

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001174	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/15/2015
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NAME OF PROVIDER OR SUPPLIER METRO SPECIALTY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MISSOURI AVE, BLDG 18 JEFFERSONVILLE, IN 47130
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Q 0000 Bldg. 00	This visit was for recertification of an ambulatory surgery center. Dates of survey: 7/13/15 through 7/15/15 Facility number: 012244 QA: cjl 08/04/15	Q 0000	NOT REQUIRED	
Q 0043 Bldg. 00	416.41(c) DISASTER PREPAREDNESS PLAN (1) The ASC must 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. (2) The ASC coordinates the plan with State and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan. Based on document review and interview, the Safety Management Program (SMP) failed to coordinate with a community, state, or federal agency between 2010 and 2015. Findings:	O 0043	Metro Specialty has enrolled as a triage center for Clark County disaster preparedness and abides by the Guidelines for Specific Disasters provided by Clark County (attached). This is reflected in the P&P (attached). The administrator is responsible for 1)being facility contact person	08/31/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 0082 Bldg. 00	<p>1. Review of facility documents between 4/2010 and 7/2015 lacked evidence of coordination with a community, state, or federal agency for disaster preparedness.</p> <p>2. On 3/15/15 at 1:15pm, A1, Administrator, indicated the facility had not coordinated disaster preparedness with any outside agency.</p> <p>416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.</p> <p>(b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care.</p> <p>(c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.</p> <p>(c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies. Based on document review and interview, the Quality Assurance Performance Improvement (QAPI)</p>			O 0082	<p>2)maintaining Disaster Plan binder in office. This entire program will be in place 8/31/15 and will be reviewed annually. Clark County will send out a quarterly practice phone call to the administrator.</p> <p>On 7/30/15 the Metro QA/PI plan was reviewed by the administrator and monitors were selected (see attachment). The first QA/PI</p>		09/17/2015

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	<p>program failed to incorporate quality indicator data for monitors from 5/2014 through 7/2015.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the document titled The Quality Assessment Performance Improvement (QAPI) Plan, indicated Data Collection to include, but not limited to, the following: Performance improvement priorities identified by the governing board; follow-up and trending of unacceptable or unexpected patient outcomes such as hospital transfers, medication error, complications, etc.,; variances identified in patient care services; assessment of care and timeliness of services; a minimum of 1 study completed each quarter with a focus on clinical, administrative and cost of care issues, as well as on actual patient outcomes. The plan was approved 1/7/14. 2. Review of QAPI documentation between 5/2014 and 7/2015 lacked evidence of data collection or monitoring, by the QAPI committee. 3. On 7/15/15 at 11:45am, A1, Administrator, indicated evidence of data collection for selection of monitors, identification of opportunities for 		<p>committee meeting is scheduled for 8/24/2015 and will be held quarterly thereafter as organized by the administrator. Monitors will be evaluated quarterly for appropriateness. Quarter 3 data will be reported to the Board of Managers and Med Exec Committee at the next members meeting on 9/17/15. QA/PI program will be overseen and implemented by the Administrator.</p>				

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Q 0083 Bldg. 00	<p>improvement, and analysis of monitors was not available and had not been incorporated into committee activity.</p> <p>416.43(d) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.</p> <p>(2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results Based on document review and interview, the Center failed to ensure that a quality improvement project was in place within the past year.</p> <p>Findings:</p> <p>1. Review of the document titled The Quality Assessment Performance Improvement (QAPI) Plan, indicated a minimum of 1 performance improvement (PI) study was to be completed each quarter with a focus on clinical, administrative and cost of care issues, as well as on actual patient outcomes. The plan was approved 1/7/14.</p> <p>2. Review of QAPI documentation between 5/2014 and 7/2015 lacked</p>	O 0083	<p>Administrator will identify patient care area for Quality Study. Quality Study will be completed by 9/15/15 and reported to the Board of Managers and Med Exec Committee at next meeting on 9/17/15. Quality monitoring and improvement studies will be ongoing and reported quarterly per policy. This program will be overseen and implemented by the administrator.</p>	09/17/2015	

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Q 0084 Bldg. 00	<p>evidence of an active performance improvement study.</p> <p>3. On 7/15/15 at 12:00pm, A1, Administrator, indicated no evidence of a current or active PI study was available.</p> <p>416.43(e) GOVERNING BODY RESPONSIBILITIES The governing body must ensure that the QAPI program-</p> <p>(1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.</p> <p>Based on document review and interview, the Governing Body (GB) failed to ensure the Quality Assurance Performance Improvement (QAPI) program addressed and evaluated priorities for improvement or implemented activities on an ongoing basis between 5/2014 and 7/2015.</p> <p>Findings:</p> <p>1. Review of the document titled The Quality Assessment Performance</p>	O 0084	<p>Quarter three quality data will be reported by the administrator to the Board of Managers and Medical Executive Committee at the next meeting, 9/17/2015 and will be documented in the meeting minutes. This is an ongoing program that will be maintained quarterly and per policy. This program will be overseen by the administrator. (See attachments)</p>	09/17/2015

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	<p>Improvement (QAPI) Plan, indicated the following: The QAPI committee will report at least quarterly to the Board of Managers. A minimum of 1 performance improvement (PI) study to be completed each quarter with a focus on clinical, administrative and cost of care issues, as well as on actual patient outcomes. The plan was approved 1/7/14.</p> <p>2. Review of documents titled Members Meeting, dated 5/5/15, 1/6/15, 9/9/14, and 5/7/14 indicated quality reports were provided on 5/5/15, 1/6/15, and 5/7/14. The documents lacked evidence of quality reports provided to the board between 5/7/14 and 1/6/15.</p> <p>3. Review of QAPI documentation between 5/2014 and 7/2015 lacked evidence of an active performance improvement study.</p> <p>3. On 7/15/15 at 12:00pm, A1, Administrator, indicated GB meeting minutes lacked evidence of the board reviewing quality reports between 5/2014 and 7/2015 and that no evidence of a current or active PI study was available.</p>			

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Q 0121 Bldg. 00	<p>416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel. Based on document review and interview, the center failed to ensure medical staff (MS) were appointed to their position and granted privileges in accordance with recommendation for 8 of 9 MS members (MD#1, MD#2, MD#3, MD#4, MD#6, AH#1, AH#2, & AH#3) and failed to maintain documentation of appropriate licensure of 1 physician (MD#6) and 2 Allied Health (AH#1 & AH#3).</p> <p>Findings:</p> <p>1. Review of the document titled Medical Staff Bylaws, Section V, indicated the following: Every two years...the category and privileges that should be granted for the ensuing two year period; shall be submitted to appropriate committees. The Medical Director shall notify each Staff member whether or not he/she has been reappointed to the Staff, stating the category and privileges granted. MS Bylaws were last approved 1/22/13.</p>	Q 0121	Credentialing files (MD, anesthesia and AHP) will be evaluated for completeness. All files will be completed and reappointments made by 9/15/2015. Reappointments will be reported at the 9/17/2015 meeting and documented in meeting minutes. A spreadsheet with all required documents and each practitioner will be created to consolidate expiration dates for easier visualization. The administrator will create "reminders" utilizing Outlook task manager which will alert her to expiring credentials, licenses or other items one month ahead of time. In addition to the spreadsheet and task reminders, 6 files (2 of each) will be audited monthly for completeness. Credentialing files are kept locked in administrators office and will be maintained by administrator.	09/15/2015			

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	<p>2. Review of the document titled Rules and Responsibilities of the Medical Staff indicated "Allied Health Professionals" shall refer to non-physician health care providers who: a) Do not hold a Doctor of Medicine or Doctor of Osteopathy...degree. b). Meet all applicable state and federal requirements for practice. The document indicated Qualifications as follows: Only an Allied Health professional holding a current, active license, certificate or other credentials as may be required by applicable state law...is eligible to...provide services. Only those Allied Health Professionals who have completed the application process and who have been granted specific privileges may practice in the facility. The facility lacked documentation of approval or review date of the document.</p> <p>3. Review of MS credential files for MD#1 - MD#6 & AH#1 - AH#3 indicated the following:</p> <p>a. Most recent appointment for MD#1 was 1/7/14, MD#1 requested and was granted privilege for 23 Hour Observation Admission on 5/7/14. The file lacked evidence of MD#1 being granted surgical privileges for this appointment.</p> <p>b. Most recent appointment for MD#2</p>			

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	<p>was 1/22/13 and surgical privileges were granted at that time. The file lacked evidence of reappointment or granting of privileges between 1/22/15 and 7/15/15.</p> <p>c. Most recent appointment for MD#3 was 1/22/13 and surgical privileges were granted at that time. The file lacked evidence of reappointment or granting of privileges between 1/22/15 and 7/15/15.</p> <p>d. Most recent appointment for MD#4 was 1/7/14, MD#1 requested and was granted privileges for 23 Hour Observation Admission and Interpretation of Fluoroscopy on 5/7/14. The file lacked evidence of MD#4 being granted surgical privileges for this appointment.</p> <p>e. Most recent appointment for MD#5 was 1/22/13 and surgical privileges were granted at that time. The file lacked evidence of reappointment or granting of privileges between 1/22/15 and 7/15/15.</p> <p>f. The file for MD#6 lacked evidence of appointment or granting of privileges for the center. The file lacked evidence of a license.</p> <p>g. The file for AH#1 lacked evidence of appointment or granting of privileges for the center. The file lacked evidence of AH#1 having an Indiana license.</p> <p>h. The file for AH#2 lacked evidence of appointment to the MS, but indicated privileges were granted 2/14/14.</p> <p>g. The file for AH#3 lacked evidence of</p>			

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	<p>appointment or granting of privileges for the center. The file lacked evidence of a license.</p> <p>4. Review of facility documents titled Cases by Surgeon - Summary Report, indicated MD#1, MD#2, MD#3, MD#4 and MD#5 each performed surgical procedures during 2014.</p> <p>5. Review of patient medical records indicated the following: AH#1 was the operating room assistant (ORA) for patient (Pt) # 29 on 7/13/15 and Pt#30 on 7/13/15. AH#3 was the ORA for Pt#27 on 6/4/15 and Pt#28 on 6/4/15.</p> <p>6. On 7/15/15 at 1:25pm, A1, Administrator, indicated MD#s 1-5 perform procedures in the center, MD#6 is contracted for anesthesia and should have approved appointment and privileges, AH#1 and AH#3 are First Assists for MD members and should be appointed and privileged. A1 verified lack of documentation for appointments, privileges, and State licensure.</p>			

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Q 0162 Bldg. 00	<p>416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ul style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on document review and staff interview, the medical staff failed to complete an operative note according to facility policy for 6 of 26 medical records reviewed (patients #6, 8, 11, 14, 19 and 20).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "REQUIRED DOCUMENTATION" last reviewed/revised 9/9/14 stated on page 92: "5. Operative Reports All patients undergoing surgical procedures at Metro 	Q 0162	Process for operative reports evaluated. Physicians in-serviced (during the week of 7/15/15) by business office manager on retrieving and electronically signing reports within 24 hour period. Signed reports set to autoprnt to facility printer. PACU RN places signed operative note on the chart after post-operative call. This will be evaluated monthly during nurse chart audits (5% or thirty charts, whichever greater) The process will be evaluated when compliance falls below 100% and will be overseen by the administrator.	09/15/2015

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	<p>Specialty Surgery Center require an operative report as part of the medical record. The operative report must be written or dictated immediately after an operative procedure."</p> <p>2. Review of medical records indicated the following: (A) Patient #6 had surgery on 3/6/15. The operative note was dictated on 3/9/15. (B) Patient #8 had surgery on 6/2/15. The medical record lacked an operative note. (C) Patient #11 had surgery on 6/2/15. The medical record lacked an operative note. (D) Patient #14 had surgery on 6/11/15. The operative note was dictated on 6/15/15. (E) Patient #19 had surgery on 6/8/15. The medical record lacked an operative note. (F) Patient #20 had surgery on 6/11/15. The medical record lacked an operative note.</p> <p>3. Staff member #02 verified the medical record information beginning at 12:25 p.m. on 7/15/15.</p>			

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Q 0181 Bldg. 00	<p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on document review and observation, the facility failed to follow medication administration policy and acceptable standard of practice for 1 of 2 observations.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "MEDICATION ADMINISTRATION" last reviewed/revised 9/9/14 stated under policy: "To provide a safe, effective administration of prescribed medications, all medications will be ordered, administered and recorded according to accepted standards of practice." 2. APIC (Association for Professionals in Infection Control) position paper titled "Safe injection, infusion, and medication vial practices in healthcare." states "Disinfect IV ports & vial stoppers by wiping and using friction with a sterile 70% isopropyl alcohol, ethyl/ethanol alcohol, iodophor, or other approved antiseptic swab. Allow port to dry before accessing....." and "Cleanse the access diaphragm of vials using friction with a sterile 70% isopropyl alcohol, ethyl/ethanol alcohol, iodophor, or other 			O 0181	<p>On 8/8/2015 a mandatory staff meeting was held (see attachment) and Safe Injection Practice policy and guidelines reviewed. Staff will periodically be monitored for compliance by Infection Control RN. Annual inservice on Safe Injection Practices will be documented in employee file. This requirement will be overseen by the Infection Control Nurse and Administrator.</p>		08/08/2015

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Q 0223 Bldg. 00	<p>approved antiseptic swab. Allow the diaphragm to dry before inserting any device into the vial....."</p> <p>3. During observation in the operating room beginning at 10:50 a.m. on 7/14/15, staff member #01 was observed drawing up medications x 3 without wiping the vial stopper of the medication vials with alcohol or other antiseptic wipe and was observed administering medications x 4 through an I.V. port without wiping the port with alcohol or other antiseptic wipe prior to the administration.</p> <p>416.50(b) NOTICE - PHYSICIAN OWNERSHIP The ASC must disclose, in accordance with Part 420 of this subchapter, and where applicable, provide a list of physicians who have financial interest or ownership in the ASC facility. Disclosure of information must be in writing. Based on document review and interview, the center failed to provide evidence of informing patients of physician ownership or financial interest in the facility prior to procedures for 30 of 30 patients (Pt) (Pt#'s 1-30).</p> <p>Findings:</p> <p>1. Review the policy & procedure (P&P)</p>	Q 0223	Business Office Manager updated patient acknowledgment form to include "your surgeon may have financial interest" These forms immediately replaced the old forms and patients sign them at check in. (See attachment)	07/16/2015			

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Q 0234 Bldg. 00	<p>1.01 titled Patient Rights and Responsibilities indicated within the PROCEDURE: #6. Patient Brochures which are provided to the patient prior to the day of surgery disclose the following:</p> <p>b. Physician ownership. The P&P was last approved 9/9/14.</p> <p>2. Review of medical records for Pt's#1 through 30 lacked evidence of the patients being informed of physician ownership/financial interest in the facility.</p> <p>3. On 7/14/15 at 11:00am, A2, Office Manager, verified lack of documentation of patient receipt of physician ownership/financial interest.</p> <p>416.50(g) CONFIDENTIALITY OF CLINICAL RECORDS The ASC must comply with the Department's rules for the privacy and security of individually identifiable health information, as specified at 45 CFR parts 160 and 164. Based on document review, observation, and interview, the center failed to ensure confidentiality of identifiable health information for 2 dictations.</p> <p>Findings:</p>	O 0234	Nurse administrator immediately instructed the front reception personnel to obtain signatures from all vendors during check-in on the "Metro Specialty Business Agreement" (attached). In addition, Metro has utilized the vendor credentialing service, Sympler, which went live	08/01/2015			

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	<p>1. Review of the policy titled Visitors/Vendors indicated the following: All visitors who are providing a service for the center...will sign in at the front desk and sign a confidentiality statement form. This form will be kept in a file at the front desk. All members of the staff are responsible for adhering and implementing this policy. The policy was approved 9/9/14.</p> <p>2. On 7/14/15 at 9:55am, in the employee kitchen area, the following was observed: In the presence of a person self identified as a sales representative, an unidentified person reported patient information including patient name, date of procedure, operative procedure description and patient status into a telephone in the room within 5 feet of the facility visitor. The same process occurred again in the presence of the same representative at 10:20am.</p> <p>3. On 7/14/15 at 12:45pm, A1, Administrator, indicated physicians/staff should not dictate or provide patient information in the presence of visitors without the visitor first signing a confidentiality statement and signing in at each visit. A1 indicated the visitor present at 9:55am and 10:20am did not have a confidentiality statement on file and had not signed in on the log at the</p>		8/1/2015. All vendors will check in and out with Symplr prior to admittance to the patient care area. The phone was removed from the employee lounge and surgeons have been instructed to use phones strategically placed in more private areas with limited access to vendors and visitors. Compliance with vendor credentialing and HIPAA will be overseen by administrator.	

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Q 0266 Bldg. 00	<p>front desk.</p> <p>416.52(c)(2) DISCHARGE - ORDER [The ASC must -] Ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy.</p> <p>Based on document review and staff interview, the medical staff failed to ensure discharge orders were written for 2 of 2 pain management patients (patients #2 and 20).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of patient #2 medical record indicated the following: <ol style="list-style-type: none"> He/she had a pain management procedure performed on 5/4/15. The record lacked an order to discharge the patient from the facility. Review of patient #20 medical record indicated the following: <ol style="list-style-type: none"> He/she had a pain management procedure performed on 6/11/15. The record lacked an order to discharge the patient from the facility. Staff member #02 verified the above beginning at 12:25 p.m. on 7/15/15. 	O 0266	<p>Nurse administrator changed pain management standing orders to reflect an order for discharge per facility policy. Orders were reviewed and approved by respective physicians.</p> <p>Compliance will be monitored monthly during the nurse chart audit (5% or 30 charts, whichever is greater). (See Attachments)</p>	08/15/2015

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S 0000 Bldg. 00	4. Staff member #N4 indicated in interview at 1:50 p.m. on 7/15/15 that the facility had no policy addressing discharge orders for pain management patients. This visit was for a State licensure survey. Facility number: 12244 Dates: 7/13/15 to 7/15/15 QA: cjl 08/04/15	S 0000		
S 0110 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5) The governing body shall do the following: (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. Based on document review and	S 0110	Quarterly meeting will include presentation of quality data to	09/17/2015

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	<p>interview, the Governing Body (GB) failed to review, at least quarterly, reports of the Quality Assurance and Performance Improvement (QAPI) program for the past 2 of 4 quarters and did not review 19 of 20 monitors (Response to patient emergencies, nursing, injuries, medication errors, housekeeping, pest control, pharmacy, lab, medical record, radiology (internal), radiology (external), biohazardous waste, linen service, maintenance, transcription, discharge, transfers, security, sentinel events).</p> <p>Findings:</p> <p>1. Review of the document titled THE QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI) PLAN indicated the following: The QAPI Committee will report at least quarterly to the Board of Managers. The following services for patient care shall be monitored and evaluated on an ongoing basis: staffing, infection prevention and control, housekeeping, sanitation, safety, maintenance of physical plant and equipment, patient care statistics, discharge planning services. The QAPI plan (P&P) was approved 1/7/14.</p> <p>2. Review QAPI documents titled</p>		<p>Board of Managers and Medical Executive Committee per policy beginning 9/17/15. Agenda items and meeting minutes will be documented and kept by the administrator. Quality monitors will be evaluated annually and as necessary with communication of changes to the Board as evidenced in meeting minutes. The QA/PI program is ongoing and will be overseen by the administrator.</p>				

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	<p>Agenda - Quality Council Quarterly Reporting dated Jan 2015 included documentation of QAPI monitors and standards for the following: Infection control, Response to patient emergencies, nursing, injuries, medication errors, housekeeping, pest control, pharmacy, lab, medical record, radiology (internal), radiology (external), biohazardous waste, linen service, maintenance, transcription, discharge, transfers, security, sentinel events. Other like titled documents were dated Sept 2014, and May 2014. The documents lacked evidence of meeting minutes, attendance by any committee member, or presentation to the GB.</p> <p>3. Review of documents titled Members Meeting indicated the following: Meeting 5/5/15 included a Quality Report of the following: Infection Control, Peer Review, Incident reports, Patient Satisfaction. Meeting 1/6/15 lacked evidence of a Quality Report. Meeting 9/9/14 lacked evidence of a Quality Report. Meeting 5/7/14 indicated a Quality Report that included Infection Control, Peer Review, Incident Reports, and Patient Satisfaction was presented to the GB.</p> <p>4. On 7/15/15 at 11:45am, A1, Administrator, indicated the Agenda documents were all that were available to</p>			

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S 0230 Bldg. 00	<p>show QAPI activity and that of the selected monitors, only reporting of infection control shows in GB meeting minutes.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</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>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview the Governing Body (GB) failed to provide for periodic review of the center and its operation by a utilization review or other committee composed of three or more duly licensed physician having no financial interest in the facility between 2010 and 2015.</p> <p>Findings:</p> <p>1. Review of facility documents lacked evidence of any utilization review activity by a committee of three or more duly licensed physician having no</p>	S 0230	Utilization Committee members will be established at the 9/17/15 Members Meeting, chosen by the Board of Managers on the recommendation of the Administrator. This will be documented in the September meeting minutes. Committee members will be 3 medical physicians with no financial interest in the facility. Each committee member will audit a predetermined amount of charts (totaling 5% or 30, whichever greater) for appropriateness of care. Utilization Committee findings/minutes will be maintained by the administrator	09/30/2015

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S 0300 Bldg. 00	<p>financial interest in the facility from 2010 to July, 2015.</p> <p>2. On 7/15/15 at 1:20pm A1, Administrator, indicated a committee of three or more duly licensed physicians having no financial interest in the facility to review the center and its operations, did not exist.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the center failed to implement and maintain an effective, organized Quality Assessment Performance Improvement (QAPI) program within the past 4 quarters.</p> <p>Findings:</p> <p>1. Review of the document titled THE QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT</p>	S 0300	<p>and kept in her office. This program will be ongoing.</p> <p>Quality committee members will meet quarterly, beginning 9/17/15. Agenda items and minutes will be reported to the Board of Managers, maintained and stored by the Administrator in a binder for Quality Improvement. This program is ongoing and will be maintained by the administrator. (see attachment)</p>	09/17/2015			

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S 0442 Bldg. 00	<p>(QAPI) PLAN indicated: Membership shall include a physician member of the Medical Staff, Administrator or designee, business office manager or designee, safety office, medical director or designee and any other interested persons...the committee will meet no less than quarterly. The plan (P&P) was approved 1/7/14.</p> <p>2. Review of QAPI documents titled Agenda - Quality Council Quarterly Reporting, provided as evidence of QAPI meetings, were dated Jan 2015, Sept 2014, and May 2014. The documents lacked evidence of meeting minutes or attendance by any committee member.</p> <p>3. On 7/15/15 at 11:45, A1, Administrator, indicated no other documentation of QAPI committee meetings or evidence of attendance could be produced.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending</p>						

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S 0710 Bldg. 00	<p>changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on document review and staff interview, the facility failed to ensure documentation of disease history or immunization to Varicella for 3 of 6 staff members (staff members #N1, N2, and N5).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Staff members #N1, N2, and N5 personnel files lacked documentation of disease history or immunization to Varicella. Staff member #03 verified the above information beginning at 11:50 a.m. on 7/15/15. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p>	S 0442	All staff health files will be evaluated by employee health RN and completed by 9/15/15. A monthly audit of 5 files will be completed by Employee Health RN to spot check for completeness. Any employee who fails to return required documentation to facility by stated date will not be allowed to work until submitted. Employee Health Nurse will report to Administrator for accountability of duties.	09/15/2015			

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	<p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p> <p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to</p>			

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	<p>perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on document review and interview, the Medical Staff (MS) failed to maintain current documentation of approved delineation of surgical privileges for 8 of 9 MS members (MD#1, MD#2, MD#3, MD#4, MD#6, AH#1, AH#2, & AH#3) and failed to maintain documentation of appropriate licensure of 1 physician (MD#6) and 2 Allied Health (AH#1 & AH#3).</p> <p>Findings:</p> <p>1. Review of the document titled Medical Staff Bylaws, Section V, indicated the following: Every two years...the category and privileges that should be granted for the ensuing two year period; shall be submitted to</p>	S 0710	<p>Credentialing files will be evaluated for completeness, all files will be complete with documentation by 9/15/15. Reappointments will be noted at 9/17/15 Board meeting and reflected in minutes. Administrator will maintain spreadsheet with each practitioners requirements and expiration dates. Files will be audited monthly (2 from: Medical staff, anesthesia and AHP) Files will be stored and maintained by administrator.</p>	09/15/2015	

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	<p>appropriate committees. The Medical Director shall notify each Staff member whether or not he/she has been reappointed to the Staff, stating the category and privileges granted. MS Bylaws were last approved 1/22/13.</p> <p>2. Review of the document titled Rules and Responsibilities of the Medical Staff indicated "Allied Health Professionals" shall refer to non-physician health care providers who: a) Do not hold a Doctor of Medicine or Doctor of Osteopathy...degree. b). Meet all applicable state and federal requirements for practice. The document indicated Qualifications as follows: Only an Allied Health professional holding a current, active license, certificate or other credentials as may be required by applicable state law...is eligible to...provide services. Only those Allied Health Professionals who have completed the application process and who have been granted specific privileges may practice in the facility. The facility lacked documentation of approval or review date of the document.</p> <p>3. Review of MS credential files for MD#1 - MD#6 & AH#1 - AH#3 indicated the following:</p> <p>a. Most recent appointment for MD#1 was 1/7/14, MD#1 requested and was</p>			

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	<p>granted privilege for 23 Hour Observation Admission on 5/7/14. The file lacked evidence of MD#1 being granted surgical privileges for this appointment.</p> <p>b. Most recent appointment for MD#2 was 1/22/13 and surgical privileges were granted at that time. The file lacked evidence of reappointment or granting of privileges between 1/22/15 and 7/15/15.</p> <p>c. Most recent appointment for MD#3 was 1/22/13 and surgical privileges were granted at that time. The file lacked evidence of reappointment or granting of privileges between 1/22/15 and 7/15/15.</p> <p>d. Most recent appointment for MD#4 was 1/7/14, MD#1 requested and was granted privileges for 23 Hour Observation Admission and Interpretation of Fluoroscopy on 5/7/14. The file lacked evidence of MD#4 being granted surgical privileges for this appointment.</p> <p>e. Most recent appointment for MD#5 was 1/22/13 and surgical privileges were granted at that time. The file lacked evidence of reappointment or granting of privileges between 1/22/15 and 7/15/15.</p> <p>f. The file for MD#6 lacked evidence of appointment or granting of privileges for the center. The file lacked evidence of a license.</p> <p>g. The file for AH#1 lacked evidence of appointment or granting of privileges for</p>			

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	<p>the center. The file lacked evidence of AH#1 having an Indiana license.</p> <p>h. The file for AH#2 lacked evidence of appointment to the MS, but indicated privileges were granted 2/14/14.</p> <p>g. The file for AH#3 lacked evidence of appointment or granting of privileges for the center. The file lacked evidence of a license.</p> <p>4. Review of facility documents titled Cases by Surgeon - Summary Report, indicated MD#1, MD#2, MD#3, MD#4 and MD#5 each performed surgical procedures during 2014.</p> <p>5. Review of patient medical records indicated the following: AH#1 was the operating room assistant (ORA) for patient (Pt) # 29 on 7/13/15 and Pt#30 on 7/13/15. AH#3 was the ORA for Pt#27 on 6/4/15 and Pt#28 on 6/4/15.</p> <p>6. On 7/15/15 at 1:25pm, A1, Administrator, indicated MD#s 1-5 perform procedures in the center, MD#6 is contracted for anesthesia and should have approved appointment and privileges, AH#1 and AH#3 are First Assists for MD members and should be appointed and privileged. A1 verified lack of documentation for appointments, privileges, and State licensure.</p>			

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S 0888 Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review and staff interview, the medical staff failed to complete an operative note according to facility policy for 6 of 26 medical records reviewed (patients #6, 8, 11, 14, 19 and 20).</p> <p>Findings include:</p>	S 0888	<p>Process for operative notes evaluated by administrator. Physicians inserviced by business office manager on electronically signing reports in 24 hour window. Reports set to auto-print once signed. PACU RNs will perform daily audit after performing post operative phone call to ensure presence of report.</p>	09/15/2015

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	<p>1. Facility policy titled "REQUIRED DOCUMENTATION" last reviewed/revised 9/9/14 states on page 92: "5. Operative Reports All patients undergoing surgical procedures at Metro Specialty Surgery Center require an operative report as part of the medical record. The operative report must be written or dictated immediately after an operative procedure."</p> <p>2. Review of medical records indicated the following: (A) Patient #6 had surgery on 3/6/15. The operative note was dictated on 3/9/15. (B) Patient #8 had surgery on 6/2/15. The medical record lacked an operative note. (C) Patient #11 had surgery on 6/2/15. The medical record lacked an operative note. (D) Patient #14 had surgery on 6/11/15. The operative note was dictated on 6/15/15. (E) Patient #19 had surgery on 6/8/15. The medical record lacked an operative note. (F) Patient #20 had surgery on 6/11/15. The medical record lacked an operative note.</p> <p>3. Staff member #02 verified the medical</p>		Process will be evaluated by administrator when compliance falls below 100%.				

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S 1004 Bldg. 00	<p>record information beginning at 12:25 p.m. on 7/15/15.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(1)</p> <p>Pharmaceutical services must have the following:</p> <p>(1) A designated professional person with prescriptive authority, or a pharmacist, who is responsible for the control of drug stocks in the center. Based on interview and document review, the center failed to designate a professional person or pharmacist with Indiana prescriptive authority to be responsible for the control of drug stocks in the center from 2/2010 to 7/2015.</p> <p>Findings:</p> <p>1. On 7/13/15 at 12:00pm, A1, Administrator, indicated the facility drug stock is overseen by a contract pharmacist from another state. A1 indicated an Indiana license had been determined unnecessary.</p> <p>2. Review of the document titled CONSULTANT PHARMACIST</p>	S 1004	Administrator will assist current consultant in obtaining Indiana pharmacy license to bring to compliance. If Indiana license not obtained by this date, administrator will secure interim Indiana licensed pharmacist until current consultant obtains license. Annual review of licensure will ensure facility remains compliant with state requirement.	09/15/2015

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	<p>SERVICES AGREEMENT indicated the pharmacist entered into agreement with the center to provide consultant services on 2/10/10. The document indicated the pharmacist duties to include, but not limited to, the following: review, monitor, update, evaluate, and propose revisions to policies & procedures (P&P); conduct training to Facility personnel; perform monthly review of narcotics and controlled substances; review medical records and perform reconciliation; review the list of medications and advise related to additions, deletions, and related issues; establish emergency procedures; evaluate, monitor, and review all adverse medication reactions; monitor all medication errors. The document further indicated the Contractor makes the following covenants to the Partnership:</p> <p>3.1 Permits and Licenses...a. maintain all applicable licenses, permits and accreditations required by any applicable Regulatory Authority...</p> <p>3. Review of policy & procedure (P&P) titled 11.02 Pharmacy Consultant indicated the consultant should be duly licensend in the appropriate state and meets the responsibilities of a qualified consultant pharmacist as set forth by federal and state statutes, rules or regulations. The P&P was last approved 9/9/14.</p>			

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S 1012 Bldg. 00	<p>4. Review of the contract pharmacist credentials lacked evidence of the pharmacist having an Indiana license.</p> <p>5. On 7/15/15 at 1:30pm, A1 verified that the contract pharmacist was the responsible party for control of drug stock in the facility and that he/she did not have an Indiana license.</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 document review and observation, the facility failed to follow medication administration policy and acceptable standard of practice for 1 of 2 observations.</p> <p>Findings include;</p> <p>1. Facility policy titled "MEDICATION</p>	S 1012	on 8/8/15 a mandatory staff meeting was held (see attachments) and Safe Injection practices were reviewed. Staff will be periodically monitored for compliance by Infection Control Nurse. Annual inservice on safe injection practices will be documented in employee file. This will be overseen by Inf. Control RN and Administrator.	08/08/2015

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	<p>ADMINISTRATION" last reviewed/revised 9/9/14 states under policy: "To provide a safe, effective administration of prescribed medications, all medications will be ordered, administered and recorded according to accepted standards of practice."</p> <p>2. APIC (Association for Professionals in Infection Control) position paper titled "Safe injection, infusion, and medication vial practices in healthcare." states "Disinfect IV ports & vial stoppers by wiping and using friction with a sterile 70% isopropyl alcohol, ethyl/ethanol alcohol, iodophor, or other approved antiseptic swab. Allow port to dry before accessing....." and "Cleanse the access diaphragm of vials using friction with a sterile 70% isopropyl alcohol, ethyl/ethanol alcohol, iodophor, or other approved antiseptic swab. Allow the diaphragm to dry before inserting any device into the vial....."</p> <p>3. During observation in the Operating room beginning at 10:50 a.m. on 7/14/15 staff member #01 was observed drawing up medications x 3 without wiping the vial stopper of the medication vials with alcohol or other antiseptic wipe and was observed administering medications x 4 through an I.V. port without wiping the port with alcohol or other antiseptic wipe</p>			

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S 1198 Bldg. 00	<p>prior to the administration.</p> <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 Safety Management Program (SMP) failed to coordinate with a community, state, or federal agency between 2010 and 2015.</p> <p>Findings:</p> <p>1. Review of facility documents between 4/2010 and 7/2015, lacked evidence of coordination with a community, state, or federal agency for disaster preparedness.</p> <p>2. On 3/15/15 at 1:15pm, A1, Administrator, indicated the facility had not coordinated disaster preparedness with any outside agency.</p>	S 1198	Metro Specialty has enrolled as a triage center for Clark County disaster preparedness and abides by the Guidelines for Specific Disasters provided by Clark County. This is reflected in P&P. The administrator is responsible for being facility contact and maintaining facility Disaster Plan binder. This program will be in place by 8/31/15 and will be reviewed by the administrator annually.	08/31/2015			