

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001078	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/19/2014
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NAME OF PROVIDER OR SUPPLIER EYECARE CONSULTANTS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 101 NW FIRST ST STE 104 EVANSVILLE, IN 47708
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 009564</p> <p>Survey Date: 8/18-19/14</p> <p>Surveyors: Trisha Goodwin, RN BSE Public Health Nurse Surveyor/Administrator Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 09/10/14</p>	S000000		
S000104	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(a)(2)</p> <p>The governing body shall do the following:</p> <p>(2) Adopt bylaws and function accordingly.</p> <p>Based on document review and interview, the governing board (GB)</p>	S000104	<p>410 IAC 15-2.4-1 GOVERNING BODY POWERS AND DUTIES PLAN OF CORRECTION: The Center's Governing Body will ensure that it assumes full legal responsibility for</p>	09/22/2014

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>failed to conduct business according to their bylaws in any voting instance within the past four (4) quarters.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the center's document titled Governing Board Bylaws, to last be approved 2/11/14, in the section labeled Article V: General Business indicated within 5.1: The governing board shall consist of four individuals, two of whom are appointed by the parent company and two of whom are appointed by the physician entity and in 5.5: A quorum of the board shall consist of the four (4) board members. If a quorum is present when a vote is taken, the affirmative vote of a majority of the board present shall be the act of the board. 2. Review of the document titled Committees (2014) listed four (4) members among the GB; two (2) physicians and two (2) non-physicians, one of which was facility employee A1. 3. In interview on 8/18/14 at 2:00pm employee A1 indicated the list 		<p>determining, implementing and monitoring policies governing the Center's total operation. The Center's Governing Body will ensure that a quorum is present at the Board meetings when a vote is taken.</p> <p>SYSTEMIC CHANGES: The Center has named the Center Director as the fourth member, representing the physician's. Going forward, no voting will occur without a quorum of Governing Body members in attendance. (Attachment A)</p> <p>RESPONSIBLE PARTY AND MONITORING: The Chairman of the Governing Body will be responsible for ensuring that the Governing Body oversees and is accountable for the adoption of bylaws and function according to those bylaws. 9/22/2014</p>		

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S000110	<p>titled Committees did not include two (2) parent company members and two (2) physician entities and agreed to check further.</p> <p>4. Review of the document presented 8/18/14 at 3:30, reported by A1 to be an email from the parent company, indicated A1 is not a member of the center's GB and listed the GB members.</p> <p>5. Review of meeting minute documents titled Board of Governors Meeting dated 9/5/13, 12/17/13, 2/11/14, and 5/1/14 indicated approval of affirmative votes, but failed to include a quorum as indicated above.</p> <p>6. In interview on 8/18/14 at 3:30pm employee A1 confirmed the above 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 (a)(5)</p>			

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S000320	<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 interview the governing body (GB) failed to review reports of the quality assessment and improvement program (QAPI) for the past four (4) quarters.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of GB meeting minutes 9/5/13, 12/17/13, 2/11/14, and 5/1/14 indicated A1, the infection control officer (ICO), informed the GB the QAPI Committee met and the minutes are filed separately. In interview on 8/19/14 at 1:10pm employee A1 confirmed reports from the QAPI Committee were not being distributed to the GB members. 	S000110	<p>410 IAC 15-2.4-1 GOVERNING BODY POWERS AND DUTIES PLAN OF CORRECTION: The Center's Governing Body will ensure that it reviews at least quarterly, reports of management operations.</p> <p>SYSTEMIC CHANGES 1) Quality Improvement Committee Minutes will be reviewed and final approval obtained during each of the quarterly Board Meetings. 2) The Governing Body will conduct quarterly meetings using the attached agenda (Attachment B). Continued from page 2 The meeting will discuss QAPI Committee findings including Medical Records/Utilization Review/Peer Review; Infection Review; Cancellation Log Reporting; Occurrence Analysis; Unplanned Transfers; Tissue/Pathology Summary; Patient Satisfaction; Safety Review; Pharmacy, Risk Management and Quality Improvement Studies. Data from appropriate Performance Improvement indicators will be reviewed and analyzed</p> <p>RESPONSIBLE PARTY AND MONITORING: The Chairman of the Governing Board will be responsible for ensuring that the Governing Body oversees and is accountable for the quality assurance and performance improvement program, ensures facility policies and procedures are administered in a manner to provide quality health care in a safe environment. Board meeting minutes will reflect information reported and conclusions reached as well as recommended changes to make desired improvements. The Center Director will ensure staff assigned to perform QAPI and infection control responsibilities have appropriate training, specific job descriptions and adequate time to complete perform assignments. She will report on policy adherence and patient safety no less than quarterly to the QAPI Committee for communication to the Governing Body and more often if issues are identified. 09-22-2014</p>	09/22/2014	
	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND				

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	<p>IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</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>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the facility failed to include the activities of nursing, discharge, transfer and medication errors in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include the activities of nursing, discharge, transfer or medication errors.</p> <p>2. In interview on 8/19/14 at 1:10pm employee A1 confirmed the above. No further documentation was provided prior to exit.</p>	S000320	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND PLAN OF CORRECTION: The Eyecare Consultants Surgery Center will have an ongoing and written plan of quality improvement implementation that evaluates all functions.</p> <p>IMMEDIATE ACTION: The QAPI plan includes measurement, analysis and tracking of quality indicators, adverse patient events, infection control program and other aspects of performance that includes care and services furnished at the Center. The QAPI plan includes utilization of infection control data, safety data, risk data, high risk/high volume and problem prone process data to monitor the effectiveness of its services and quality of its care. Performance Improvement indicators for ongoing monitoring includes but is not limited to: monitoring of post operative infections, adverse patient events, Continued from page 3 hospital transfers, tissue review, procedural and anesthesia complications, employee exposures, adverse drug reactions, medication errors, and patient satisfaction. The quarterly QAPI minutes will be available to the Governing Body for review and action.</p> <p>SYSTEMIC CHANGES: 1) Staff will be in-serviced on the QAPI Plan and all of the components including Risk Management Activities. 2) Review of the facility's QAPI program will include the activities of nursing, discharge, transfer, or medication errors.</p> <p>RESPONSIBLE PARTY AND MONITORING: The Center Director is responsible for maintaining an ongoing, data driven quality assessment and performance improvement program including the risk management program at the Center. It is the ultimate responsibility of the Governing body to ensure compliance with the Risk Management Program at the Center. The Operating Board has appointed the QAPI Committee to review and analyze Risk Management data and to make recommendations.</p>	09/22/2014			

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S000400	<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 and document review, the facility failed to provide an environment that minimized risk to patients in 2 instances of medication administration.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Beginning at 9:45 a.m. on 8/18/14, Anesthesia provider #1 was observed administering I.V. medications x 2 to patient #30. He/she did not cleanse the stopper on the medication vial with alcohol prior to drawing up the medication nor did he/she cleanse the I.V. port with alcohol prior to the administration of the medication. Facility policy titled "MEDICATION Administration" last reviewed/revised 9/13/12 states on page 2: "Medications 	S000400	<p>The Governing Body also has given the Center Director the authority to coordinate and implement the Risk Management Program.. The Center Director will ensure compliance with holding and documenting quarterly QAPI meetings to review collected data and make recommendations. The QAPI minutes will be reported to the Governing Body for review and approval. 09-22-2014</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM The Center will provide an environment that minimizes risk to patients during medication administration. PLAN OF CORRECTION: The Center will ensure that drugs are prepared and administered according to established policies and acceptable standards of practice. IMMEDIATE ACTION: All caregivers at the Center will comply with safe injection practices including entry into vials which will be done using careful technique, including alcohol swabbing, with friction, of rubber stopper prior to use. SYSTEMIC CHANGES Safe Injection Practices will be reviewed with each caregiver with the expectation of 100% compliance. Continued from page 4 1) Center policy "Procurement and Preparation" and 2) Center policy "Administration of Medication " has been reviewed with all clinical Center Staff to ensure understanding of the policy. 3) Center policy "Safe Injection Practices" has been reviewed with all clinical Center Staff to ensure understanding of the policy. (Attachment C) RESPONSIBLE PARTY AND MONITORING: The Center Director is responsible for monitoring compliance with Drug Administration. The Center Director or their designee will coordinate a minimum of 10 unannounced observations of safe injection practices to include all aspects of policy and all caregivers for the next three weeks. Each variance will be addressed with the individual at the time of occurrence and tracked in a blinded report for trending. Trended behavior will be addressed individually for causes. If 100% compliance is achieved, ongoing</p>	10/03/2014

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S000730	<p>are prepared and administered according to established policies and acceptable standards of practice."</p> <p>3. APIC position paper titled "Safe injection practices....." states "Cleanse the access diaphragm of vials using friction and sterile 70% isopropyl alcohol, ethel alcohol, iodophor, or other approved antiseptic swab. Allow the diaphragm to dry before inserting any device into the vial."</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(1)</p> <p>These bylaws and rules must be as follows:</p> <p>(1) Be approved by the governing board.</p> <p>Based on document review and interview, the medical staff (MS) failed to enforce bylaws and rules to carry out responsibilities within the past four (4) quarters.</p> <p>Findings:</p> <p>1. Review of the center's MS rules and bylaws, indicated to last be</p>	S000730	<p>monitoring shall occur on at least a monthly basis and will be documented on a Surveillance Tool. (Attachment C)</p> <p>If 100% compliance is not achieved, re-education shall occur and the monitoring process will start over. The results of all audits will be tabulated and presented to the QAPI Committee on a quarterly basis for review and recommendations. Recommendations will be presented to the Governing Body quarterly for review and approval. 10-03-2014</p> <p>410 IAC 15-2.5.4 MEDICAL STAFF, ANESTHESIA AND SURGICAL PLAN OF CORRECTION: The Center's Governing Body will ensure that it assumes full legal responsibility for determining, implementing and monitoring policies governing the Center's total operation. The Center's Governing Body will ensure that a Medical Staff representation is present at the annual Medical Staff meeting. SYSTEMIC CHANGES: The Governing Body has amended the Medical Staff Bylaws to reflect that representation from the Medical Staff will be in attendance at the annual Continued from page 5 Medical Staff meeting. RESPONSIBLE PARTY AND MONITORING: The Chairman of the Governing Body will be</p>	09/22/2014

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S001010	<p>approved 2/11/14, in section 1.4 Meetings indicates the full MS shall meet at least annually ...and in section 1.5 Quorum and Voting; majority of the MS shall constitute a quorum ...</p> <p>2. Review of the document titled List of Doctors, provided by A1 as the list of MS, indicated 23 physicians to be on the center's MS.</p> <p>3. Review of the center's meeting minutes titled Medical Staff Meeting indicated the following: 5/6/14 four (4) MS members present, 2/18/14 four (4) MS members present, 11/12/13 four (4) MS members present, and on 8/22/13 four (4) MS members present.</p> <p>4. In interview on 8/18/14 at 3:30pm employee A1 confirmed the meeting attendance did not meet the MS quorum requirement.</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</p>		<p>responsible for ensuring that the Governing Body oversees and is accountable for the adoption of bylaws and function according to those bylaws. 09-22-2014</p>	

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	<p>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 and observation, the facility failed to ensure anesthesia staff adhered to the medication administration policy in 2 instances.</p> <p>Findings include:</p> <p>1. Facility policy titled "MEDICATION Administration" last reviewed/revised 9/13/12 states on page 1: "Prior to the administration of any medication, patients are identified using two (2) identifiers. These identifiers may include, but are not limited to: the patient's name, an assigned identification number, date of birth, or other person specific identifier."</p> <p>2. During observation of care provided to patient #30 beginning at 10:10 a.m. on 8/19/14, the following was observed:</p> <p>(A) Anesthesia provider #1 administered two (2) different medications to patient #30 without identifying the patient per policy prior to the administration of the medication.</p>	S001010	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES</p> <p>PLAN OF CORRECTION: The Center will ensure that drugs are prepared and administered according to established policies and acceptable standards of practice.</p> <p>IMMEDIATE ACTION: All caregivers at the Center will comply with safe medication administration practices including the use of unique patient identifiers that are consistently used throughout care.</p> <p>SYSTEMIC CHANGES Safe Medication Administration Practices will be reviewed with each caregiver with the expectation Continued from page 6 of 100% compliance.</p> <p>1) Center policy "Administration of Medication " has been reviewed with all clinical Center Staff to ensure understanding of the policy.</p> <p>2) The article "Syringe Swaps in the OR Still Harming Patients" has been reviewed with all clinical Center staff .</p> <p>3) The Article "Patient Identification & Medication Administration." (Attachment D)</p> <p>RESPONSIBLE PARTY AND MONITORING: The Center Director is responsible for monitoring compliance with Drug Administration. The Center Director or their designee will coordinate a minimum of 10 unannounced observations of safe medication administration practices to include all aspects of policy and all caregivers for the next three weeks. Each variance will be addressed with the individual at the time of occurrence and tracked in a blinded report for trending. Trended behavior will be addressed individually for causes. If 100% compliance is achieved, ongoing monitoring shall occur on at least a monthly basis and will be documented on the Environment of Care If 100% compliance is not achieved, re-education shall occur and the monitoring process will start over. The results of all audits will be tabulated and presented to the QAPI Committee on a quarterly basis for review and recommendations. Recommendations will be presented to the Governing Body quarterly for review and approval. 09-16-2014</p>	09/16/2014	

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S001198	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the facility failed to coordinate emergency disaster and preparedness with an appropriate governmental agency on a regular basis.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of facility documents for calendar year 2013 and the first 2 quarters of 2014 indicated no documentation for coordination of emergency disaster and preparedness with an appropriate governmental agency. Review of a document on letter head from the local Emergency Management Agency (EMA) dated 6/22/09 indicated the center agreed to be an active 	S001198	<p>410 IAC 15-2.2-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE</p> <p>The ASC will maintain a written disaster preparedness plan that provides for the emergency care of patients, staff, and others in the facility in the event of fire, natural disaster, functional failure of equipment or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. The emergency and disaster plan will be coordinated with appropriate community, state and federal agencies.</p> <p>PLAN OF CORRECTION: The Eyecare Consultants Surgery Center has contacted the Indiana State Department of Health on 9/16/2014 for coordination of emergency preparedness.</p> <p>The staff have been in-serviced on the Emergency Management Disaster Preparedness Plan and Disaster Preparedness Management Policy.</p> <p>RESPONSIBLE PARTY AND MONITORING: The Center Director is responsible for ensuring compliance with the Disaster Preparedness Plan requirements. The Center Director will be responsible for updating the Disaster Preparedness as changes are needed. Compliance to process will be monitored during the annual policy review function of the QAPI Committee.</p> <p>Recommendations will be submitted to the Governing Body to review and approve at that time. 09-16-2014</p>	09/16/2014

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	<p>participant in the City-County Comprehensive Emergency Management Plan. No further documentation of participation was provided.</p> <p>3. In interview on 8/19/14 at 11:45am, employee A1 indicated the ASC has not regularly participated with a community, state or federal agency for emergency and disaster preparedness. No further documentation was provided prior to exit.</p>				