

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001181	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/21/2015
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NAME OF PROVIDER OR SUPPLIER  COLUMBUS SPECIALTY SURGERY CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2425 NORTH PARK DRIVE SUITE 20 COLUMBUS, IN 47203
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S000000	This visit was for a State licensure survey.  Facility Number: 012820  Dates: 01-20-15 to 01-21-15  Surveyors: Trisha Goodwin, RN BS Public Health Nurse Surveyor  Jennifer Hembree, RN Public Health Nurse Surveyor  QA: cloughlin 02/11/15	S000000		
S000153	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)  Require that the chief executive officer develop and implement policies and programs for the following:  (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.  Based on document review and interview, the Chief Executive Officer (CEO) failed to ensure documentation of job specific orientation for 6 of 11 staff	S000153	Correction: Staff member's #S2, S3, S4, S5, S6, and N6 were given job specific orientation to Columbus Specialty Surgery Center on 1.30.2015. Their	01/30/2015

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>members (staff members #S2, S3, S4, S5, S6, and N6) and orientation to the center or personnel policies for 1 (S5) contracted employee.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Staff members #S2, S3, S4, S5, S6 and N6 personnel files lacked documentation of job specific orientation.</li> <li>Staff member #N3 (Clinical Administrator) verified the above beginning at 4:45 p.m. on 1/21/15. <b>3. On 1/20/15 at 4:00pm A1, Administrator, indicated employee S4 is the on-site medical records person and S5 is the contracted certified medical records consultant. A1 indicated qualifications of S5 are kept in the center, but no personnel file was maintained for the individual. A1 further indicated S5 was paid by the center and does perform duties within the center.</b></li> <li><b>4. Review of the medical records consultant contract lacked documentation of orientation to the center or personnel policies.</b></li> <li><b>5. On 1/21/15 at 5:30pm A1 confirmed orientation was not conducted for S5.</b></li> </ol>		<p>orientation documentation was signed and placed in their personnel file. Contracted Service Provider (S5) was given orientation to CSSC according to the CSSC policys and procedures for a contracted service provider on 2.4.2015.Prevention of Future deficiency: All employees and contracted service providers will be oriented appropriately and have their orientation documentation completed and placed in their personnel file according to CSSC policys and procedures. Responsible Party: Orientation of staff members and contracted service providers will be assigned to OR Charge Nurse; OR Staff, Pre/Post Op Charge Nurse, Pre/Post Op Staff, Business Office Manager, and Business Office Staff. The Business Office Manager will make sure all proper documentation is in their personnel files. The Administrator will verify all orientation has been completed and documentation is placed in their files.</p>		

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S000224	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(2)</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>(2) Ensure that the services performed under a contract are provided in a safe and effective manner and are included in the center's quality assessment and improvement program. Based on document review and interview, the governing body of the center failed to ensure 11 services performed under contract were included in the center's quality assessment and improvement program (QAPI).</p> <p>Findings:</p> <p>1. Review of governing body meeting minutes dated 12/4/13, 3/5/14, 6/25/14, &amp; 12/3/14 lacked documentation of QAPI reports for the following contracted services: Biomedical engineering, Bio hazardous waste, Transcription, Pharmacy, Linen service, Medical records, Laboratory Service, Radiology Services, Maintenance, Security, &amp;</p>	S000224	<p>Correction: A Quality Monitoring spreadsheet was developed to monitor and evaluate the safe and effective manner of contracted services including but not limited to; Biomedical engineering, Bio hazardous waste, Transcription, Pharmacy, Linen service, Medical records, Laboratory Service, Radiology Services, Maintenance, Security, &amp; Tissue transplant for CSSC. This monitoring spreadsheet will be completed on a quarterly basis and will be included and reviewed at all QAPI mtgs. and reviewed by the Board of Managers. Prevention of Future deficiency: To ensure the contracted services are provided in a safe and effective manner, the Quality Monitoring</p>	01/26/2015			

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S000228	<p>Tissue transplant.</p> <p>2. Review of QAPI committee meeting minutes dated 1/17/14, 4/18/14, 6/3/14, &amp; 12/3/14 lacked documentation of the following contracted services being included: Biomedical engineering, Bio hazardous waste, Transcription, Pharmacy, Linen service, Medical records, Laboratory Service, Radiology Services, Maintenance, Security, &amp; Tissue transplant.</p> <p>3. On 1/20/15 at 2:30pm A2, Performance Improvement Coordinator, confirmed QAPI program had not implemented monitoring/inclusion of the above services and functions.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one</p>		<p>spreadsheet will be completed quarterly and reviewed at the QAPI quarterly mtgs. and reviewed by the Board of Managers according to the CSSC polycys and procedures. Evidence of this will be placed in mtg. minutes. Responsible Party: The Risk Manager will complete the Quality Monitoring spreadsheet quarterly and review it at the QAPI mtgs. The Administrator will then review this spreadsheet and communicate/review with the Board of Mangers.</p>		

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	<p>(1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing body failed to ensure all physicians performing surgery maintained admitting privileges at one or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located for MD#1, MD#2, MD#3, &amp; MD#4</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of medical staff credential files for MD#1, MD#2, MD#3 &amp; MD#4 indicated each performed surgery in the center. Each lacked documentation of having admitting privileges to a hospital in the same or contiguous county.</li> <li>On 1/21/15 at 4:00pm, A1, Administrator, confirmed the above and no further documentation was provided prior to exit.</li> </ol>	S000228	<p>Correction: Verification of hospital privileges documentation was placed in Medical staff members MD#1, MD#2, MD#3, AND MD#4 credentialing files on 1.22.15.</p> <p>Prevention of Future deficiency: As outlined in the CSSC policy and procedure all physicians performing surgery will maintain admitting privileges at one or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located. All credentialing files will be reviewed on an ongoing basis to confirm all required documentation. Responsible Party: The Governing Board establishes and is responsible for the initial credentialing and reappointment process. The Clinical Administrator and Business Office Manager will maintain and review all credentialing files for compliance.</p>	01/23/2015			

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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 implement a center-wide quality assessment and performance improvement (QAPI) program which included all in-house and contracted services.</p> <p>Findings:</p> <p>1. Review of the Policy &amp; Procedure (P&amp;P) titled Quality Plan, effective 1/1/14, indicated within the PROCEDURE: The following services will be monitored on an ongoing basis for effective preventive measures to avoid undesired outcomes. Infection control, Response emergencies, Staffing, Medication errors, Housekeeping, Bio hazardous waste, Transcriptions service, Pharmacy, Linen Service, Medical Records, Pathology Service, Laboratory Service, Radiology Services, Discharge, Transfers, Serious Adverse Events.</p>	S000310	<p>Correction: A Quality Monitoring spreadsheet was developed to monitor and evaluate the safe and effective manner of center services including but not limited to; Response Emergencies, staffing, medicatin errors, housekeeping, medical records, laboratory service, discharge, maintenance, radiology, and contracted services including but not limited to; Biomedical engineering, Bio hazardous waste, Transcription, Pharmacy, Linen service, Medical records, Laboratory Service, Radiology Services, Maintenance, Security, &amp; Tissue transplant for CSSC. This monitoring spreadsheet will be completed on a quarterly basis and will be included and reviewed at all QAPI mtgs. and reviewed by the Board of Managers.Prevention of Future deficiency: To ensure the center services and contracted services are provided in a safe and effective manner, the Quality</p>	01/26/2015	

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S000400	<p>2. Review of QAPI committee meeting minutes dated 1/17/14, 4/18/14, 6/3/14, &amp; 12/3/14 lacked documentation of the following center services being included: Response emergencies, Staffing, Medication errors, Housekeeping, Medical records, Laboratory Service, Discharge, Maintenance, &amp; Radiology and the following contracted services: Bio medical engineering, Bio hazardous waste, Transcription, Pharmacy, Linen service, Medical records, Pathology, Laboratory Service, Radiology Services, Maintenance, Security, &amp; Tissue transplant.</p> <p>3. On 1/20/15 at 2:30pm, A2, Performance Improvement Coordinator, confirmed QAPI program had not implemented monitoring/inclusion of the above services and functions.</p> <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, interview, and document review, the facility failed to</p>	S000400	<p>Monitoring spreadsheet will be completed quarterly and reviewed at the QAPI quarterly mtgs. and reviewed by the Board of Managers according to the CSSC polycys and procedures. Evidence of this will be placed in mtg. minutes. Responsible Party: The Risk Manager will complete the Quality Monitoring spreadsheet quarterly and review it at the QAPI mtgs. The Administrator will then review this spreadsheet and communicate/review with the Board of Mangers.</p> <p>Correction: The Infection Control Policies were reviewed with the clinical staff members including</p>	01/22/2015			

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	<p>provide an environment that minimized infection risk to patients for 1 of 2 operating rooms (OR).</p> <p>Findings include:</p> <p>1. During observations beginning at 12:10 p.m. on 1/20/15, the following was observed: (A) A Neptune system was observed in the janitor closet. The portable system was observed adjacent to the floor drain and mop bucket. (B) During terminal cleaning of the OR beginning at 12:15 p.m. on 1/20/15, staff member #S2 (Housekeeping) was observed spraying CaviCide on surfaces within the OR and immediately wiping the surface with a towel. The surfaces remained wet for &lt; 10 seconds.</p> <p>2. During observation in the OR beginning at 11:43 a.m. on 1/21/15, the portable Neptune devise was observed brought into the OR by staff member #N7 (RN) and was used during the procedure.</p> <p>3. Staff member #N7 indicated in interview at 12:20 p.m. on 1/21/15 that the portable Neptune device is "usually" cleaned between cases and that he/she had not cleaned the device prior to bringing into the OR from the janitor closet.</p>		<p>staff member #S2 by the Clinical Administrator on 1/22/15. The Neptune devise is now being cleaned according to the CSSC Infection Control Policies and Procuedures to minimize infection risk to patients. If at any point it is docked in the janitor room, it is cleaned with cavicide and allowed to dry, according to the cavicide label instructions for 3 minutes, before being brought back into the Operating room for use on a procedure. During terminal cleaning, staff member #S2 will now allow the Cavicide to remain wet for the appriate time according to the CSSC policies and the caviced lable instructions. Prevention of Future deficiency: Inform the staff and housekeeping of our Infection Control Program. To maintain a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. All staff will continue to be educated on an ongoing basis according to the centers policies. Responsible Party: Administrator. However it is the responsibilty of all CSSC staff to maintain a safe and healthful environment.</p>		

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S000432	<p>4. Review of label instructions for the CaviCide indicated the surface must remain wet for three (3) minutes to be effective.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and staff interview, the infection control committee failed to ensure staff followed manufacturer recommendations for one (1) container of high level disinfection solution used.</p> <p>Findings include:</p> <p>1. Label instructions for Cidex OPA test strips states "Test solution before each usage to guard against dilution which</p>	S000432	<p>Correction: The Infection Control Policies were reviewed with the clinical staff members including staff member #N6 by the Clinical Administrator on 1/22/15. The Cidex OPA solution is tested each use with the Cidex OPA test strips. Documentation is placed in the Cidex log. Prevention of Future deficiency: Inform the staff of our Infection Control Program. To maintain a safe and healthful environment that minimizes infection exposure and risk to patients, health care</p>	01/22/2015

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S000630	<p>may lower the ortho-phthalaldehyde level of the solution below its MRC. Test solution before immersing instruments."</p> <p>2. Review of the Cidex OPA test log for 11/24/14 to present indicated the solution was tested on a daily basis and not with each use.</p> <p>3. Staff member #N6 (Instrument Tech) indicated in interview beginning at 1:25 p.m. on 1/21/15 that he/she tests the solution each day and not with each use. He/she indicated that the solution may be used only once a day or up to eight (8) times a day.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on observation and document</p>	S000630	<p>workers, and visitors. Staff will continue to be educated on an ongoing basis according to the centers policies. Staff will have documentation in their personnel file of their annual compentencies. Responsible Party: Administrator. However it is the responsibilty of all CSSC staff to maintain a safe and healthful environment.</p> <p>Correction: Anesthesia staff including Anesthesia provider #1</p>	01/23/2015

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S000710	<p>review, the facility failed to ensure anesthesia staff accurately documented records for 1 patient observation (patient #30).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During observation of care provided to patient #30 beginning at 10:45 a.m. on 1/21/15, anesthesia provider #1 was observed at bedside at 11:25 a.m. and did not assess the patient's lungs. The patient was observed throughout the preoperative and intraoperative phase and the patient's lung sounds were not checked.</li> <li>2. Review of facility policy titled "ANESTHESIA SERVICES" last reviewed/revised 12/13 states on page 47: "A. Pre-operative evaluation.....is the responsibility of a physician who is a member of the Anesthesia Staff....." Page 150 states: "A. Pre-operative 1. system review....."</li> <li>3. Anesthesia provider #1 checked "Within Normal Limits" under the respiratory section on the anesthesia evaluation form for patient #30.</li> </ol> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p>		<p>was inserviced of the Centers Anesthesia Service Policies and Procedures. Anesthesia will perform a pre-operative evaluation including a "systems review" prior to surgery and document accurately in the patients chart. Prevention of Future Deficiency: Inservice the Anesthesia staff to the centers Anesthesia Service policies and procedures. Periodic visual audits will be performed to confirm anesthesia staff is performing a preoperative evaluation according to the centers policies and procedures. The Administrator will report these findings to the committees by utilizing the QA process. Responsible Party: Anesthesia Providers will be responsible for performing a preoperative evaluation according to the centers policies and procedures.</p>				

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	<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> <p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board</p>			

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	<p>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. Based on document review and interview, the medical staff failed to maintain documentation of privileges to perform surgical procedures in a hospital for MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, &amp; MD#7.</p> <p>Findings:</p> <p>1. Review of medical staff credential files for MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, &amp; MD#7 indicated each performed surgery in the center. Each lacked documentation of having surgical privileges in a hospital.</p> <p>2. On 1/21/15 at 4:00pm, A1,</p>	S000710	<p>Correction: Verification of hospital privileges documentation was placed in Medical staff members MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, and MD#7 credentialing files on 1.22.15. Prevention of Future deficiency: As outlined in the CSSC policy and procedure all physicians performing surgery will maintain admitting privileges at one or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located. All credentialing files will be reviewed on an ongoing basis to confirm all required documentation. Responsible Party: The Governing Board establishes and is responsible for</p>	01/22/2015			

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S000830	<p>Administrator, confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(i)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and post-anesthesia responsibilities as follows:</p> <p>(i) The completion, within forty-eight (48) hours before surgery, of a preanesthesia evaluation for each patient by an individual qualified to administer anesthesia for all types of anesthetics other than local and updated according to center policy (when more than forty-eight (48) hours) before surgery.</p> <p>Based on document review and observation, the facility failed to ensure anesthesia staff performed a preoperative evaluation according to policy for 1 patient observation (patient #30).</p> <p>Findings include:</p>	S000830	<p>the initial credentialing and reappointment process. The Clinical Administrator and Business Office Manager will maintain and review all credentialing files for compliance.</p> <p>Correction: Anesthesia staff including Anesthesia provider #1 was inserviced of the Centers Anesthesia Service Policies and Procedures. Anesthesia will perform a pre-operative evaluation including a "systems review" prior to surgery and document accurately in the</p>	01/23/2015

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S000888	<p>1. Review of facility policy titled "ANESTHESIA SERVICES" last reviewed/revised 12/13 states on page 47: "A. Pre-operative evaluation.....is the responsibility of a physician who is a member of the Anesthesia Staff....." Page 150 states: "A. Pre-operative 1. system review....."</p> <p>2. During observation of care provided to patient #30 beginning at 10:45 a.m. on 1/21/15, anesthesia provider #1 was observed at bedside at 11:25 a.m. and did not assess the patient's lungs. The patient was observed throughout the preoperative and intraoperative phase and the patient's lung sounds were not checked.</p> <p>3. Anesthesia provider #1 checked "Within Normal Limits" under the respiratory section on the anesthesia evaluation form for patient #30, however, did not perform an evaluation of the patient's lungs.</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>patients chart. Prevention of Future Deficiency: Inservice the Anesthesia staff to the centers Anesthesia Service policies and procedures. Periodic visual audits will be performed to confirm anesthesia staff is performing a preoperative evaluation according to the centers policies and procedures. The Administrator will report these findings to the committees by utilizing the QA process. Responsible Party: Anesthesia Providers will be responsible for performing a preoperative evaluation according to the centers policies and procedures.</p>				

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	<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 document review and staff interview, the surgical staff failed to document an operative note that included findings immediately following surgery for 6 of 29 medical records (patients #11, 18, 19, 20, 23, and 29).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Rules and Responsibilities of the Medical Staff, last approved 6/25/12 states "Operative Reports/Post-operative Progress Reports.....Operative reports or operative progress notes shall be dictated or written in the medical record immediately after surgery and shall contain a description of the findings....."</li> <li>Patient #11 had surgery on 10/13/14. His/her operative report was dictated 10/15/14. The record contained a "BRIEF OPERATIVE NOTE" dated</li> </ol>	S000888	<p>Correction: The check box titled "see dictation" for Operative Findings on the Brief Operative Note was removed. Operative Findings are written out on the brief operative note allowing for completed immediate operative note. Prevention of Future Deficiency: Charts are audited quarterly by an outsided source, as well as internally according to CSSC policies and procedures. Charts audits will be reviewed quarterly at the QAPI mtgs and documented in the minutes for the Board of Managers review. Responsible Party: The Governing Board establishes and is responsible for the center's Policies and Procedures. However, the Clinical Administrator oversees that the assigned nursing personnel are checking charts for complete operative reports during audits.</p>	01/21/2015	

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	<p>10/13/14, however under operative findings, the document had "see dictation" checked.</p> <p>3. Patient #18 had surgery on 7/15/14. His/her operative report was dictated 7/22/14. The record contained a "BRIEF OPERATIVE NOTE" dated 7/15/14, however under operative findings, the document had "see dictation" checked.</p> <p>4. Patient #19 had surgery on 7/15/14. His/her operative report was dictated 7/22/14. The record contained a "BRIEF OPERATIVE NOTE" dated 7/15/14, however under operative findings, the document had "see dictation" checked.</p> <p>5. Patient #20 had surgery on 8/6/14. His/her operative report was dictated 8/11/14. The record contained a "BRIEF OPERATIVE NOTE" dated 8/6/14, however under operative findings, the document had "see dictation" checked.</p> <p>6. Patient #23 had surgery on 9/30/14. His/her operative report was dictated 10/6/14. The record contained a "BRIEF OPERATIVE NOTE" dated 9/30/14, however under operative findings, the document had "see dictation" checked.</p> <p>7. Patient #29 had surgery on 11/19/14. His/her operative report was dictated</p>			

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S001010	<p>11/23/14. The record contained a "BRIEF OPERATIVE NOTE" dated 11/19/14, however under operative findings, the document had "see dictation" checked.</p> <p>8. Staff member #N3 (Clinical Administrator) verified the medical record information at 5:00 p.m. on 1/21/15.</p> <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 document review, observation and interview, the center failed to implement their policy &amp; procedure (P&amp;P) to maintain drugs in a safe manner by not removing 6 expired medications from their medication cabinet.</p>	S001010	Correction: The 5 vials of Ciprofloxacin 400mg 40ml single dose vials w/ expiration date of January 1st 2015 and the 1 vial of Levaquin 500 mg/20ml w/ expiration date 11/13 were all removed from stock and disposed of in a manner that prevents unauthorized acces,	01/21/2015

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the P&amp;P titled MEDICATION EXPIRATION DATES, effective 1/1/14, indicated the following:               <ol style="list-style-type: none"> <li>Medication expirations are checked monthly</li> <li>If the drug has expired, it should be pulled and set for replacement.</li> <li>Outdated drugs are to be turned over to the Administrator or designated staff for return or disposal</li> </ol> </li> <li>On 1/20/15 at 3:00pm during tour of facility in the presence of AI, Administrator, the following was observed in the medication cabinet of the pre-operative area: 5 Ciprofloxacin 400 mg 40 ml single dose vials with expiration date 1 Jan 2015 and 1 Levaquin 500 mg/20 ml vial with expiration date 11/13.</li> <li>On 1/20/15 at 3:00pm, AI confirmed the above medications were expired and should have been removed from stock. AI also indicated the consultant pharmacist and staff are responsible to check for outdated medications on a regular basis.</li> <li>Review of center documents titled Consultant Pharmacist Quarterly Inspections dated 6/25/13, 12/10/13 &amp;</li> </ol>		<p>protects safety, and meets state and federal requirements. Prevention of Future Deficiency: Medications will be checked monthly for expirations according CSSC Policies and Procedures. As well, the center's Pharmacy consultant will check for expired drugs during onsite inspections. Responsible Party: The Pre/Post Op Charge Nurse will oversee and schedule the nursing staff to perform medication inspections for expirations. The Pharmacy Consultant will also participate during inspections.</p>	

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S001148	<p>6/10/14 indicated the consultant pharmacist inspected medication cabinets on those dates.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(A)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals must be available, along with training or instruction, or both, of the appropriate center personnel, in the maintenance and operation of fixed and movable equipment.</p> <p>Based on document review and interview, the center failed to provide periodic inspection and preventive maintenance of the back-up generator by qualified personnel.</p> <p>Findings:</p>	S001148	<p>Correction: Documentation of proper inspection and preventative maintenance for the center's back-up generator was placed in staff member #S6 employee file. Prevention of Future deficiency: All employees performing periodic inspections and preventative maintenance will</p>	01/26/2015

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S001152	<p>1. On 1/20/15 at 2:30pm A1, Administrator, indicated employee S6 as the person responsible for providing inspection and regular preventive maintenance for the back-up generator.</p> <p>2. Review of personnel file for S6 lacked documentation of training or instruction of preventive maintenance of the back-up generator.</p> <p>3. On 1/21/15 at 5:30pm, A1 confirmed lack of documentation for generator training of employee A6 and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(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>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plan and equipment by qualified personnel as follows:</p> <p>(B) All mechanical equipment</p>		<p>be trained appropriately and have their training documentation completed and placed in their personnel file according to CSSC policies and procedures. Employee files are reviewed on an ongoing basis according to the CSSC policies and procedures. Responsible Party: The Administrator will verify all training has been completed and documentation is placed in their files.</p>	

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	<p>(pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the center failed to document appropriate frequency of the back-up generator in accordance with the manufacturer's recommended maintenance schedule.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the back-up generator Owner's Manual section titled maintenance Schedule Page 2-2 indicated Maintenance procedures to be performed at Daily Intervals.</li> <li>Review of center documents titled Generator Weekly Checks dated January 2014, March 2014, April 2014, May 2014, June 2014, July 2014, Aug. 2014, Sept. 2014, Oct. 2014, November 2014, and Dec. 2014 and the document titled Monthly Emergency Generator Equipment Test Under Dynamic Load, Year 2014 lacked documentation of daily maintenance procedures performed per manufacturer recommendations.</li> <li>On 1/21/15 at 5:30pm A1,</li> </ol>	S001152	<p>Correction: The manufacturer's recommended maintenance schedule and center's policies were reviewed with the staff. Maintenance is performed according to the acceptable standards of practice according to the manufacturer. Prevention of Future deficiency: As outlined in the CSSC Policy and Procedure manual, all mechanical equipment will have appropriate maintenance performed according to manufacturer's recommended schedule. As well documentation will be completed and filed appropriately. This documentation will be reviewed quarterly at the QAPI mtgs and documented in the minutes for the Board of Managers review. Responsible Party: The Administrator as designated by the Board of Managers, is responsible for maintaing maintenance services and for the overall performance of these services. The Administrator is responsible for the overall maintenance for equipment and the physical plant.</p>	01/26/2015			

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S001166	<p>Administrator, confirmed daily checks were not being performed on the generator.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on document review and interview, the center failed to maintain evidence of preventive maintenance on all patient care equipment.</p> <p>Findings:</p> <p>1. Review of the policy/procedure (P&amp;P) titled Equipment Maintenance, effective 1/1/14, indicated All preventative maintenance will be done according to</p>	S001166	<p>Correction: Preventative maintenance was performed on CSSC's EKG machine, suction machine, patient stretchers, and wheelchairs according to the polycys and procedures for CSSC and manufacturer's guidelines. Documentation was completed and appropriately filed in the Administrators office. Prevention of Future defieny: As outlined in the CSSC Equipment Maintenance Policy and Procedure manual, all patient</p>	01/26/2015

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	<p>manufacturer's guidelines. If no manufacturer guidelines exist, Heartland Medical will maintain that item with preventative maintenance yearly or as is usual and customary for that particular item according to their guidelines.</p> <p>2. Review of 2014 preventive maintenance (PM) documents lacked documentation of PM for the following equipment: EKG (electrocardiogram) machine, suction machine, patient stretcher(s), &amp; wheelchair.</p> <p>3. On 1/21/15 at 11:25am A1, Administrator, indicated non-electrical equipment is visually inspected by staff, but is not documented and electrical equipment PM is provided under contract arrangement(s). A1 confirmed lack of documentation for the above items.</p>		<p>care equipment will have preventative maintenance performed according to manufacturer's guidelines. As well documentation will be completed and filed appropriately. This documentation will be reviewed quarterly at the QAPI mtgs and documented in the minutes for the Board of Managers review. Responsible Party: The Administrator as designated by the Board of Managers, is responsible for maintaing contracts and agreements for maintenance services and for the overall performance of these services. The Administrator is responsible for the overall maintenance for equipment and the physical plant.</p>	