

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001018	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/01/2012
NAME OF PROVIDER OR SUPPLIER  GROSSNICKLE EYE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2251 DUBOIS DR WARSAW, IN 46580		
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005399</p> <p>Survey Date: 1/30/2012 through 2/1/2012</p> <p>Surveyors:</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 02/15/12</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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S0116	<p>410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</p> <p>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on document review and staff interview, the Governing Board failed to ensure 3 of 3 allied health workers, credentialed by the medical staff, had a DEA as per the facility's policies and procedures (#12, 13 and 14).</p> <p>Findings included:</p> <p>1. The medical staff credentialed files were reviewed on 1/30/2012. Staff members #12, 13, and 14 requested assorted medication administration privileges and they were approved by the medical staff and the Governing Board.</p>	S0116	The policy that addresses credentiaing criteria was updated to include CRNA providers do not need to show proof of a DEA number. The administrator was responsible for changing this policy.This policy change should eliminate future discrepencies regarding the information required for CRNA credentialing.	02/23/2012			

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	<p>2. The controlled substances the facility will use in surgery by the Anesthesiologist or the Nurse Anesthetist are Versed or Fentanyl. Both of these medications are preprinted on the IV Sedation Record.</p> <p>3. Grossnickle Eye Center, Inc Medical Staff Credentialing/Privileging Criteria states, "The Governing Body/BOD has specific criteria for the credentialing and recredentialing of practitioners based upon the size and complexity of the organization and regulatory standards. On the initial application for privileges, the applicant is required to provide evidence of training, experience, and current competence in performance of the procedures for which privileges are requested. The following shall be included in the information provided for evaluation: ... DEA Certification/Registration and any state license action, ..."</p> <p>4. At 2:45 PM on 1/31/2012, staff member #1 indicated the actual practices for CRNAs are in conflict with what the facility's credentialing requirements for Allied Health Staff. The staff member indicated the physicians are to sign the anesthesiology reports after the CRNAs provided the medication. The CRNAs would fill out the reports of what and how</p>						

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	much medication was administered and the physician would sign the report.			
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S0434	<p>410 IAC 15-2.5-1(f)(2)(E)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on observation, policy and procedure review, and interview, the facility failed to ensure intravenous (IV) medications were administered according to aseptic techniques in one of one case observation (#N26).</p> <p>Findings included:</p> <p>1. During the surgical case observation at 10:15 AM on 01/31/12, the anesthesiologist, staff member #P9, was observed withdrawing medication from an open, multidose vial and injecting it into the hub of an intravenous line of patient #N26 without first cleaning the vial or the IV hub with an alcohol swab.</p> <p>2. The facility policy "Medication Guidelines", last reviewed 12/09, indicated, "...3. All medications drawn up for injection will be drawn up using proper aseptic technique, which includes</p>	S0434	<p>The current medication guideline policy and procedure was reviewed with the ASC staff and anesthesia providers. The surgery manager will monitor staff and anesthesia providers for compliance of this policy. Periodic observation will be completed to assess compliance and will be reported to the infection control/safety committee for 2 quarters. At that time, the committee will determine if further monitoring is required.</p>	02/07/2012			

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	proper hand hygiene."  3. At 11:00 AM on 02/01/12, staff member #P2 indicated proper aseptic technique, which included cleaning medication vials and injection sites, was the standard of practice at the facility.				

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S0772	<p>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 medical staff rules and regulations review, observation, medical record review, and interview, the facility failed to ensure all patients undergoing surgical procedures had a history and physical performed by a physician within 30 days of the procedure for 25 of 25 patient records reviewed (#N1- N25).</p> <p>Findings included:</p>	S0772	A new H&P form is being created for the physician to complete the current history and physical assesment the day of the procedure.The surgery manager will create the new form and educate the staff and physicians.The surgery manager will monitor compliance of these changes.This will be monitored through our quarterly chart audits.The operative	03/01/2012
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	<p>1. The facility's Medical Staff Rules and Regulations, last approved on 06/23/11, indicated on page 4, "...2.03 A history and physical examination is required and shall be indicated on the patient's medical record prior to all surgical procedures. (a) A medical history and physical assessment will be completed by a physician no more than 30 days before the date of the surgery/procedure. (b) A H&amp;P may be performed on the day of the procedure. (c) If the H&amp;P is not completed the day of the procedure, documentation shall be completed in the medical record by a physician that health status remains unchanged or appropriate changes noted."</p> <p>2. At 9:00 AM on 02/01/12, the admission process of patient #N25 was observed. Nursing staff member #P3 and anesthesiologist staff member #P9 both listened to the patient's heart and lungs and reviewed a hard copy form of a history and physical performed on 01/11/12, but the form was not signed. Staff member #P3 indicated this form was sent from the physician's office and was used to update the patient's information. However, when the surgeon, staff member #P11, arrived at 9:20 AM, and reviewed this same information on the computer, it was not dated 01/11/12. This</p>		note/discharge summary has been changed to note the H&P was completed before the start of the procedure.				

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	<p>information was dated and signed by the physician as if it was performed today and not just updated.</p> <p>3. Review of the electronic medical records for patients #N1- N25 indicated all of the history and physicals were dated as being done on the day of surgery instead of just being updated that day. The records also indicated 20 of the 25 patients, (#N1, N2, N3, N5, N6, N7, N9- N12, N14- N23), had "High blood pressure, no symptoms today" recorded on the form actually done in the physician's office.</p> <p>The "Operative Note/Discharge Summary", dictated on the day of surgery, for all of the medical records reviewed, (#N1- N25), indicated, "...A history and physical was performed prior to admission." The records did not contain any previous history and physicals, but only the ones dated the day of surgery.</p> <p>4. At 10:00 AM on 02/01/12, the history and physical process was discussed with staff members #P1 and P2. Both staff members confirmed the information that was reviewed by the surgeon on the computer on the day of surgery lacked documentation of a date and authentication to determine when it was done and by whom. Both staff members</p>				

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	indicated that since the information was reviewed and the condition of the heart, lungs, and mental status was confirmed that day, that constituted a history and physical being performed that day.			

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S1010	<p>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 and procedure review, and interview, the facility failed to ensure all mutidose vials and glucometer test strips were dated according to policy and to prevent outdated usage.</p> <p>Findings included:</p> <p>1. During the tour of the facility at 10:45 AM on 01/31/12, accompanied by staff member #P2, the following observations were made at the medication cabinet in the nurses' station:</p> <p>A. An open, ten milliliter multidose vial of Naloxone HCl with a manufacturer's expiration date of 1 May 2012. The open date was written in as 10/12/11, over 3 months ago, but no discard date was written in.</p> <p>B. An open, twenty milliliter multidose vial of Labetalol HCl with a manufacturer's expiration date of 1 Aug.</p>	S1010	<p>The medication expiration policy was reviewed with the nursing staff. Multidose injectable vials will be labeled with an expiration date of 28 days. The pharmacy nurse will update the "expired drug" policy. The surgery manager will monitor compicance of this policy and the pharmacy nurse will continue to monitor outdates with her monthly medication audit check.</p> <p>The glucometer policy was updated to include that the discard date will be marked on the glucometer strip bottles. This was reviewed with the staff.</p>	02/07/2012			

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	<p>2013. The open date was written in as 1/09/12, but no discard date was written in.</p> <p>2. During the tour of the pre-op area at 11:00 AM on 01/31/12, accompanied by staff member #P2, an open, but not dated, container of glucose test strips for the One Touch Ultra glucometer were observed with a manufacturer's expiration date of 04/2013, but no written in discard date. The manufacturer's instructions on the label were to discard 6 months after opening.</p> <p>3. The facility policy "Administration of Medications", last reviewed 12/09, indicated, "...6. All multidose medications must be labeled with date opened and refer to NUR 4/8 Pharmacy Inventory/Med. Expiration Dates policy for expiration dates to be marked."</p> <p>4. The facility policy "Medication Expiration Dates", last reviewed 3/11, indicated a discard date for Labetalol of 28 days after opening and 120 days after opening for the One Touch Test Strips. The policy did not specifically address Naloxone, but listed 28 days after opening under "Miscellaneous" for multidose vials.</p> <p>5. During the tour at 10:45 AM on</p>						

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	01/31/12, staff member #P2 indicated the Naloxone and Labetalol weren't dated with a 28 day discard date because they were used so seldom and the manufacturer's expiration date was used instead.				

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S1180	<p>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 staff interview, the facility failed to identify the Safety Committee by the Medical Staff/Governing Board.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 1/30/2012, staff member #2 indicated he/she was the safety officer/Infection Control Officer. The staff member indicated the Infection Control Committee also acts as the Safety Committee. The staff member indicated the Medical Staff Bylaws defines the committees and their functions. The staff member confirmed the written functions of the Infection Control Committee in the Medical Staff Bylaws did not address the functions defined in the facility's Safety Program. The staff member indicated he/she does not conduct written routine inspections of the facility and that he/she does put more emphasis on the infection control safety concerns.</p>	S1180	The Medical Staff Bylaws were updated to reflect the responsibility changes of the infection control committee. The infection control committee has been changed to the Infection Control/Safety Committee. The added responsibilities of the committee now include the monitoring of general safety activities of the facility. The administrator updated the bylaws and will monitor the activities of this committee quarterly.	02/23/2012			

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	<p>2. Grossnickle Eye Center, Inc. Medical Staff Bylaws were reviewed. Article X, Committees and Their Functions, defines the following committees: Bylaws Credentials Committee, Infection Control Committee, and Continuous Quality Improvement Committee. The functions of the Infection Control Committee did not define the safety committee as one of its functions. The Infection Control Committee does not define general safety and facility hazards as an indicator. The Medical Staff Bylaws/Governing Board Bylaws does not define the Safety Committee.</p> <p>3. The Safety Program S-1 states, "A written, ongoing, and effective facility-wide safety program will be maintained and monitored. This program will include a system for collecting and evaluating information about hazards and safety practices within the facility. The Safety Committee for monitoring and guiding the Safety Program; including but not limited to: periodical inspection of all personnel in the proper use of safety, emergency and fire extinguishing equipment, review of the emergency plan, fire disaster drills, smoking on corporation grounds, all types of hazards and accommodations for disabled individuals."</p>			
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S1182	<p>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 on document review and staff interview, the facility failed to ensure a process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 1/30/2012, staff member #2 indicated he/she was the safety officer/Infection Control Officer. The staff member indicated the Infection Control Committee also acts as the Safety Committee. The staff member indicated the Medical Staff Bylaws defines the committees and their functions. The staff member confirmed the written functions of the Infection Control Committee in the Medical Staff Bylaws did not address the functions defined in the facility's Safety Program. The staff member indicated he/she does not conduct written routine inspections of the facility and the he/she does put more emphasis on the infection control safety concerns.</p>	S1182	The safety policy S1 was updated and states periodic hazard and safety assessments of the facility will be completed. Findings will be reported to the infection control/safety committee. The safety officer will create a facility safety check list that will be completed quarterly. The administrator will monitor the infection control/safety committee activities quarterly.	02/28/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001018	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/01/2012
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	<p>2. Grossnickle Eye Center, Inc. Medical Staff Bylaws were reviewed. Article X, Committees and Their Functions, defines the following committees: Bylaws Credentials Committee, Infection Control Committee, and Continuous Quality Improvement Committee. The functions of the Infection Control Committee did not define the safety committee as one of its functions. The Infection Control Committee does not define general safety and facility hazards as an indicator. The Medical Staff Bylaws/Governing Board Bylaws does not define the Safety Committee.</p> <p>3. The Safety Program S-1 states, "A written, ongoing, and effective facility-wide safety program will be maintained and monitored. This program will include a system for collecting and evaluating information about hazards and safety practices within the facility. The Safety Committee for monitoring and guiding the Safety Program; including but not limited to: periodical inspection of all personnel in the proper use of safety, emergency and fire extinguishing equipment, review of the emergency plan, fire disaster drills, smoking on corporation grounds, all types of hazards and accommodations for disabled individuals."</p>			
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	<p>4. The facility has an ASC Safety Report Summary addressed in the Infection Control Committee reports.. The 4 quarters of Infection Control meetings were reviewed. The Safety Report Summary addressed infection control issues and not safety hazards and practices. Items addressed on the report included: Consent Error, Expired Lens Implanted, Transfers, Medication Errors, etc.</p> <p>5. The facility conducts staff meetings and they were reviewed. The Grossnickle Eye Center, Inc..had 5 recorded staff meetings for 2011. The staff meetings addressed 'Safety Updates'. The 3/1/2011 staff meeting only addressed an ASC fire drill was conducted on 3/1/2011. However, the other 4 staff meetings noted on Safety Updates, "None Discussed". Those meetings were held 11/1/11, 9/13/11, 7/12/11, and 5/3/11.</p>				