

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001047	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER WHITEWATER SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 CHESTER BLVD RICHMOND, IN 47374
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S 0000 Bldg. 00	<p>This visit was for a state licensure survey.</p> <p>Facility Number: 001222</p> <p>Survey Date: June 30 thru July2, 2004</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 07/10/14</p>	S 0000		
S 0110 Bldg. 00	<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,</p>			

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>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 interview, the facility's governing board failed to review reports of the facility's quality assessment and performance improvement (QAPI) program for 2 of 4 quarters in calendar year 2013, and the reports which were reviewed did not include reports for 2 directly-provided services (nursing and transcription) and 6 other activities (discharge, transfer, infection control, medication errors, response to patient emergencies and reportable events).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the governing board meeting minutes for calendar year 2013 indicated the governing board reviewed QAPI activities on January 16 (first quarter), and September 18 (third quarter), but none for the second and fourth quarter. 2. In interview on 7-2-14 at 12:15 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit. 	S 0110	<p>To correct this deficiency, we have scheduled review dates for the third Wednesday of the starting quarter months (Jan, April, July, Oct). We have updated the Governing Body meeting template to include a QAPI report review section. We have also updated the QAPI meeting template to include all the required reports, services and activities to ensure all items are addressed at each meeting. The QAPI template consists of sections for Bioengineering, BioHazardous Waste, Housekeeping, Lab, Laundry/Linen, Maintenance, Medical Records, Nursing, Pharmacy & Therapeutics, Radiology, Security, Tissue, Transcription, Discharge, Transfers, Infection Control, Medication Errors, Patient Emergencies, Reportable Events, Patient Satisfaction, Physical Environment, Other monitors & benchmarking, QI studies, Policies & Procedures, Business Operations and Other Business. These templates were updated on 7/11/14. We will prevent this deficiency from recurring in the future by having pre-scheduled dates for reviews, as indicated above, on the third Wednesday of</p>	07/16/2014

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S 0150 Bldg. 00	<p>3. Review of the governing board meeting minutes for calendar year 2014 indicated the governing board failed to review QAPI activities for the directly-provided services of nursing and transcription, and the activities of discharge, transfer, infection control, medication errors, response to patient emergencies and reportable events.</p> <p>4. In interview, on 7-2-14 at 12:15 pm, employee #A1 confirmed there were no above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c) (5) (A)</p> <p>(c) The governing body shall do the following:</p> <p>(5) Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(A) Ensuring the employment of personnel, in accordance with state and federal rules, whose qualifications are commensurate with anticipated job responsibilities.</p>		<p>the starting quarter months (Jan, April, July, Oct). This will also be prevented by utilizing the new Governing Body and QAPI meeting templates that include all the required reports, services and activities. The Clinical Director, or designee in their absence, will be responsible for ensuring the meeting reviews take place and the templates are used to address the identified areas. Deficiencies will be corrected by Wednesday July 16, 2014 at the scheduled Governing Body and QAPI meeting review.</p>	

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	<p>Based on document review and interview, the facility failed to employ personnel in accordance with qualifications which were commensurate with job descriptions for 3 (#P5, #P6 and #P8) of 8 personnel files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of 8 personnel files indicated file #P5 was hired as an LPN (licensed practical nurse). 2. Review of the facility's Job Description for an LPN indicated two (2) years of experience of clinical experience with an emphasis in PACU, surgery or ER is required. 3. Review of #P5's resume indicated #P5 having work experience as a Group Home Nurse, Administrator of a Creative Learning Workshop, Director of a workshop and day rehabilitation center, Floor Nurse at a residential facility, and a primary nurse in a physician's office. 4. Based on the above documentation, employee #P5 did not have qualification of two (2) years of experience of clinical experience with an emphasis in PACU, surgery or ER. 5. Review of 8 personnel files indicated 	S 0150	To correct this deficiency, the Governing Body will review and update the current job descriptions to ensure all employment personnel qualifications for PACU, OR and/or ER experience from required to preferred to ensure consistency with practice. The current employees and all future hires will sign the updated job descriptions once they are updated and approved through the Governing Body. The job descriptions were updated on 7/11/2014 and are awaiting approval from the Governing Body on 7/16/14. This deficiency will be prevented in the future by updated the job descriptions to be consistent with practice and ensuring all new hires meet qualifications indicated on the job description. The HR manager, Clinical Director or designee, in their absence, will be responsible for ensuring applicants meet the defined qualifications on the updated job descriptions. This deficiency will be corrected by July 23, 2014, once the Governing Body has approved and employees have signed the updated job descriptions.	07/23/2014			

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	<p>file #P6 was hired as a Preop/PACU RN.</p> <p>6. Review of the facility's Job Description for a Preop/PACU RN indicated two (2) years experience of clinical experience with an emphasis in PACU, surgery or ER is required.</p> <p>7. Review of #P6's resume indicated #P6 had work experience as an RN Charge Nurse in a Ventilator Unit, a Director of Clinical Education/LPN, a Director of Marketing/LPN and as an ADON/LPN, all positions in long term care facilities, but no experience of clinical experience with an emphasis in PACU, surgery or ER is required.</p> <p>8. Based on the above documentation, employee #P6 did not have the qualification of two (2) years of experience of clinical experience with an emphasis in PACU, surgery or ER.</p> <p>9. Review of 8 personnel files indicated file #P8 was hired as a Clinical Director.</p> <p>10. Review of the facility's Job Description for a Clinical Director indicated minimum of three (3) years of ambulatory surgery clinical experience as a registered nurse.</p> <p>11. Review of P#8's resume indicated</p>			

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S 0224 Bldg. 00	<p>P#8 had work experience in outpatient dialysis centers and a hospital's Intensive Care/Coronary Care unit, but no ambulatory surgery clinical experience as a registered nurse.</p> <p>12. Based on the above documentation, employee #P8 did not have the qualification of a minimum of three (3) years of ambulatory surgery clinical experience as a registered nurse.</p> <p>13. In interview, on 7-1-14 at 2:20 pm, employee #A1 confirmed all the above-stated findings and no further documentation was provided prior to exit.</p> <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.</p> <p>Based on document review and interview, the governing board could not</p>	S 0224	To correct this deficiency, we have scheduled review dates for	07/16/2014

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	<p>ensure 11 (bioengineering, biohazardous waste, housekeeping, laboratory, laundry/linen, maintenance, medical records, pharmacy, radiology, security and transcription) of 11 contracted services were provided in a safe and effective manner.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's QAPI program and governing board meeting minutes for calendar year 2013, indicated the governing board did not review reports for the contracted services of bioengineering, biohazardous waste, housekeeping, laboratory, laundry/linen, maintenance, medical records, pharmacy, radiology, security and transcription. In interview, on 7-2-14 at 12:15 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit. 		<p>the third Wednesday of the starting quarter months (Jan, April, July, Oct). We have updated the Governing Body meeting template to include a QAPI report review. This update was completed on 7/11/14. We have also updated the QAPI meeting template to include all the required reports, services and activities to ensure all items are addressed during each meeting. the QAPI template consist of sections for Bioengineering, BioHazardous Waste, Housekeeping, Lab, Laundry/Linen, Maintenance, Medical Records, Nursing, Pharmacy & Therapeutics, Radiology, Security, Tissue, Transcription, Discharge, Transfers, Infection Control, Medication Errors, Patient Emergencies, Reportable events, Patient Satisfaction, Physical Environment, Other monitors, Benchmarking, QI studies, Policies & Procedures, Business Operations and Other Business. This template was updated on 7/11/14 We will prevent this deficiency from recurring in the future, by having pre-scheduled dates for reviews, as indicated above, on the third Wednesday of the starting quarter months (Jan, April, July, Oct). This will also be prevented by utilizing the new Governing Body and QAPI meeting templates that include all required reports, services and activities. The Clinical Director, or</p>		

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S 0328 Bldg. 00	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the center failed to take appropriate action to address two (2) opportunities for improvement found through the quality assessment and improvement (QAPI) program by not documenting the outcome of the action taken, its effectiveness, continued follow-up, and impact on patient care.</p> <p>Findings:</p>	S 0328	<p>designee in their absence, will be responsible for ensuring the meeting reviews take place and the templates are used to address the identified areas. This deficiency will be corrected by July 16, 2014 at the scheduled Governing Body and QAPI meeting review.</p> <p>This deficiency will be corrected by developing a "Quarterly Peer Review Results" form that will be reviewed with each physician after peer reviews are completed. The individual forms will be placed in each physicians medical staff file. The "Quarterly Peer Review Results" form will include the physician name, quarter and year, number of cases performed & reviewed, number of cases with unacceptable items & a list of those items, along with follow up on the unacceptable items. The</p>	07/23/2014	

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S 0826	<p>1. Review of a document entitled ANESTHESIA PEER REVIEW indicated MD#8 reviewed the anesthesia record of Patient's ID 5/16/51, a patient of anesthesiologist MD#1. Further review of the document indicated MD#8 indicated the Preoperative Evaluation was Unacceptable, and needs completed.</p> <p>2. Review of a document entitled ANESTHESIA PEER REVIEW, indicated MD#8 reviewed the anesthesia record of Patient's ID 6/18/07, a patient of anesthesiologist MD#9. Further review of the document indicated MD#8 indicated the Preoperative Evaluation and Postoperative & Discharge Orders were Unacceptable.</p> <p>3. In interview, on 7-2-14 at 11:00 am, employee #A1 was requested to provide documentation of follow-up to the above-stated findings and the employee indicated there was no documentation of follow-up to the action taken, its effectiveness, continued follow-up and impact on patient care.</p>		Physician and Clinical Director will sign the forms, once they are reviewed and follow up completed and placed in each physicians medical staff file. The forms will be reviewed with the QAPI team during the quarterly meeting reviews under the peer review section of the updated meeting minute template. The Peer Review nurse and Clinical Director, or designee in their absence, will be responsible for ensuring these tasks are completed. The deficiency will be corrected by July 23, 2014 once the Governing Body and QAPI meeting reviews on July 16, 2014 and physician signatures have been obtained.	
	410 IAC 15-2.5-4			

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Bldg. 00	<p>MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</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>(E) Safety training required of personnel. Based on document review and interview, the facility failed to follow facility policy and failed to have safety training for areas in which anesthetics were used for 1 (MD#1) of 5 physician credential files reviewed.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled PATIENT SAFETY IN THE OPERATING ROOM indicated, regarding patient safety activities, used the terms personnel (5 times), and facility team (3 times). These terms were not specifically defined, therefore they were interpreted as referring to anyone employed and/or credentialed by the medical staff of the facility.</p> <p>1. Review of 5 physician credential files who performed procedures in areas where anesthetics were used indicated MD#1 did not have any safety training in areas</p>	S 0826	<p>This deficiency will be corrected by developing and instituting an OR Safety Training Program that each medical staff will be required to complete. The OR Safety Training will be a power point presentation educating on the OR Safety items outlined in our policies. An OR Safety Training Acknowledgement form will be utilized to place in each medical staff file. The medical staff and Clinical Director will be required to sign the acknowledgement form prior to placing in the medical staff file. We will prevent this deficiency from recurring in the future by auditing medical staff files on an annual basis to ensure all acknowledgement forms are on file. This will also be added to the medical staff credentialing checklist used by the HR/Credentialing Manager. The Clinical Director and HR/Credentialing Manager will be responsible for ensuring the medical staff have completed the OR Safety Training and the acknowledgement forms are on</p>	07/30/2014

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	<p>where anesthetics were used.</p> <p>2. In interview, on 7-1-14 at 3:00 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>		file. This deficiency will be corrected by July 30, 2014		