2/11. Therefore the Lifepak 12 was late at least 10 months for it's manufacturer required 12 month preventive maintenance.</p> <p>2. At 10:15 AM on 1/4/.2012, the Pre-op</p>	S1162	<p>January 16, 2012 A service contract was negotiated with Crothall Facilities Management, Inc. to handle preventive maintenance on all Center owned bio-medical equipment. Preventive maintenance on all Center items will be completed by March 30, 2012. Responsible Person Clinical Coordinator</p>	02/03/2012			

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	<p>area was toured. The Noninvasive Blood Pressure Monitor &amp; Digital Pulse Oximeter was observed with a required PM tag on it indicating the next due date for preventive maintenance (PM) was 3/11. The facility's required 12 month preventive maintenance was late from being done at least 9 months.</p> <p>3. At 11:00 AM on 1/4/2012, the Operating Room was toured. The Bair Hugger Model 750 Temperature Management fluid warming unit was observed with a required PM tag on it indicating the next due date for preventive maintenance (PM) was 2/11. The facility's required 12 month preventive maintenance was late from being done at least 10 months.</p> <p>4. At 1:30 PM on 1/4/2012, staff member #1 indicated the Biomedical engineering was managed by Marion General Hospital. The staff member indicated he/she was informed that the hospital has not maintaining the required preventive maintenance on all the patient care equipment due to lack of the merger between Marion General Hospital and River View Surgery Center. The staff member indicated the hospital was behind on majority of the patient care equipment require 12 month preventive maintenance.</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>5. Marion General Hospital provided staff member #1 at 1:00 PM on 1/4/2012 River View Center Asset Inventory preventive maintenance schedule document. The document has every patient care equipment listed on it that River View Surgery center was utilizing. The log contains 162 patient care equipment that were required a 12 month preventive maintenance. The log identifies each piece of equipment with RVSC item number. This log also indicated which units have been discarded and no longer being used. The log contained 29 units that were no longer in use at the facility. However, the log provided during the survey from staff member #1 indicated there were 133 patient care equipment that are behind in their required 12 month preventive maintenance. The last PM completed dated on the 133 pieces of equipment ranged between 2/24/2010 to 5/7/2010. The pieces of equipment that are behind on their preventive maintenance included: electrosurgical units, ECG module, infusion pump, exam light, patient warmer, vacuum pump, anesthesia units, insufflator, etc.</p>						

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S1180	<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 documentation review and staff interview, the facility failed to ensure there was an Environmental of Care Committee as defined by the River View Surgery Center Emergency Management Program.</p> <p>Findings included:</p> <p>1. The Emergency Management Program Article V section A states, "The Board of Directors receives regular reports of the activities of the Emergency Management Program from the Environmental of Care Committee Chairmen. The Board reviews the reports and, as appropriate, communicates concerns about identified issues and regulatory compliance. The Board provides support to facilitate the ongoing activities of the Emergency Management Program."</p>	S1180	<p>2/22/2012 Developed the environment of Care/Quarterly Safety Inspection Checklist for the clinical staff meeting held with Dr. Keppler, Medical Director. 2/27/2012 Developed the environment of Care Committee/Safety Management Program for initial phase of education, competency and consideration of the 16 functions of the Safety Committee during meeting. members identified as Dixie, Rebecca, Robin, Dr. Keppler and D. Martin, Marion General Hospital Safety Officer Consultant. 2/27/2012 Safety officer Identified Dixie Dixon. 2/27/2012 The Environment of Care/Quarterly Safety Inspection Checklist to be used in conjunction with existing the Center daily Safety and Security Opening and Cloing Checklist. By March 30, 2012 Training and Competency of identified Safety Officer to be completed with compentency/evaluation to be</p>	02/03/2012	

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	<p>2. The Board of Managers Meeting Minutes were reviewed for 2011. The Board minutes did not evidence that the Environmental of Care Committee was reporting to the Board as detailed in the Emergency Management Plan.</p> <p>3. At 1:45 PM on 1/4/2012, staff member #1 indicated the surgery center does not have an Environmental of Care Committee. However, the staff member indicated the Register Nurses in the facility conduct an open and close walk through of the center. The documentation would be handed to staff member #1 and would never be reported to any other committee. The staff member confirmed there were no Environmental of Care committee minutes that could be provided for review as the Emergency Management Plan details.</p>		<p>placed in Safety Officer's personnel file. After Training and Competency completed as described above, the Environment of Care/Quarterly Safety Inspection Checklist to be done by identified Safety Officer. After the quarterly Environment of Care inspection by the identified Safety Officer, a Safety Committee Meeting to be held for discussion, resolution, recommendations, follow-up for any deficiencies that may have been found or concerns noted. Then the above documented information to be reported at quarterly Board of Managers/MQIC's meetings. Through the program development, committee members chosen and schedules developed, this facility will be in compliance and avoid this deficiency. The documentation process via use of spread sheets will assist in the closing of the communication loop, thus all persons will be informed of Environment of Care status/concerns. By March 30, 2012 the above mentioned steps will be completed. Responsible person Medical Director and Clinical Coordinator</p>		