

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001020	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/12/2013
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NAME OF PROVIDER OR SUPPLIER  NOVAMED EYE SURGERY CENTER OF NEW ALBANY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W FIRST ST NEW ALBANY, IN 47150
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Q000000	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 005401</p> <p>Survey Date: 12/11/2013 through 12/12/2013</p> <p>Surveyors: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 12/18/13</p>	O000000		
Q000061	<p>416.42(a)(1) ANESTHETIC RISK AND EVALUATION A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.</p> <p>Based on observation and document review, the facility failed to ensure an assessment was performed by a physician prior to surgery for 2 patients</p>	O000061	Physicians will assess each patient in the pre-op area prior to surgery and sign off on the CRNA assessment. A Governing Board/Medical Advisory	01/28/2014

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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Q000181	<p>(patients #28 and #29).</p> <p>Findings include:</p> <p>1. Facility policy titled "STANDARDS FOR ANESTHESIA CARE" last reviewed/revised 4/29/13 states under pre-anesthesia care on page 1: "2. A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed....."</p> <p>2. During observations beginning at 11:00 a.m. on 12/12/13, the following was observed: (A) Patients #28 and #29 were examined by a nurse anesthetist (CRNA) prior to surgery and not a physician.</p> <p>3. Staff member #1 indicated in interview at 4:00 p.m. on 12/12/13 that the facility utilizes the CRNA for pre-operative assessments of the patient and not a physician.</p> <p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on observation, staff interview, and document review, the facility failed to dispose of expired or unusable medications for 2 of 2 drug cabinets, 1</p>	O000181	<p>Committee meeting will be held on January 27, 2014. The State Report regarding deficiencies and plans of correction will be discussed at that time. The physicians will be informed of their obligations for patient assessment at that time. The Administrator and Director of Nursing will monitor for compliance.</p> <p>On 12/13/2013 the crash cart, medication refrigerator, and drug storage cabinets were inspected and reviewed by the Infection Control Nurseto assure outdates</p>	12/27/2013			

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	<p>crash cart, and one (1) medication refrigerator and failed to ensure controlled substances were counted and verified per facility policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation of medications within the crash cart at 1:30 p.m. on 12/12/13 indicated the cart had one (1) bag of .9% Sodium Chloride that expired 10/13, one (1) multi-dose vial of Flumazenil .5 mg/5 ml that had 3/4 of contents used and was dated as opened on 10/2/13 &gt; 28 days.</li> <li>2. Observation of the drug storage cabinet within the post operative area beginning at 1:40 p.m. on 12/12/13 indicated the cabinet contained one (1) bottle of Methazolamide with an expiration date of 11/13.</li> <li>3. Observation of a second drug storage cabinet within the pre-post operative area beginning at 1:45 p.m. on 12/12/13 indicated the cabinet contained thirty nine (39) boxes of Refresh Optive eye drops with an expiration date of 10/13.</li> <li>4. Observation of the medication refrigerator beginning at 1:50 p.m. on 12/12/13 indicated the refrigerator contained &gt; 20 syringes of Shugarcaine</li> </ol>		<p>had been removed. Outdated medications were disposed of according to policy. On 12/26/2013, the Infection Control Nurse was counseled by the Administrator and Director of Nursing regarding outdated and opened medication vials. The Infection Control Nurse agreed to compliance and better documentation. The Director Of Nursing will oversee the monthly checks. On December 16, 2013, the Director of Nursing met with staff members and the CRNA to educate them on the controlled substance protocol. Going forward there will be 2 nurses counting in and out on narcotics. Wastes of controlled substances were also discussed and confirmed that there will be 2 nurses signing a waste. The Director of Nursing and the Pharmacy consultant will monitor for compliance.</p>		

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	<p>which was labeled "store in freezer".</p> <p>5. Staff member #1 indicated in interview at the time of observations that the Shugarcaine could be stored in the refrigerator for a period of 3 days and had been pulled for M.D. #2 cases the previous day.</p> <p>6. Review of the schedule indicated that M.D. #2 had no procedures planned on 12/12/13 and 12/13/13, therefore the medication was not going to be administered within the timeframe of 3 days.</p> <p>7. Facility policy titled "CONTROLLED SUBSTANCES" last reviewed/revised 4/29/13 states under policy: "Inventories will be counted, verified, and co-signed by a Registered Nurse and another licensed professional at the beginning and at the end of the work day."</p> <p>8. Review of the controlled substance log book indicated that there were dates including, but not limited to 8/17 and 12/12/13 that the controlled substances were checked by only one individual.</p> <p>9. Anesthesia provider #1 indicated in interview at 3:00 p.m. on 12/12/13 that he/she completed the controlled</p>			

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Q000241	<p>substance count himself/herself this a.m.</p> <p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.</p> <p>Based on observation and document review, the facility failed to provide a sanitary environment and an environment that minimized risk to patients in the pre-operative area, operating room, and recovery area.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>According to the Centers for Medicare and Medicaid Services (CMS), Blood glucose meters can become contaminated with blood and, if used for multiple residents, must be cleaned and disinfected after each use.</li> <li>Review of the 2013 Glucometer Cleaning report indicated there were 10 Blood Glucose tests performed on</li> </ol>	O000241	<p>On December 26, 2013, the Infection Control Nurse was counseled by the Administrator and the Director of Nursing regarding the Glucometer Cleaning Protocol. It was stressed that going forward, the cleaning documentation must coincide with patient use as well as routine disinfection. The Infection Control Nurse agreed to compliance and better documentation. The Director of Nursing will monitor the checklist protocol. On December 16, 2013, the pre-op staff and CRNA was counseled by the Director of Nursing regarding the stethoscope storage and infection control practices. The prefilled syringes were also addressed at that time regarding storage and handling. Any syringes dropped will be discarded. The Director of Nursing will monitor the infection control practices of the staff and CRNA. On December 26, 2013, the Infection Control Nurse was counseled by the Administrator and Director of Nursing regarding the patient nutrition refrigerator</p>	01/02/2014

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	<p>patients in 2013 and revealed the glucometer was not disinfected after being used on 8 of the 10 patients.</p> <p>3. At 3:00 PM on 12/12/2013, staff member A2 confirmed the documentation provided revealed the meters were not being disinfected after every patient use.</p>		<p>cleaning, maintenance, and documentation. The Infection Control Nurse agreed to compliance and adherence to accurate documentation. The Director of Nursing will monitor compliance. On December 16, 2013 the Recovery Room /Infection Control Nurse inspected the recovery area medication cabinet as well as the crash cart for outdated medications. All outdates were disposed according to policy and the expired airway on the crash cart was replaced. The Recovery Room/ Infection Control Nurse was counseled regarding her job descriptions and Infection Control policies by the Administrator and Director of Nursing. The Director of Nursing will monitor for compliance. On December 11, 2013 the O2 tanks were relocated to a designated storage area. The Director of Nursing will monitor compliance. On December 26, 2013, the Infection Control Nurse was counseled by the Administrator and Director of Nursing regarding the cleaning protocol and accurate documentation of the patient nutrition refrigerator. The Infection Control Nurse agreed to compliance and accurate documentation. The Director of Nursing will monitor the compliance. On December 26, 2013 the Recovery Room/Infection Control Nurse was counseled by the</p>		

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	<p>4. During observations beginning at 11:00 a.m. on 12/12/13, the following infection control issues were observed:</p> <p>(A) At 12:00 p. m. on 12/12/13, anesthesia provider #1 entered the pre-operative room to assess a patient. He/she utilized a stethoscope that was stored on top of a sharps container to assess the patient. His/her clipboard containing a small plastic tray of pre-filled syringes fell into the handwashing sink with one (1) of the syringes actually falling into the sink. The clipboard and tray of syringes were utilized throughout the day.</p> <p>(B) Anesthesia provider #1 came into the operating room to assess</p>		<p>Administrator and Director of Nursing regarding the Anesthesia Equipment and Supplies Checklist. The need for accurate documentation of the daily assessment is imperative and will be closely monitored for completion. The Recovery Room /Infection Control Nurse will oversee this monitoring and documentation. The Director of Nursing will monitor the compliance.</p>				

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	<p>patient #28 after the procedure and placed the small plastic tray of pre-filled syringes on the operating room floor to assess the patient.</p> <p>(C) The patient nutrition refrigerator in the recovery area was soiled with numerous spills.</p> <p>(D) In the medication cabinet in the recovery area, there was one (1) bottle of hydrogen peroxide topical solution with an expiration date of 1/11 and one (1) box of lancets with an expiration date of 4/13.</p> <p>(E) There were eight (8) O2 tanks stored in the soiled utility room.</p> <p>(F) The crash cart contained only one (1) laryngeal airway device. The device expired 11/13.</p> <p>5. Facility policy titled "INFECTION CONTROL 50.3 Cleaning" last reviewed/revised 4/29/13 states on page 5: "Patient nourishment refrigerators are cleaned weekly and food checked and removed if outdated."</p>			

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	<p>6. Review of facility log titled "REFRIGERATOR CLEANING LOG 2013" indicated the recovery room nurse had been the individual cleaning the refrigerator throughout the year, however the month November and December were blank.</p> <p>7. Review of facility document titled "ANESTHESIA EQUIPMENT AND SUPPLIES CHECKLIST" for the month of December indicated that the anesthesia cart was checked by the recovery room nurse on 12/2/13, 12/3/13, and 12/9/13.</p> <p>5. Staff member #1 verified that the refrigerator log sheet was blank at 4:00 p.m. on 12/12/13.</p>						

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Q000242	<p>416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. Based on document review, the facility failed to ensure the infection control officer was responsible for the infection control activities within the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The infection control officer (staff member #N4) indicated in writing on the infection control document request that he/she is "not involved" in establishing techniques and systems for identifying, reviewing, and reporting infections, reviewing employee exposure incidents and making appropriate recommendations to minimize risk, nor reviewing and recommending changes in procedures, policies and programs.</li> <li>2. Review of the job description for the infection control officer indicated that he/she was responsible for the above. The job description was signed by staff member #N4 on 5/22/12.</li> </ol>	O000242	<p>On December 26, 2013, the Infection Control Nurse was counseled by the Administrator regarding the Job Description for the Infection Control Officer and the infection control activities within the facility. It was explained to the Infection Control Nurse that she would be responsible for identifying, reviewing, reporting infections, and exposure incidents to make recommendations to minimize risk. The Infection Control Nurse confirmed her understanding of these job requirements and will comply. The Director of Nursing will monitor for compliance and documentation. The Infection Control Nurse will be trained on January 6, 2014 to compile the Complication Reports and provide accurate documentation. The Director of Nursing will monitor the training and compliance.</p>	01/09/2014			

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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005401</p> <p>Survey Date: 12/11/2013 through 12/12/2013</p> <p>Surveyors:</p> <p>Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/18/13</p>	S000000			

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S000010	<p>410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a)</p> <p>Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules.</p> <p>Based on documentation review and staff interview, the facility failed to ensure 5 of 5 transportation drivers had a Public Passenger Chauffeurs License as required by policy and state law (A3, A4, A5, A6, and A7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Position Description for Drivers (last approved 7/25/2011) indicated the drivers are to have a clean record, valid state Driver License, chauffeur license, etc., as required by state regulation.</li> <li>2. The personnel records for A3, A4, A5, A6, and A7 did not evidence the drivers had a Pubic Passenger Chauffeur License.</li> <li>3. At 9:30 AM on 12/12/2013, staff member A3 indicated none of</li> </ol>	S000010	<p>The Clinical Director met with the Director of Transportation on December 19, 2013 to determine a plan for educating drivers to acquire the Public Passenger Chauffeurs License. The transportation director will complete his training and acquire a Public Passenger Chauffeurs License by January 31, 2013. He will then be able to instruct and educate the drivers for their completion of such license. The February 28, 2014 has been chosen so the drivers will have sufficient time to obtain the physical required by the Department of Transportation. From this time forward, any new driver will be required to hold a Public Passenger Chauffeurs License prior to employment.</p>	02/28/2014			

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S000400	<p>his/her drivers have a Public Passenger Chauffeur License.</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 and document review, the facility failed to provide a sanitary environment and an environment that minimized risk to patients in the pre-operative area, operating room, and recovery area.</p> <p>Findings include:</p> <p>1. During observations beginning at 11:00 a.m. on 12/12/13, the following infection control issues were observed: (A) At 12:00 p. m. on 12/12/13, anesthesia provider #1 entered the pre-operative room to assess a patient. He/she utilized a stethoscope that was stored on top of a sharps container to assess the patient. His/her clipboard containing a small plastic tray of pre-filled syringes fell into the</p>	S000400	<p>On December 16, 2013, the pre-op staff and CRNA were counseled by the Director of Nursing regarding the stethoscope storage and infection control practices. The prefilled syringes were also addressed at that time regarding storage and handling. Any syringes dropped will be discarded. The Director of Nursing will monitor the infection control practices of the staff and CRNA. On December 26, 2013 the Infection Control Nurse was counseled by the Administrator and Director of Nursing regarding the patient nutrition refrigerator cleaning, maintenance, and documentation. The Infection Control Nurse agreed to compliance and adherence to accurate documentation. The Director of Nursing will monitor compliance and documentation. On December 13, 2013, the</p>	12/16/2013

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	<p>handwashing sink with one (1) of the syringes actually falling into the sink. The clipboard and tray of syringes were utilized throughout the day.</p> <p>(B) Anesthesia provider #1 came into the operating room to assess patient #28 after the procedure and placed the small plastic tray of pre-filled syringes on the operating room floor to assess the patient.</p> <p>(C) The patient nutrition refrigerator in the recovery area was soiled with numerous spills.</p> <p>(D) In the medication cabinet in the recovery area, there was one (1) bottle of hydrogen peroxide topical solution with an expiration date of 1/11 and one (1) box of lancets with an expiration date of 4/13.</p> <p>(E) There were eight (8) O2 tanks stored in the soiled utility room.</p> <p>(F) The crash cart contained only one (1) laryngeal airway device. The device expired 11/13.</p> <p>2. Facility policy titled "INFECTION CONTROL 50.3 Cleaning" last reviewed/revised 4/29/13 states on page 5: "Patient nourishment refrigerators are cleaned weekly and food checked and removed if outdated."</p> <p>3. Review of facility log titled "REFRIGERATOR CLEANING LOG</p>		<p>Recovery Room/Infection control Nurse inspected the recovery area medication cabinet as well as the crash cart for outdates. All outdates were disposed according to policy, the expired airway was replaced. The recovery room/infection control nurse was counseled by the Administrator and Director of Nursing regarding her job descriptions and infection control policies. The Director of Nursing will monitor for compliance. On December 11, 2013, the O2 tanks were relocated to a designated storage area. The Director of Nursing will monitor compliance. On December 26, 2013 the Infection Control Nurse was counseled by the Administrator and Director of Nursing regarding the cleaning protocol and documentation of the patient nutrition refrigerator. The Infection Control Nurse agreed to compliance and accurate documentation. The Director of Nursing will monitor the compliance and documentation. On December 26, 2013 the Recovery Room/Infection Control Nurse was counseled by the Administrator and Director of Nursing regarding the Anesthesia Equipment and Supplies Checklist. The need for accurate documentation of the daily assessment is imperative and will be closely monitored for completion. The</p>				

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S000408	<p>2013" indicated the recovery room nurse had been the individual cleaning the refrigerator throughout the year, however the month November and December were blank.</p> <p>4. REVIEW of facility docuemnt titled "ANESTHESIA EQUIPMENT AND SUPPLIES CHECKLIST" for the month of December indicated that the anesthesia cart was checked by the recovery room nurse on 12/2/13, 12/3/13, and 12/9/13.</p> <p>5. Staff member #1 verified that the refrigerator log sheet was blank at 4:00 p.m. on 12/12/13.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(d)</p> <p>(d) The center shall designate a person qualified by training or experience as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on document review, the facility failed to ensure the infection control officer was responsible for the infection control activities within the facility.</p> <p>Findings include:</p>	S000408	<p>Recovery Room/Infection Control Nurse will oversee this monitoring and documentation. The Director of Nursing will monitor the compliance.</p> <p>On December 26, 2013 the Infection Control Nurse was counseled by the Administrator and the Director of Nursing regarding the job description for the Infection Control Officer and the infection control activities within the facility. It was</p>	01/06/2014			

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	<p>1. The infection control officer (staff member #N4) indicated in writing on the infection control document request that he/she is "not involved" in establishing techniques and systems for identifying, reviewing, and reporting infections, reviewing employee exposure incidents and making appropriate recommendations to minimize risk, nor reviewing and recommending changes in procedures, policies and programs.</p> <p>2. Review of the job description for the infection control officer indicated that he/she was responsible for the above. The job description was signed by staff member #N4 on 5/22/12.</p>		<p>explained to the Infection Control Nurse that she would be responsible for identifying, reviewing, reporting infections, and exposure incidents to make recommendations to minimize risk. The Infection Control Nurse confirmed her understanding of these job requirements and will comply. The Director of Nursing will monitor for compliance and documentation. The Infection Control Nurse will be trained on January 6, 2014 to compile the Complication Reports and provide accurate documentation. The Director of Nursing will monitor the training and compliance.</p>		

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S000414	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on document review and staff interview, the facility failed to ensure infection control meetings were conducted on a quarterly basis.</p> <p>Findings include:</p> <p>1. Review of infection control meeting minutes for previous 12 months indicated there have been only 2 meetings in 2013. The facility had a</p>	S000414	On December 16, 2013 the Director of Nursing met with the Infection Control Nurse regarding the necessity of quarterly infection control meetings. A meeting was scheduled and held on December 26, 2013. It was decided that the quarterly meeting will be held on the 4th Thursday of the last month of each quarter. The Infection Control Nurse will schedule an agenda and hold these quarterly meetings. The Administrator, Director of	12/26/2013			

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S000432	<p>meeting on 3/12/13 and on 6/10/13.</p> <p>2. Staff member #2 verified the above in interview at 4:35 p.m. on 12/12/13.</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 documentation review and staff interview, the facility failed to disinfect the Blood Glucose meters after each use.</p> <p>Findings included:</p> <p>1. According to the Centers for Medicare and Medicaid Services (CMS), Blood glucose meters can become contaminated with blood and, if used for multiple residents,</p>	S000432	<p>Nursing, and Medical Director will monitor the compliance.</p> <p>On December 26, 2013, the Infection Control Nurse was counseled by the Administrator and the Director of Nursing regarding the Glucometer Cleaning Protocol. It was stressed that going forward, the cleaning documentation must coincide with patient use as well as routine disinfection. The Infection Control Nurse agreed to compliance and better documentation. The Director of Nursing will monitor the checklist protocol.</p>	12/26/2013	

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	<p>must be cleaned and disinfected after each use.</p> <p>2. Review of the 2013 Glucometer Cleaning report indicated there were 10 Blood Glucose tests performed on patients in 2013 and revealed the glucometer was not disinfected after being used on 8 of the 10 patients.</p> <p>3. At 3:00 PM on 12/12/2013, staff member A2 confirmed the documentation provided revealed the meters were not being disinfected after every patient use.</p>				

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S000444	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</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>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on document review, observation, and staff interview, the facility failed to follow policy related to mask use for one day of observation.</p> <p>Findings include;</p> <p>1. Facility policy titled "DRESS CODE FOR CLINICAL AREAS" last reviewed/revised 4/29/13 states on page 2: "d. Masks.....They are not to be dangling from the neck. Masks must be changed after each procedure, when wet or contaminated, and when leaving restricted areas."</p> <p>2. During observations in the pre-operative, operative, and post operative area beginning at 11:00 a.m. on 12/12/13, numerous staff members</p>	S000444	<p>Separate meetings with staff and physicians were held to inform them of the policy regarding surgical mask. All were instructed to change their masks after each procedure, or when wet, contaminated, or leaving a restricted area. The Infection Control Nurse and the Director of Nursing will monitor for compliance.</p>	12/19/2013

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S000840	<p>including, but not limited to, M.D. #1, staff member #N3, N10 and anesthesia provider #1 were observed wearing a mask throughout the day and not changing it between cases, wearing the mask into unrestricted patient care areas from the restricted area, and leaving mask dangling from their neck.</p> <p>3. Staff member #N3 indicated in interview at 1:45 p.m. on 12/12/13 that he/she changes his/her mask "every 5 cases or so."</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(2)</p> <p>(c) The anesthesia service is responsible for all anesthesia administered in the center as follows:</p> <p>(2) A requirement that anesthesia equipment must be checked for operational readiness and safety prior to patient administration. Documentation to that effect shall be included in the patient's medical record.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the Recovery Anesthesia Equipment and</p>	S000840	On December 26, 2013 the Recovery Room/Infection Control Nurse was counseled by the Administrator and Director of Nursing regarding the Anesthesia Equipment and Supplies	01/02/2014			

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	<p>Supplies Checklist was completed as per policy.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Routine Duties of Admitting/Recovery Area Personnel policy (Last approved April 29, 2013) requires the Code Carts to be checked daily for all supplies listed on the Anesthesia Equipment and Supplies Checklist are on the cart, all equipment work appropriately, and there are no outdates. All items are to be recorded on the checklists.</li> <li>2. The Anesthesia Equipment and Supplies Checklists were reviewed for 2013. The facility only provided 14 records from the Recovery Department. Nine of the 14 records that were provided were also incomplete.</li> <li>3. At 2:00 PM on 12/12/2013, staff member A2 confirmed the facility could only provide approximately 6% Anesthesia</li> </ol>		<p>Checklist. The need for accurate documentation of the daily assessment is imperative and will be closely monitored for completion. The Recovery Room /Infection Control Nurse will oversee this monitoring and documentation. The Director of Nursing will monitor the compliance.</p>		

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S001006	<p><b>Equipment and Supplies Checklists for the Recovery Department for 2013.</b></p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(2)</p> <p>Pharmaceutical services must have the following:</p> <p>(2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed.</p> <p>Based on document review and staff interview, the facility failed to ensure controlled substances were counted and verified per facility policy.</p> <p>Findings include:</p> <p>1. Facility policy titled "CONTROLLED SUBSTANCES" last reviewed/revised 4/29/13 states under policy: "Inventories will be counted, verified, and co-signed by a Registered Nurse and another licensed professional at the beginning and at the end of the work day."</p> <p>2. Review of the controlled substance log book indicated that there were dates including, but not limited to 8/17 and 12/12/13 that the controlled substances were checked by only one individual.</p>	S001006	<p>On December 16, 2013, the Director of Nursing met with staff members and the CRNA to educate them on the controlled Substance Protocol. Going forward there will be 2 Nurses counting in and out on narcotics. Wastes of controlled substances were also discussed and confirmed that there will be 2 nurses signing a waste. The Director of Nursing and the Pharmacy consultant will monitor for compliance.</p>	12/17/2013

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S001012	<p>3. When asked, anesthesia provider #1 indicated in interview at 3:00 p.m. on 12/12/13 that he/she completed the controlled substance count himself/herself this a.m.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(B)</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>(B) Drug administration according to established center policies and acceptable standards of practice.</p> <p>Based on observation, staff interview, and document review, the facility failed to dispose of expired or unusable medications for 2 of 2 drug cabinets, 1 crash cart, and one (1) medication refrigerator.</p> <p>Findings include:</p> <p>1. Observation of medications within the crash cart at 1:30 p.m. on 12/12/13 indicated the cart had one (1) bag of .9% Sodium Chloride that expired 10/13, one</p>	S001012	<p>On December 16, 2013, the Director of Nursing spoke with staff regarding the outdated medications in the cabinet and crash cart, as well as expired eye drops in the pre-post op areas. Policy states that multidose medications vials may be used up to 28 days after opening. The opened and outdated medications were disposed of according to policy. The cabinets and cart will be checked by Recovery Room and Pre-op staff members monthly for outdates. The Director of Nursing and Pharmacy</p>	01/02/2014

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	<p>(1) multi-dose vial of Flumazenil .5 mg/5 ml that had 3/4 of contents used and was dated as opened on 10/2/13 &gt; 28 days.</p> <p>2. Observation of the drug storage cabinet within the post operative area beginning at 1:40 p.m. on 12/12/13 indicated the cabinet contained one (1) bottle of Methazolamide with an expiration date of 11/13.</p> <p>3. Observation of a second drug storage cabinet within the pre-post operative area beginning at 1:45 p.m. on 12/12/13 indicated the cabinet contained thirty nine (39) boxes of Refresh Optive eye drops with an expiration date of 10/13.</p> <p>4. Observation of the medication refrigerator beginning at 1:50 p.m. on 12/12/13 indicated the refrigerator contained &gt; 20 syringes of Shugarcaine which was labeled "store in freezer".</p> <p>5. Staff member #1 indicated in interview at the time of observations that the Shugarcaine could be stored in the refrigerator for a period of 3 days and had been pulled for M.D. #2 cases the previous day.</p> <p>6. Review of the schedule indicated that M.D. #2 had no procedures planned on</p>		<p>consultant will monitor the compliance. The Shugarcaine which was labeled "store in freezer" was mistakenly pulled for cases. The unused syringes were discarded. Staff was reminded to only pull the amount needed for the day. The Director, Recovery Room Nurse, and OR nurses will monitor for compliance. Recovery Room nurses were educated on the monitoring of medication outdates and our pharmacy formulary which does not include any sample medications. It was re-iterated to the staff that the surgery center does not dispense any medications.</p>				

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S001026	<p>12/12/13 and 12/13/13, therefore the medication was not going to be administered within the timeframe of 3 days.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)(i)</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>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(i) Drug cabinets must be accessible only to authorized personnel.</p> <p>Based on document review, the facility failed to ensure a second witness wasted controlled substances for 1 controlled substance log book reviewed.</p> <p>Findings include:</p> <p>1. Review of the controlled substance log book had instances where the controlled substance wastage had no witness including, but not limited to:</p>	S001026	<p>On December 16, 2013, the Director of Nursing met with staff members and the CRNA to educate them on the controlled Substance Protocol. Going forward there will be 2 Nurses counting in and out on narcotics. Wastes of controlled substances were also discussed and confirmed that there will be 2 nurses signing a waste. The Director of Nursing and the Pharmacy consultant will monitor for compliance</p>	12/16/2013	

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	(A) On 8/7/13, Versed 2 mg was wasted by one (1) staff member only. (B) On 10/11/13, Versed 3 mg was wasted by one (1) staff member only. (C) On 11/21/13, a total of Versed 5 mg and Fentanyl 50 mg was wasted by one (1) staff member only.				