

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001147	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/10/2015
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NAME OF PROVIDER OR SUPPLIER  INVERNESS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8004 CARNEGIE BOULEVARD FORT WAYNE, IN 46804
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Q 0000  Bldg. 00	This visit was for a re-certification survey.  Facility Number: 004581  Survey Date: 12-07/10-2015  QA: cjl 01/05/16  IDR Committee met on 02-03-16; Tags Q0221, Q0222 & Q0224 were deleted. JL	Q 0000		
Q 0041  Bldg. 00	416.41(a) CONTRACT SERVICES When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner. Based on document review and interview, the facility failed to include a monitor and standard for 2 services furnished by a contractor in its quality assessment and performance improvement (QAPI) program.  Findings include:  1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the contracted ambulance and transcription services.	Q 0041	Effective 12/30/2015, the ambulance company and medical transcriptionist were added to the Inverness Surgery Center Contractor Database. The activities of the parties will be monitored going forward on the database tool and reviewed quarterly at each Quality Improvement (QI) and Medical Executive Meeting. The Quality Improvement Committee Chair and the Quality Improvement Committee reviewed and approved the materials on 1/7/2016, and referred the amended policy to the Medical	01/25/2016

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 0123 Bldg. 00	<p>2. Interview of employee #A1, Director, on 12-08-15 at 11:10 am, confirmed the above and no other documentation was provided prior to exit.</p> <p>416.45(c) OTHER PRACTITIONERS If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities.</p> <p>Based on document review and interview, the facility failed to ensure a governing body approved policy that described a process for overseeing and evaluating clinical activities of practitioners other than physicians in 1 instance.</p> <p>Findings include:</p> <p>1. On 12-07-2015 at 11:15 am, employee #A1, Director, was requested to provide documentation of a governing body approved policy that described a process for overseeing and evaluating clinical activities of practitioners other than physicians.</p> <p>2. Interview of employee #A2, Quality Accreditation, on 12-09-2015 at 10:35</p>	Q 0123	<p>Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The Director, the chair of the QI committee and medical director will assure that the surveillance continues going forward.</p> <p>Effective 01/06/2016, specific wording was added to policy ADM 37 by the medical director and director: Contract/Float Student/Vendor Orientation, stating the facility director will have oversight of allied health personnel activities in the Center. The Quality Improvement Committee reviewed and approved the materials on 1/7/2016 and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The Medical Executive Committee and credentialing staff will review personnel during the re-credentialing process every two years. The director will review the allied health staff quarterly to ensure ongoing compliance.</p>	01/25/2016

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Q 0162  Bldg. 00	<p>am, indicated there was no policy and no other documentation was provided prior to exit.</p> <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"> <li>(1) Patient identification.</li> <li>(2) Significant medical history and results of physical examination.</li> <li>(3) Pre-operative diagnostic studies (entered before surgery), if performed.</li> <li>(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.</li> <li>(5) Any allergies and abnormal drug reactions.</li> <li>(6) Entries related to anesthesia administration.</li> <li>(7) Documentation of properly executed informed patient consent.</li> <li>(8) Discharge diagnosis.</li> </ul> <p>Based on interview and document review, the facility failed to have a policy for the operative report to describe findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body, failed to ensure the legibility of 2 of 20 medical records reviewed, records #1 and</p>	O 0162	Per the survey findings, Medical Staff Rules and regulations, and facility policies, and subsequent chart review, the director and quality management coordinator created a checklist containing the items consistently missed by surgeons and anesthesiologists on 12/30/15. The checklist will be placed on the front of each chart starting 1/29/16, and will serve to	01/25/2016

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	<p>#14 and failed to ensure the physician authenticated the surgical consent indicating they had explained the procedure, risks and benefits to the patient, for 1 of 1 record for both doctors #60 and #61, records #5 and #7.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 12-07-2015 at 11:15 am, employee #A1, Director, was requested to provide documentation of a policy for the operative report to describe findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body.</li> <li>Interview of employee #A1 on 12-08-2015 at 1:45 pm indicated there was no policy, as requested above, and no other documentation was provided prior to exit.</li> <li>Review of the policy Guidelines for Maintaining the Medical Record as a Medical-legal Document, MR 02, last updated 5/5/15, indicated under "Procedure": all entries into the medical record must be neat, accurate, concise, and legible.</li> <li>Review of the policy Documentation: Charting and Charts, MR 01, last updated 5/5/15, indicated under "Procedure": all</li> </ol>		<p>reinforce topics that include but are not limited to: Proper authentication, timing, dating and legibly signing appropriate medical record entries. Proper method for identifying and managing charting errors. Completion of all times, equipment checks, vital signs, summaries and updates. Correct procedure for timing, managing, and authenticating verbal and standing orders, consents, diagnoses and other entries. Correct procedure for pre and post-procedure evaluations and summaries. A summary reminder was sent to each medical staff member by the medical director reiterating the requirements for documentation practices in the facility on 1/2/16. The director and Quality Improvement Committee chair conducted re-education for the clinical staff regarding the requirements for proper documentation in the medical record on 1/4 and 1/5/2016. The actions will be reviewed and approved by the Medical Executive Committee on 1/21/16. The Peer Review Committee, the medical records manager, and third party medical record auditor will monitor documentation going forward to ensure compliance.</p>	

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	<p>documentation in the chart must be accurate, concise, and legible; and, if an error is made, draw one line through it and print "error" above it...".</p> <p>5. Review of the medical staff rules and regulations, approved 11/24/14, indicated under section XL. Admitting Procedures, in item D., The consent form shall be completed prior to the procedure tor treatment. The physician or his/her designee shall be responsible for obtaining the patient's signature, properly witness and placing the the form on the patient's chart.</p> <p>6. Review of medical records indicated:  A. Patient #1 had write overs on the "Surgery Began" time and "Out of Room" time on the Intraoperative Record form.  B. Patient #5 lacked authentication by the physician/surgeon (#60) as witness to the patient's consent for surgery on 2/11/15, on the form titled Consent for Procedure, Anesthetics and Other Medical Services.  C. Patient #7 lacked authentication by the physician/surgeon (#61) as witness to the patient's consent for surgery on 10/3/14, on the form titled Consent for Procedure, Anesthetics and Other Medical Services.  D. Patient #14 had illegible times with physician authentication on the Endo H</p>			

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Q 0184 Bldg. 00	<p>&amp; P form and again with the time of discharge documentation on the same form.</p> <p>7. At 4:05 PM on 12/7/15, interview with staff member #53, the quality and accreditation staff, confirmed that the medical records listed in 4. above were illegible and that surgeons #60 and #61 had failed to authenticate surgical consents for patients #5 and #7.</p> <p>416.48(a)(3) VERBAL ORDERS Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician. Based on document review and interview, the medical staff failed to ensure the implementation of the medical staff rules and regulations, and facility policy, related to the authentication of both standing orders and verbal orders for 3 of 20 patient records, medical records #2, #8 and #12.</p> <p>Findings Include: 1. Review of the medical staff rules and regulations, last approved on 11/24/14, indicated in section VII., that all orders on the patient chart must be signed, dated and timed by the physician when available and that chart completion is</p>	O 0184	Per the survey findings, Medical Staff Rules and regulations, and facility policies, and subsequent chart review, the director and quality management coordinator created a checklist containing the items consistently missed by surgeons and anesthesiologists on 12/30/15. The checklist will be placed on the front of each chart, starting 1/29/16 and will serve to reinforce topics that include but are not limited to: Correct procedure for timing, managing, and authenticating verbal, written and standing orders, consents, diagnoses and other entries. A summary reminder was sent to each medical staff member by the	01/25/2016

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Q 0201 Bldg. 00	<p>within thirty (30) days.</p> <p>2. Review of the policy Physician Standing/routine Orders, MR 04, last updated on 5/5/15, indicated under "Procedure" that Standing/Routine orders will be authenticated, signed, dated and timed by the physician when the patient is identified by the physician pre-operatively.</p> <p>3. Review of medical records indicated:  A. Patient #2 had verbal orders on 8/19/15 that were not authenticated, dated and timed by the physician.  B. Pt. #8 had a page of standing orders that included verbal orders that were never authenticated, dated, or timed.  C. Pt. #12 had a page of standing orders, with additional verbal orders, that were never authenticated on 1/15/15.</p> <p>4. At 4:05 PM on 12/7/15, interview with staff member #53, the quality and accreditation staff member, confirmed that physicians were not following facility policies and rules and regulations related to authentication, dating and timing of standing and verbal orders.</p> <p>416.49(a) LABORATORY SERVICES If the ASC performs laboratory services, it</p>		<p>medical director reiterating the requirements for documentation practices in the facility on 1/2/16. The director and Quality Improvement Committee chair conducted re-education for the clinical staff regarding the requirements for proper documentation in the medical record on 1/4 and 1/5/2016. The actions will be reviewed by the Medical Executive Committee on 1/21/16. The Peer Review Committee, the medical records manager and third party medical record auditor will monitor documentation going forward to ensure compliance.</p>	

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	<p>must meet the requirements of Part 493 of this chapter. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of this chapter. The referral laboratory must be certified in the appropriate specialties and subspecialties of services to perform the referral test in accordance with the requirements of Part 493 of this chapter. Based on document review and interview, the facility failed to ensure review by the physician of results of pathological specimen reports received by the facility for 4 of 4 patients with pathology reports in the medical records, patients #2, #7, #17 and #19.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of medical staff rules and regulations indicated in section XII., that all surgical specimens shall be sent to the Pathologist and that the Pathologist shall prepare, sign and submit a written report to the Surgery Center and this report shall be included in the patient's medical record.</li> <li>Review of medical records for patients #2, #7, #17 and #19 indicated the presence of pathology reports, but no indication that a physician had been apprised of the results, or had seen the reports.</li> </ol>	O 0201	<p>On 1/6/2016, the Director and Medical Executive Committee reviewed the Patient Care Policy 069: Specimens to be sent to the Laboratory. The policy was amended to include specific language regarding the pathology report - All pathology reports will be authenticated by the physician of record and contained in the permanent record. The Quality Improvement Committee Chair and the Quality Improvement Committee reviewed and approved the materials on 1/7/2016, and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. Medical records will be reviewed quarterly, going forward, by the peer review staff and third-party auditor to ensure ongoing compliance.</p>	01/25/2016			

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Q 0241 Bldg. 00	<p>3. At 12:05 PM on 12/9/15, interview with staff member #54, the medical records staff person, confirmed that there is no policy requiring a physician to acknowledge pathology reports for those specimens of patients who are also hospital patients, and that the hospital's computer system, and lab, has no way of letting the surgery center staff know that the physician has reviewed and acknowledged review of a pathology report. It was confirmed that a report could be filed that might indicate a malignancy that could be missed without having a physician sign off on having reviewed a pathology report.</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. Based on observation, document review and interview the facility created an unsanitary condition in 1 instance (Biohazard Waste Storage area), failed to ensure that housekeeping services were provided in a manner that maintained cleanliness in two areas toured and failed to ensure that facility staff performed between case cleaning by appropriately disinfecting items in the surgery suite per</p>	O 0241	On 12/15/2015 the director informed the cleaning contractor that effective 12/15/15 the housekeeping carts will be stored in the General Supply room. The new storage location of the carts will eliminate the potential of cross contamination from the carts to other areas of the center. The charge nurse will check the location of the carts upon opening each business day going forward.	01/25/2016

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	<p>facility policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On 12-09-2015 at 3:25 pm in the presence of employee #A1, Director, and employee #A2, Quality Accreditation, it was observed in the Biohazard Waste Storage area there was also stored 2 cleaning carts which were used throughout the facility.</li> <li>2. In the above situation, having items stored in the room where infectious waste was stored, and those items were then taken throughout the facility, posed a cross-contamination issue and was an infection exposure and risk.</li> <li>3. Review of the policy Clean Environment and Housekeeping, PC 109, last updated 5/5/15, indicated in section 8. "Weekly Cleaning", that air returns are cleaned weekly.</li> <li>4. While on tour of the surgery suites on 12/8/15 at 10:29 AM in the company of staff member #53, the quality and accreditation specialist, and staff member #56, the housekeeping supervisor, it was observed in OR (operating room) #2 that the wall air vents/returns had an accumulation of dust present.</li> <li>5. Staff members #53 and #56 confirmed</li> </ol>		<p>On 12/15/16, the director and infection preventionist reviewed the housekeeping logs and cleaning responsibilities per policy PC 109A - Clean Environment and Housekeeping. The cleaning contracted staff were re-educated to include high dusting and cleaning of the operating rooms, sterile areas, sub-sterile areas, refrigerators, and break room in their daily duties on 12/21/15. The facility policy, PC 109A Clean Environment and Housekeeping was restated to include the two-minute contact time for Cavicide. The policy was reviewed and approved by the Infection Control committee on 12/29/15 and will be presented to the medical executive committee for review and approval on 1/21/16. The infection preventionist educated the contract cleaners and Facility staff on 1/4/16 and 1/5/16. The director and infection preventionist will monitor the cleanliness and dry times of the cleaning agents during the monthly and quarterly audits to ensure compliance going forward.</p>				

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	<p>that the wall vents were dusty at 10:29 AM on 12/8/15.</p> <p>6. While on tour of the facility at 10:35 AM on 12/8/15 in the company of staff members #53 and #56, it was observed in the staff break room that both refrigerators had a large accumulation of dust on the tops of the appliances.</p> <p>7. Staff members #53 and #56 agreed that housekeeping is to clean the tops of the appliances and that it had not been done for some time due to the noted accumulation of dust present.</p> <p>8. Review of the manufacturer's recommendation for contact time of the CavaCide product at 10:00 AM on 12/8/15, in the company of staff members #53 and #56, indicated a 2 minute period of time for efficacy.</p> <p>9 Review of the policy OR (operating room) Protocol, PC 046, last updated 5/5/15, indicated on page 5 under "Cleaning procedures provide terminal and adequate decontamination following any operation", and in item E.: using a squeeze bottle dispenser or disinfectant solution and clean cloth, wash all flat surfaces of furniture and OR table. Allow the disinfectant to remain on the surface for the allocated time specified by</p>			

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Q 0242  Bldg. 00	<p>the manufacturer to ensure adequate disinfection.</p> <p>10. At 9:23 AM on 12/9/15, staff member #55, a surgical tech, was observed cleaning the OR suite between cases with the CavaCide product and wiping it off after 35 seconds of contact time on each horizontal surface it was applied to, including, but not limited to: the mayo stand, a large table, a smaller table, and the surgical table and arm rests.</p> <p>11. At 9:50 AM on 12/9/15, interview with staff member #51, the infection preventionist, it was stated that facility policy is a 3 minute wet contact time for CavaCide, not a 2 minute time that the manufacturer indicated. It was confirmed that 35 seconds does not follow facility policy.</p> <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 and</p>	Q 0242	Q 242 416.51(b) Infection Control	01/25/2016	

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	<p>interview, the infection control and prevent program failed to implement its TB (tuberculosis) Exposure Control Plan for 3 of 3 nursing staff hired in 2014 and 2015, and one ST (surgical tech) hired 7/27/12, staff N3, N6, N7 and N8; failed to ensure that the infection control committee maintained an active and effective infection control program in relation to the committee's failure to ensure that the proper CDC (centers for disease control and prevention) TB risk assessment was completed and approved, and failed to approve the Infection Control Plan, the TB Exposure Control Plan, and the list of cleaning products used by facility staff and the contracted housekeeping staff; failed to ensure that annual infection education was completed by all of the medical staff, as per facility policy; failed to ensure the implementation of its policy related to surgical attire in the OR (operating room) suite for 2 staff observed; and the infection preventionist failed to ensure the barrier between the endoscopy decontamination room and the OR (operating room) suite #3 was closed, except when passing items through.</p> <p>Findings Include: 1. Review of the policy XII. Tuberculosis Exposure Control Plan, with a review/revised date of 1/2015,</p>		<p>Program The director, Infection preventionist and Medical Executive Committee determined that effective 1/2/2016, all existing employees will complete a TB Symptom questionnaire annually, unless the facility plan requires an annual Quantiferon Gold or Mantoux two-stage test, per the Facility TB Exposure Control Plan. The infection preventionist will re-educate all staff immediately, and monitor compliance going forward. Per policy TM 01 Employee Laboratory Screening, all new employees will need to be tested via a two-step Mantoux test or a Quantiferon Gold test prior to starting employment. Prospective employees may waive the testing if he or she can submit documentation from negative two-step Mantoux or Quantiferon Gold tests dated within one prior calendar year, and complete a TB symptom questionnaire. The Infection Control committee will meet, review and approve the 2016 TB Exposure plan, prior to sending the plan to the Medical Executive Committee for approval. The hiring director and infection preventionist will monitor compliance going forward. The Center infection preventionist obtained the CDC Risk Assessment TB form on 12/15/15, and will incorporate this into the 2016 facility exposure plans in the Infection Control Plan for presentation to the Infection Control Committee on</p>	

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	<p>indicated under Procedure Overview, in item 5., Employee TB Screening Requirements - New Hires, that all new employees will have a baseline Quantiferon-TB Gold blood test or a 2-step TST (tuberculin skin test), with the first test being performed prior to their start date and the subsequent test administered 1 - 3 weeks after the first test. All other staff will be required to be screened according to the risk level of the Center, with an annual questionnaire to be completed with the facility being a low risk facility.</p> <p>2. Review of employee files indicated:</p> <p>A. Staff member N3 was hired 7/10/14 and failed to have a Quantiferon TB test, or a 2 step TB test done, a questionnaire was completed instead.</p> <p>B. Staff member N6, a ST, was hired 7/27/12 and had only the 2012 TB questionnaire, with none in the file since that time.</p> <p>C. Staff member N7 was hired 10/28/15 and failed to have a Quantiferon TB test, or a 2 step TB test done, a questionnaire was completed instead.</p> <p>D. Staff member N8 was hired 9/16/15 and failed to have a Quantiferon TB test, or a 2 step TB test done, a questionnaire was completed instead.</p> <p>3. At 10:40 AM on 12/9/15, interview</p>		<p>February 11, 2016 for review and approval. The infection Preventionist also updated the current listing of approved cleaning products in PC 109 and presented it to the committee for approval on February 11, 2016. The infection preventionist will present the approved plan and cleaning product listing to Medical Executive Committee for approval, on February 25, 2016.</p> <p>The infection preventionist amended the Infection Control Committee meeting sign-in sheets on December 29, 2015, to eliminate confusion over whether a participant attended the meeting or only reviewed the materials in absentia. The amended sign-in roster will make physician attendance at the meeting readily apparent.</p> <p>The Center director and medical director, working with the infection preventionist, agreed to immediately change the format of the mandatory infection control education program for physicians. Effective 1/2/2016, the team determined that all physician training programs will undergo continued surveillance for compliance and participation from the infection preventionist until all physicians supply an attestation of training completion, to be kept on file at the Center.</p> <p>The infection preventionist on 1/7/2016 completed are-education</p>	

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	<p>with staff member #50, the facility administrator, confirmed that there were no other TB questionnaires for staff member N6, other than the one from 2012, and that it was thought the infection preventionist may only be doing annual TB questionnaires for full time staff, and that is why N6 may have been missed in 2013, 2014, and 2015.</p> <p>4. At 12:10 PM on 12/9/15, interview with staff member #53, the quality and accreditation staff member, confirmed that the infection preventionist was not following the TB policy for new hires by having the staff complete TB questionnaires instead of doing the Quantiferon test, or doing 2 step testing. It was also confirmed that all of the questionnaires were incomplete.</p> <p>5. Review of the infection control committee meeting of 2/2/15 indicated a discussion took place related to a TB Action Plan which would be updated annually, but was not approved by the committee. The TB "screening worksheet" presented was not the CDC approved TB risk assessment for facilities.</p> <p>6. Review of the infection control committee meeting of 5/4/15 indicated the Infection Control Plan for 2015, and</p>		<p>program for all staff and physicians, per the facility policy, PC046 OR Protocol. The program included the proper way to don and wear haircovering in the operating room. The infection preventionist will monitor the compliance daily, going forward.</p> <p>The director placed a work order to have the door between OR3 and the Endo processing room repaired on 12/14/15. The repairs were made 12/15/15, permitting the door to close properly. The safety officer will monitor the proper closing of this and other doors in the Center on her monthly rounds.</p>	

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	<p>the TB Action Plan were presented, but documentation was lacking that would indicate the committee approved these plans.</p> <p>7. Review of the document "Cleaning and Disinfecting", updated February 2015 by the infection preventionist, had no documentation of approval by the infection control committee, at any of the 2/2/15, 5/4/15 and 9/2/15 meetings, as per review of those meeting minutes.</p> <p>8. At 12:40 PM on 12/8/15 and 11:40 AM on 12/9/15, interview with the infection preventionist, staff member #51, and the quality/accreditation staff member, employee #53, confirmed that meeting minutes of the infection control committee for the last 12 months failed to indicate approval of the infection control plan, the TB risk assessment and plan, and the cleaning products utilized at the facility. It was also confirmed that the TB risk assessment tool was not the 7 page Attachment B, from the CDC.</p> <p>9. Review of the policy Continuing Education, TM 03, last updated 5/5/15, indicated that all staff including physicians are required to complete annual educational competencies/programs.</p>			

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	<p>10. Review of the July 14, 2015 letter to physicians, with an attached "mandatory" infection education document, indicated the physicians were to "review the material and complete the form that verifies you have read the information", then return the form in the self addressed, stamped envelope.</p> <p>11. Review of the infection control committee meeting minutes for 9/2/15 indicated an annual packet was sent out to each physician that practices at the surgery center and that verification letters would be retained in a binder showing physician education/competence. The meeting minutes also indicated the physicians were completing the reading information and returning the verifications.</p> <p>12. At 12:40 PM on 12/8/15 and 11:40 AM on 12/9/15, interview with the infection preventionist, staff member #51, indicated 22 of 49 physicians had not returned the verification letters indicating annual infection education. There has been no encouragement by the medical director, or infection control committee medical staff member, in relation to contact with physicians to complete this task, as requested per the infection control committee, and as per policy requirements.</p>			

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	<p>13. Review of the policy Center Personnel Attire, PC 047, last updated 5/5/15, indicated on page 6, under 2. Head/Hair Covering, that all head and facial hair was to be completely covered by the bouffant head covering.</p> <p>14. At 9:05 AM on 12/8/15, while observing in OR suite #2, in the company of staff member #53, the quality and accreditation person, it was observed that the anesthesiologist and the surgeon both had hair at the back of the head that was not contained within the bouffant head covering.</p> <p>15. At 9:10 AM on 12/8/15, staff member #53 confirmed that staff had hair not contained within the bouffant head covering.</p> <p>16. While on tour of the surgery suites at 10:30 AM on 12/8/15 and 10:15 AM on 12/9/15, in the company of staff member #53, the quality and accreditation specialist, it was observed that the door between the OR suite #3 and the scope decontamination room was open and could not be closed.</p> <p>17. Interview with staff member #53 at 10:30 AM on 12/8/15 and 10:20 AM on 12/9/15 confirmed that the door would</p>			

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Q 0262 Bldg. 00	<p>not close, and it was unknown how long it had been in a permanently open position. It was also confirmed that, per standards of practice, the door between clean and dirty areas was to be closed at all times, unless passing through the doorway.</p> <p>416.52(a)(2) PRE-SURGICAL ASSESSMENT Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals.</p> <p>Based on document review and interview, the facility failed to ensure that H &amp; P's (history and physicals) were completed per facility policy, and medical staff rules and regulations, for 6 of 20 medical records reviewed, records #1, #2, #7, #8, #16, and #19; and failed to ensure that a pre anesthesia evaluation was performed prior to the surgical procedure for 7 of 20 patients, patients #1, #5, #7, #8, #14, #19, and #20.</p>	Q 0262	Per the survey findings, Medical Staff Rules and regulations, and facility policies, and subsequent chart review, the director and quality management coordinator created a checklist containing the items consistently missed by surgeons and anesthesiologists on 12/30/15. The checklist will be placed on the front of each chart starting 1/29/16, and will serve to reinforce topics that include but are not limited to: Proper authentication, timing, dating and legibly signing appropriate	01/25/2016

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	<p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of the medical staff rules and regulations, last approved 11/24/14, indicated in item VII., that all physician entries into the medical record must be dated, timed and signed when the entry is made to verify compliance of chart completion within thirty (30) days, and in section IX., that a pertinent history and physical examination shall be performed according to the Centers guidelines, and a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.</li> <li>Review of the policy History and Physical, MR 03, last updated 5/5/15, indicated under "Procedure", H &amp; Ps done outside of the facility must be performed within 30 days from the date of surgery. The surgeon must also review and indicate any changes to the patient's status or no change on the date of surgery.</li> <li>Review of medical records indicated:               <ol style="list-style-type: none"> <li>Patient #1 lacked the documentation of a time that the H &amp; P was completed on 12/1/15, and lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure.</li> </ol> </li> </ol>		<p>medical record entries. Proper method for identifying and managing charting errors. Completion of all times, equipment checks, vital signs, summaries and updates. Correct procedure for timing, managing, and authenticating verbal and standing orders, consents, diagnoses and other entries. Correct procedure for pre and post-procedure evaluations and summaries. A summary reminder was sent to each medical staff member by the facility medical director reiterating the requirements for documentation practices in the facility on 1/2/16. The director and quality Improvement committee chair conducted re-education for the clinical staff regarding the requirements for proper documentation in the medical record on 1/4/16 and 1/5/2016. The actions will be reviewed by the Medical Executive Committee on 1/21/16. The Peer Review Committee, the medical records manager and third party medical record auditor will monitor documentation going forward to ensure compliance.</p>	

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	<p>B. Patient #2 had a H &amp; P done 8/17/15 and surgery on 8/19/15 with no update note written on the day of surgery for the H &amp; P done two days prior.</p> <p>C. Pt. #5 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure on 2/11/15.</p> <p>D. Pt. #7 had no date and time documented for the H &amp; P done for a surgery date of 10/3/14, and lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure.</p> <p>E. Pt. #8 lacked the documentation of a time that the H &amp; P was completed on 3/9/15, and lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure.</p> <p>F. Pt. #14 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure on 11/17/15.</p> <p>G. Pt. #16 had an office H &amp; P from 4/7/15 for an 11/17/15 date of surgery, which was beyond the 30 day requirement.</p> <p>H. Pt. #19 lacked the documentation of a time that the H &amp; P was completed on</p>			

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S 0000  Bldg. 00	<p>11/19/15, and lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure.</p> <p>I. Pt. #20 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure on 11/19/15.</p> <p>4. At 4:05 PM on 12/7/15, interview with staff member #53, the quality and accreditation staff member, confirmed that the H &amp; Ps listed in 3. above were not per facility policy or medical staff rules and regulations and that without the anesthesia provider timing the pre anesthesia evaluation, it cannot be determined that these were done prior to the start of surgery for patients #1, #5, #7, #8, #14, #19, and #20.</p> <p>This visit was for a State licensure survey.</p> <p>Facility Number: 004581</p>	S 0000		

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S 0172 Bldg. 00	<p>Survey Date: 12-07/10-2015</p> <p>QA: cjl 01/05/16</p> <p>IDR Committee met on 02-03-16; Tag S1168 was changed. JL</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review and interview, the chief executive officer failed to ensure that annual infection education was completed by all of the medical staff, as per facility policy.</p> <p>Findings Include: 1. Review of the policy Continuing Education, TM 03, last updated 5/5/15, indicated that all staff including</p>	S 0172	The Center director and medical director, working with the infection preventionist, agreed to immediately change the format of the mandatory infection control education program for physicians. Effective 1/2/2016, the team determined that all physician training programs will undergo continued surveillance for compliance and participation from the infection preventionist until all physicians supply an attestation	01/25/2016

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	<p>physicians are required to complete annual educational competencies/programs.</p> <p>2. Review of the July 14, 2015 letter to physicians, with an attached "mandatory" infection education document, indicated the physicians were to "review the material and complete the form that verifies you have read the information", then return the form in the self addressed, stamped envelope.</p> <p>3. Review of the infection control committee meeting minutes for 9/2/15 indicated an annual packet was sent out to each physician that practices at the surgery center and that verification letters would be retained in a binder showing physician education/competence. The meeting minutes also indicated the physicians were completing the reading information and returning the verifications.</p> <p>4. At 12:40 PM on 12/8/15 and 11:40 AM on 12/9/15, interview with the infection preventionist, staff member #51, indicated 22 of 49 physicians had not returned the verification letters indicating annual infection education. There has been no encouragement by the medical director, or infection control committee medical staff member, in</p>		<p>of training completion, to be kept on file at the Center. The infection preventionist and Infection Control Committee, reviewed and approved the materials on 1/7/2016 and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The Infection Preventionist and Medical Director will monitor compliance for each educational program moving forward.</p>	

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S 0228 Bldg. 00	<p>relation to contact with physicians to complete this task, as requested per the infection control committee, and as per policy requirements.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</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>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that physicians and podiatrists performing surgery in the facility maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located for 1 (MD#1) of 7 medical staff credential</p>	S 0228	On December 30, 2015, the facility director and quality management coordinator contracted with the hospitalist physician group of Parkview Health to provide admission to all podiatric patients from Inverness Surgery Center needing admission to the hospital from the surgery center. The Quality Improvement Committee chair	01/25/2016

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S 0310 Bldg. 00	<p>files reviewed.</p> <p>Findings:</p> <p>1. Review of 7 medical staff credential files indicated file MD#1, podiatrist, did not have documentation of admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located.</p> <p>2. Interview of employee #A2, Quality Accreditation, on 12-10-2015 at 1:34 pm, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</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>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for 2 services furnished by a contractor in its quality</p>			S 0310	<p>and the Quality Improvement Committee reviewed and approved the materials on 1/7/2016, and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. Compliance will be monitored by the Medical Executive Committee, quality committee chair and Center director through the annual facility contract review with the center director and the hospital's (Parkview Health Systems) legal department.</p> <p>Effective 12/30/2015, the ambulance company and medical transcriptionist were added to the Inverness Surgery Center Contractor Database. The</p>		01/25/2016

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S 0400 Bldg. 00	<p>assessment and performance improvement (QAPI) program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the contracted ambulance and transcription services.</li> <li>2. Interview of employee #A1, Director, on 12-08-15 at 11:10 am, confirmed the above and no other documentation was provided prior to exit.</li> </ol> <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, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors in 1 instances (Biohazard Waste Storage area).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On 12-09-2015 at 3:25 pm in the</li> </ol>	S 0400	<p>activities of the parties will be monitored going forward on the database tool and reviewed quarterly at each Quality Improvement (QI) and Medical Executive Meeting. The Quality Improvement Committee Chair and the Quality Improvement Committee reviewed and approved the materials on 1/7/2016, and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The Director, the chair of the QI committee and medical director will ensure that the surveillance continues going forward.</p> <p>On 12/15/2015 the director informed the cleaning contractor that effective 12/15/15 the housekeeping carts will be stored in the General Supply room. The new storage location of the carts will eliminate the potential of cross contamination from the carts to other areas of the center. The infection preventionist and Infection Control Committee, reviewed and approved the</p>	01/25/2016

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S 0404 Bldg. 00	<p>presence of employee #A1, Director, and employee #A2, Quality Accreditation, it was observed in the Biohazard Waste Storage area there was also stored 2 cleaning carts which were used throughout the facility.</p> <p>2. In the above situation, having items stored in the room where infectious waste was stored, and those items were then taken throughout the facility, posed a cross-contamination issue and was an infection exposure and risk.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the infection control committee failed to maintain an active and effective infection control program in relation to the committee's failure to ensure that the proper CDC (centers for disease control and prevention) TB risk</p>	S 0404	<p>materials on 1/7/2016 and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The charge nurse will check the location of the carts upon opening each business day going forward to ensure ongoing compliance.</p> <p>The Center infection preventionist obtained the CDC Risk Assessment TB form on 12/15/15. The infection preventionist updated the policy PC 109: Clean Environment and Housekeeping, on December 30, 2015, and will present the policy and CDC Risk Assessment for</p>	01/25/2016

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	<p>assessment was completed and approved; and failed to approve the Infection Control Plan, the TB Exposure Control Plan, and the list of cleaning products used by facility staff and the contracted housekeeping staff.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. Review of the infection control committee meeting of 2/2/15 indicated a discussion took place related to a TB Action Plan which would be updated annually, but was not approved by the committee. The TB "screening worksheet" presented was not the CDC approved TB risk assessment for facilities.</li> <li>2. Review of the infection control committee meeting of 5/4/15 indicated the Infection Control Plan for 2015, and the TB Action Plan were presented, but documentation was lacking that would indicate the committee approved these plans.</li> <li>3. Review of the document "Cleaning and Disinfecting", updated February 2015 by the infection preventionist, had no documentation of approval by the infection control committee, at any of the 2/2/15, 5/4/15 and 9/2/15 meetings, as per review of those meeting minutes.</li> </ol>		<p>TB form to the Infection Control committee for review and approval on 1/11/16 The Infection Control Committee will forward the materials to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The infection preventionist will also incorporate this action into the 2016 facility exposure plans for presentation to the Infection Control Committee on 1/11/2016 for review and approval. The infection preventionist will present the approved plan to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The infection preventionist will monitor form, plan and policy compliance in the quarterly infection control review to ensure compliance going forward.</p>	

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S 0414 Bldg. 00	<p>4. At 12:40 PM on 12/8/15 and 11:40 AM on 12/9/15, interview with the infection preventionist, staff member #51, and the quality/accreditation staff member, employee #53, confirmed that meeting minutes of the infection control committee for the last 12 months failed to indicate approval of the infection control plan, the TB risk assessment and plan, and the cleaning products utilized at the facility. It was also confirmed that the TB risk assessment tool was not the 7 page Attachment B, from the CDC.</p> <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>			

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S 0440	<p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed. Based on document review and interview, the infection control committee failed to ensure that the physician was present at 2 of 4 infection control committee meetings from 11/2014 to 9/2015.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of the Infection Control Committee meeting minutes of 11/21/14, 2/2/15, 5/4/15, and 9/2/15 indicated the Infection Control Physician Advisor signed that the "in lieu of attending mtg. (meeting) read meeting minutes" for the 2/2/15 meeting and lacked a signature on the sign in page for the 5/4/15 meeting.</li> <li>At 1:40 PM on 12/8/15, interview with staff member #51, the infection preventionist, confirmed that the physician had initialed not being at the 2/2/15 meeting and had not signed in at the 5/4/15, so that it cannot be confirmed that the physician was actually present at 2 of the 4 meetings held in the last 12 months.</li> </ol> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM</p>	S 0414	The infection preventionist amended the Infection Control Committee meeting sign-insheets on December 29, 2015, to eliminate confusion over whether a participant attended the meeting or only reviewed the materials in absentia. The amended sign-in roster will make physician attendance at the meeting readily apparent. The infection preventionist and Infection Control Committee, reviewed and approved the materials on 1/7/2016 and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The medical director and Infection preventionist will monitor physician attendance at the quarterly committee meetings to ensure ongoing compliance.	01/25/2016			

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Bldg. 00	<p>410 IAC 15-2.5-1(f)(2)(E)(vii)</p> <p>The infection control committee responsibilities must include, but not be 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>(vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases.</p> <p>Based on document review and interview, the infection control committee failed to implement its TB (tuberculosis) Exposure Control Plan for 3 of 3 nursing staff hired in 2014 and 2015, and one ST (surgical tech) hired 7/27/12, staff N3, N6, N7 and N8.</p> <p>Findings Include:</p> <p>1. Review of the policy XII. Tuberculosis Exposure Control Plan, with a review/revised date of 1/2015, indicated under Procedure Overview, in item 5., Employee TB Screening Requirements - New Hires, that all new employees will have a baseline Quantiferon-TB Gold blood test or a 2-step TST (tuberculin skin test), with the first test being performed prior to their start date and the subsequent test administered 1 - 3 weeks after the first</p>	S 0440	The director, Infection preventionist and Medical Executive Committee determined that effective 1/2/2016, all current employees will complete a TB Symptom questionnaire annually, unless the facility plan requires an annual Quantiferon Gold or Mantoux two-stage test, per the Facility TB Exposure Control Plan. The infection preventionist re-educated all staff 1/11/2016 and had all current employees complete a TB Symptom Questionnaire on 1/11/16. The infection preventionist and Infection Control Committee reviewed and approved the materials on 1/7/2016 and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The infection preventionist will monitor compliance going forward. Per	01/25/2016

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	<p>test. All other staff will be required to be screened according to the risk level of the Center, with an annual questionnaire to be completed with the facility being a low risk facility.</p> <p>2. Review of employee files indicated:                      A. Staff member N3 was hired 7/10/14 and failed to have a Quantiferon TB test, or a 2 step TB test done, a questionnaire was completed instead.                      B. Staff member N6, a ST, was hired 7/27/12 and had only the 2012 TB questionnaire, with none in the file since that time.                      C. Staff member N7 was hired 10/28/15 and failed to have a Quantiferon TB test, or a 2 step TB test done, a questionnaire was completed instead.                      D. Staff member N8 was hired 9/16/15 and failed to have a Quantiferon TB test, or a 2 step TB test done, a questionnaire was completed instead.</p> <p>3. At 10:40 AM on 12/9/15, interview with staff member #50, the facility administrator, confirmed that there were no other TB questionnaires for staff member N6, other than the one from 2012, and that it was thought the infection preventionist may only be doing annual TB questionnaires for full time staff, and that is why N6 may have been missed in 2013, 2014, and 2015.</p>		<p>policy TM 01 Employee Laboratory Screening, all new employees will need to be tested via a two-step Mantoux test or a Quantiferon Gold test prior to starting employment. Prospective employees may waive the testing if he or she can submit documentation from negative two-step Mantoux or Quantiferon Gold tests dated within one prior calendar year, and complete a TB symptom questionnaire. The Infection Control committee will meet, review and approve the 2016 TB Exposure plan, prior to sending the plan to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The hiring director and infection preventionist will monitor compliance going forward.</p>	

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S 0444 Bldg. 00	<p>4. At 12:10 PM on 12/9/15, interview with staff member #53, the quality and accreditation staff member, confirmed that the infection preventionist was not following the TB policy for new hires by having the staff complete TB questionnaires instead of doing the Quantiferon test, or doing 2 step testing. It was also confirmed that all of the questionnaires were incomplete.</p> <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 interview, the infection control committee failed to ensure the implementation of its policy related to surgical attire in the OR (operating room) suite for 2 staff observed.</p> <p>Findings Include:</p>	S 0444	The infection preventionist on 1/7/2016 completed a re-education program for all staff and physicians, per the facility policy, PC 046 OR Protocol. The program included the proper way to don and wear hair covering in the operating room. The infection preventionist and Infection Control Committee reviewed and	01/25/2016

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S 0450 Bldg. 00	<p>1. Review of the policy Center Personnel Attire, PC 047, last updated 5/5/15, indicated on page 6, under 2. Head/Hair Covering, that all head and facial hair was to be completely covered by the bouffant head covering.</p> <p>2. At 9:05 AM on 12/8/15, while observing in OR suite #2, in the company of staff member #53, the quality and accreditation person, it was observed that the anesthesiologist and the surgeon both had hair at the back of the head that was not contained within the bouffant head covering.</p> <p>3. At 9:10 AM on 12/8/15, staff member #53 confirmed that staff had hair not contained within the bouffant head covering.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(g)</p> <p>(g) Sterilization of equipment and supplies must be provided, within the scope of the service offered, in accordance with acceptable standards of practice or manufacturer's recommendations and applicable state laws and rules, 410 IAC 1-4. Sterilization services must be directed by a qualified person or persons and must provide for the following:</p>		approved the materials on 1/7/2016 and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The infection preventionist will monitor the compliance daily, going forward.	

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S 0472 Bldg. 00	<p>Based on observation and interview, the infection preventionist failed to ensure the barrier between the endoscopy decontamination room and the OR (operating room) suite #3 was closed, except when passing items through.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. While on tour of the surgery suites at 10:30 AM on 12/8/15 and 10:15 AM on 12/9/15, in the company of staff member #53, the quality and accreditation specialist, it was observed that the door between the OR suite #3 and the scope decontamination room was open and could not be closed.</li> <li>2. Interview with staff member #53 at 10:30 AM on 12/8/15 and 10:20 AM on 12/9/15 confirmed that the door would not close, and it was unknown how long it had been in a permanently open position. It was also confirmed that, per standards of practice, the door between clean and dirty areas was to be closed at all times, unless passing through the doorway.</li> </ol> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.4-1(2)(h)  (h) Environmental surfaces and equipment not requiring sterilization which have been contaminated by blood</p>	S 0450	The director placed a work order to have the door between OR 3 and the Endo processing room repaired on 12/14/15. The repairs were made 12/15/15, permitting the door to close properly. The safety officer will monitor the proper closing of this and other doors in the Center on her monthly rounds to ensure compliance.	12/15/2015

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	<p>or other potentially infectious materials shall be cleaned then decontaminated in accordance with acceptable standards of practice and applicable state laws and rules, 410 IAC 1-4.</p> <p>Based on document review, observation and interview, the facility failed to ensure that facility staff performed between case cleaning by appropriately disinfecting items in the surgery suite per facility policy.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. Review of the manufacturer's recommendation for contact time of the CavaCide product at 10:00 AM on 12/8/15, in the company of staff members #53 and #56, indicated a 2 minute period of time for efficacy.</li> <li>2. Review of the policy OR (operating room) Protocol, PC 046, last updated 5/5/15, indicated on page 5 under "Cleaning procedures provide terminal and adequate decontamination following any operation", and in item E.: using a squeeze bottle dispenser or disinfectant solution and clean cloth, wash all flat surfaces of furniture and OR table. Allow the disinfectant to remain on the surface for the allocated time specified by the manufacturer to ensure adequate disinfection.</li> </ol>	S 0472	<p>The facility policy, PC 109A Clean Environment and Housekeeping was amended to include a two-minute contact time for Cavicide. The infection preventionist educated the contract cleaners and Facility staff after approvals are obtained on 1/4/16 and 1/5/16. The policy was reviewed and approved by the Infection Control committee on 12/29/15 and will be presented to the medical executive committee for review and approval on 1/21/16, then to the governing body on 1/25/2016. The infection preventionist will monitor the cleanliness and dry times of the cleaning agents during the monthly and quarterly audits to ensure compliance going forward.</p>	01/25/2016

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S 0504 Bldg. 00	<p>3. At 9:23 AM on 12/9/15, staff member #55, a surgical tech, was observed cleaning the OR suite between cases with the CavaCide product and wiping it off after 35 seconds of contact time on each horizontal surface it was applied to, including, but not limited to: the mayo stand, a large table, a smaller table, and the surgical table and arm rests.</p> <p>4. At 9:50 AM on 12/9/15, interview with staff member #51, the infection preventionist, it was stated that facility policy is a 3 minute wet contact time for CavaCide, not a 2 minute time that the manufacturer indicated. It was confirmed that 35 seconds does not follow facility policy.</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2(a)</p> <p>(a) The center shall provide, or make available, those pathology and medical laboratory services and consultation necessary to meet the needs of patients as determined by the medical staff.</p> <p>Based on document review and interview, the facility failed to ensure review by the physician of results of pathological specimen reports received by the facility for 4 of 4 patients with</p>	S 0504	On 1/6/2016, the Director and Medical Executive Committee reviewed the Patient Care Policy 069: Specimens to be sent to the Laboratory. The policy was amended to include specific language regarding the pathology	01/25/2016

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	<p>pathology reports in the medical records that may not meet the needs of the patient if a malignancy was present and the chart was filed without physician review (Patients #2, #7, #17 and #19).</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. Review of medical staff rules and regulations indicated in section XII., that all surgical specimens shall be sent to the Pathologist and that the Pathologist shall prepare, sign and submit a written report to the Surgery Center and this report shall be included in the patient's medical record.</li> <li>2. Review of medical records for patients #2, #7, #17 and #19 indicated the presence of pathology reports, but no indication that a physician had been apprised of the results, or had seen the reports.</li> <li>3. At 12:05 PM on 12/9/15, interview with staff member #54, the medical records staff person, confirmed that there is no policy requiring a physician to acknowledge pathology reports for those specimens of patients who are also hospital patients, and that the hospital's computer system, and lab, has no way of letting the surgery center staff know that the physician has reviewed and acknowledged review of a pathology</li> </ol>		<p>report "All pathology reports will be authenticated by the physician of record and contained in the permanent record". The Quality Improvement Committee Chair and the Quality Improvement Committee reviewed and approved the materials on 1/7/2016, and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. Medical records will be reviewed quarterly, going forward, by the peer review staff, the medical records manager and third-party auditor to ensure ongoing compliance.</p>	

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S 0640 Bldg. 00	<p>report. It was confirmed that a report could be filed that might indicate a malignancy that could be missed without having a physician sign off on having reviewed a pathology report.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on document review and interview, the facility failed to ensure the legibility and completeness of 4 of 20 medical records reviewed, records #1, #5, #14 and #16.</p> <p>Findings Include: 1. Review of the policy Guidelines for Maintaining the Medical Record as a Medical-legal Document, MR 02, last updated 5/5/15, indicated under "Procedure": all entries in the medical record must be authenticated...timed, and dated; all entries into the medical record must be neat, accurate, concise, and legible; and, all blanks should be completed on special forms.</p>	S 0640	Per the survey findings, Medical Staff Rules and regulations, facility policies, and subsequent chart review, the director and quality management coordinator created a checklist containing the items consistently missed by surgeons and anesthesiologists on 12/30/15. The checklist will be placed on the front of each chart on 1/29/16, and will serve to reinforce charting specifics that include but are not limited to: Proper authentication, timing, dating and legibly signing appropriate medical record entries. The proper method for identifying and managing charting errors. Completion of all times, equipment checks, vital signs, summaries and updates. Correct procedure for timing, managing, and authenticating verbal and	01/25/2016

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	<p>2. Review of the policy Documentation: Charting and Charts, MR 01, last updated 5/5/15, indicated under "Procedure": all documentation in the chart must be accurate, concise, and legible; and, if an error is made, draw one line through it and print "error" above it...".</p> <p>3. Review of medical records indicated:</p> <p>A. Patient #1 lacked documentation of vital signs on the H &amp; P (history and physical) form; had write overs on the "Time Out" documentation on the Operative Safety Checklist (page 2); had write overs on the "Surgery Began" time and "Out of Room" time on the Intraoperative Record form; and, lacked documentation by the anesthesiologist of a pre-op equipment check, prior to surgery with a general anesthetic, on the Anesthesia Record form.</p> <p>B. Patient #5 lacked completion on the notice of patient rights form whether the patient received the packet of information prior to their surgery, and lacked a date with the signature of the patient.</p> <p>C. Patient #14 had illegible times with physician authentication on the Endo H &amp; P form and again with the time of discharge documentation on the same form.</p> <p>D. Patient #16 lacked documentation of vital signs on the H &amp; P form.</p>		<p>standing orders, consents, diagnoses and other entries. Correct procedure for pre and post-procedure evaluations and summaries. A summary reminder was sent to each medical staff member by the medical director reiterating the requirements for documentation practices in the facility on 1/2/16. The director and quality Improvement committee chair conducted re-education for the clinical staff regarding the requirements for proper documentation in the medical record on 1/4 and 1/5/2016. The actions will be reviewed by the Medical Executive Committee on 1/21/16. The Peer Review Committee, the medical records manager and third party medical record auditor will monitor documentation going forward to ensure compliance.</p>	

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S 0780 Bldg. 00	<p>4. At 4:05 PM on 12/7/15, interview with staff member #53, the quality and accreditation staff, confirmed that the medical records listed in 3. above were incomplete and/or illegible.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on document review and interview, the medical staff failed to ensure the implementation of the medical staff rules and regulations, and facility policy, related to the authentication of both standing orders and verbal orders for 8 of 20 patient records, medical records #2, #5, #7, #8, #12, #18, #19 and #20.</p> <p>Findings Include: 1. Review of the medical staff rules and regulations, last approved on 11/24/14,</p>	S 0780	Per the survey findings and subsequent chart review, the director and quality management coordinator created a checklist containing the items consistently missed by surgeons and anesthesiologists on 12/30/15. The checklist will be placed on the front of each chart starting 1/29/16, and will serve to reinforce topics that include but are not limited to: Proper authentication, timing, dating and legibly signing appropriate medical record entries. The	01/25/2016

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	<p>indicated in section VII., that all orders on the patient chart must be signed, dated and timed by the physician when available and that chart completion is within thirty (30) days.</p> <p>2. Review of the policy Physician Standing/routine Orders, MR 04, last updated on 5/5/15, indicated under "Procedure" that Standing/Routine orders will be authenticated, signed, dated and timed by the physician when the patient is identified by the physician pre-operatively.</p> <p>3. Review of medical records indicated:</p> <p>A. Patient #2 had two pages of standing orders signed by the physician, but lacked a date and time of the authentication, and had verbal orders on 8/19/15 that were not authenticated, dated and timed by the physician.</p> <p>B. Patient #5 had standing orders of 2/11/15 with an authentication, but no date or time, and had a second page of standing orders that lacked a time with the date and authentication.</p> <p>C. Pt. #7 had standing orders from the office on 10/2/14 to the surgery center, for a surgery on 10/3/14, that were never authenticated, dated, or timed.</p> <p>D. Pt. #8 had standing orders on 3/9/15 that were authenticated, but lacked a date and time, and had another page of</p>		<p>proper method for identifying and managing charting errors. Completion of all times, equipment checks, vital signs, summaries and updates. Correct procedure for timing, managing, and authenticating verbal and standing orders, consents, diagnoses and other entries. Correct procedure for pre and post-procedure evaluations and summaries. A summary reminder was sent to each medical staff member reiterating the requirements for documentation practices in the facility on 1/2/16 by the medical director. The director and quality Improvement committee chair conducted re-education for the clinical staff regarding the requirements for proper documentation in the medical record on 1/4/16 and 1/5/2016. The actions and results will be reviewed by the Medical Executive Committee on 1/21/16. The Peer Review Committee, the medical records manager and third party medical record auditor will monitor documentation going forward to ensure compliance.</p>				

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S 0786	<p>standing orders that included verbal orders that were never authenticated, dated, or timed.</p> <p>E. Pt. #12 had a page of standing orders, with additional verbal orders, that were never authenticated on 1/15/15.</p> <p>F. Pt. #18 had a page of standing orders from the office on 3/2/15 for surgery on 3/23/15 that were never authenticated, had post op standing orders that were never authenticated, dated, or timed, and had a third page of standing orders that were not timed after authenticated and dated.</p> <p>G. Pt. #19 had two pages of standing orders that were authenticated and dated, but not timed on 11/19/15.</p> <p>H. Pt. #20 had standing pre op orders sent from the office on 7/10/15 for surgery on 11/19/15 that were authenticated, but not dated and timed, and had standing post op orders authenticated, but not dated and timed.</p> <p>4. At 4:05 PM on 12/7/15, interview with staff member #53, the quality and accreditation staff member, confirmed that physicians were not following facility policies and rules and regulations related to authentication, dating and timing of standing and verbal orders.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND</p>			

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Bldg. 00	<p><b>SURGICAL</b> 410 IAC 15-2.5-4(b)(3)(Q)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(Q) A requirement for a center that permits patient care responsibilities by practitioners other than physicians, to have established policies and procedures, approved by the governing body, for overseeing and evaluating the nonphysician practitioners.</p> <p>Based on document review and interview, the facility failed to have a medical staff approved policy that described a process for overseeing and evaluating non-physician practitioners in 1 instance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 12-07-2015 at 11:15 am, employee #A1, Director, was requested to provide documentation of a medical staff approved policy that described a process for overseeing and evaluating non-physician practitioners.</li> <li>Interview of employee #A2, Quality Accreditation, on 12-09-2015 at 10:35 am, indicated there was no policy and no other documentation was provided prior to exit.</li> </ol>	S 0786	<p>Effective 01/06/2016, specific wording was added to policy ADM 37 by the medical director and director:</p> <p>Contract/FloatStudent/Vendor Orientation, stating the facility director will have oversight of allied health personnel activities in the Center. The Quality Improvement Committee reviewed and approved the materials on 1/7/2016 and referred the amended policy to the Medical Executive Committee and governing board for review and approval on 1/21/2016 and 1/25/2016. The Medical Executive Committee and credentialing staff will review personnel during the re-credentialing process every two years. The director will review the allied health staff quarterly to ensure ongoing compliance.</p>	01/25/2016

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S 0830  Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(i)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and post-anesthesia responsibilities as follows:</p> <p>(i) The completion, within forty-eight (48) hours before surgery, of a preanesthesia evaluation for each patient by an individual qualified to administer anesthesia for all types of anesthetics other than local and updated according to center policy (when more than forty-eight (48) hours) before surgery.</p> <p>Based on document review and interview, the facility failed to ensure that a pre anesthesia evaluation was performed prior to the surgical procedure for 7 of 20 patients, patients #1, #5, #7, #8, #14, #19 and #20.</p> <p>Findings Include: 1. Review of the medical staff rules and regulations, last approved 11/24/14, indicated in item IX., that a physician must examine the patient immediately</p>	S 0830	Per the survey findings and subsequent chart review, the director and quality management coordinator created a checklist containing the items consistently missed by surgeons and anesthesiologists on 12/30/15. The checklist will be placed on the front of each chart starting 1/29/16, and will serve to reinforce topics that include but are not limited to: Proper authentication, timing, dating and legibly signing appropriate medical record entries. The proper	01/25/2016

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	<p>before surgery to evaluate the risk of anesthesia and of the procedure to be performed.</p> <p>2. Review of medical records indicated:</p> <p>A. Patient #1 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure on 12/1/15.</p> <p>B. Pt. #5 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure on 2/11/15.</p> <p>C. Pt. #7 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure on 10//14.</p> <p>D. Pt. #8 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure on 3/9/15.</p> <p>E. Pt. #14 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure on 11/17/15.</p> <p>. F. Pt. #19 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery</p>		<p>method for identifying and managing charting errors. Completion of all times, equipment checks, vital signs, summaries and updates. Correct procedure for timing, managing, and authenticating verbal and standing orders,consents, diagnoses and other entries. Correct procedure for pre and post-procedure evaluations and summaries. A summary reminder was sent to each medical staff member by the medical director reiterating therequirements for documentation practices in the facility on 1/2/16. The director and Quality Improvement committee chair conducted re-education for the clinical staff regarding the requirements for proper documentation in the medical record on 1/4 and 1/5/2016. The actions will be reviewed by the Medical Executive Committee on 1/21/16. The Peer Review Committee, the medical records manager and third party medical record auditor will monitor documentation going forward to ensure compliance.</p>				

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S 0834 Bldg. 00	<p>procedure on 11/19/15.</p> <p>G. Pt. #20 lacked a time of the pre anesthesia evaluation on the "Anesthesia Record" form, to be able to determine that this took place prior to the surgery procedure on 11/19/15.</p> <p>4. At 4:05 PM on 12/7/15, interview with staff member #53, the quality and accreditation staff member, confirmed that without the anesthesia provider timing the pre anesthesia evaluation, it cannot be determined that these were done prior to the start of surgery for patients #1, #5, #7, #8, #14, #19 and #20.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(iii)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and postanesthesia as follows:</p> <p>(iii) The completion of a</p>			

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	<p>postanesthetic evaluation for proper anesthesia recovery of each patient prior to discharge in accordance with written policies and procedures approved by the medical staff.</p> <p>Based on document review and interview the facility failed to ensure that the post op anesthesia evaluation was authenticated, as per facility policy and medical staff rules and regulations, for 5 of 20 patient records, records #1, #5, #8, #19 and #20.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of the medical staff rules and regulations, last approved on 11/24/14, indicated in item VII., that all physician entries into the medical record must be dated, timed and signed when the entry is made to verify compliance of chart completion within thirty (30) days.</li> <li>Review of the policy Documentation: Charting and Charts, MR 01, last approved on 5/5/15, indicated under "Procedure", in the section "B. Timing and Dating of Documentation": 1. All H &amp; Ps (history and physicals), physician order sheets, consents, dictation sheets, Operative, and Post procedure reports must include the physician's signature, the date, and time the document is signed.</li> <li>Review of medical records indicated:</li> </ol>	S 0834	<p>Per the survey findings and subsequent chart review, the director and quality management coordinator created a checklist containing the items consistently missed by surgeons and anesthesiologists on 12/30/15. The checklist will be placed on the front of each chart starting 1/29/16, and will serve to reinforce charting issues that include but are not limited to: Proper authentication, timing, dating and legibly signing appropriate medical record entries. The proper method for identifying and managing charting errors. Completion of all times, equipment checks, vital signs, summaries and updates. Correct procedure for timing, managing, and authenticating verbal and standing orders, consents, diagnoses and other entries. Correct procedure for pre and post-procedure evaluations and summaries. A summary reminder was sent to each medical staff member by the medical director reiterating the requirements for documentation practices in the facility on 1/2/16. The director and quality Improvement committee chair conducted re-education for the clinical staff regarding the requirements for proper documentation in the medical</p>	01/25/2016	

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S 0860 Bldg. 00	<p>A. Patient #1 lacked documentation of the time of the postoperative anesthesia note, on the anesthesia record form, on 12/1/15.</p> <p>B. Patient #5 lacked documentation of the time of the postoperative anesthesia note, on the anesthesia record form, on 2/11/15.</p> <p>C. Patient #8 lacked documentation of the date and time of the postoperative anesthesia note, on the anesthesia record form, on 3/9/15.</p> <p>D. Patient #19 lacked documentation of the date and time of the postoperative anesthesia note, on the anesthesia record form, on 11/19/15.</p> <p>E. Patient #20 lacked documentation of the time of the postoperative anesthesia note, on the anesthesia record form, on 11/19/15.</p> <p>4. At 4:05 PM on 12/7/15, interview with staff member #53, the quality and accreditation staff person, confirmed that the medical records listed in 3. above lacked proper dating and/or timing of the postoperative anesthesia evaluation.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL</p>		<p>record on 1/4/16 and 1/5/2016. The actions will be reviewed by the Medical Executive Committee on 1/21/16. The Peer Review Committee, the medical records manager and third party medical record auditor will monitor documentation going forward to ensure compliance.</p>		

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	<p>410 IAC 15-2.5-4(d)(2)(B)</p> <p>Requirements 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>(B) A requirement that an appropriate history and physical workup must be in the chart of every patient before surgery. If this has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting practitioner which includes, but is not limited to, vital signs, allergies, any significant risk factors, and date written.</p> <p>Based on document review and interview, the facility failed to ensure that H &amp; Ps (history and physicals) were completed per facility policy, and medical staff rules and regulations, for 6 of 20 medical records reviewed, records #1, #2, #7, #8, #16, and #19.</p> <p>Findings Include:</p> <p>1. Review of the medical staff rules and regulations, last approved 11/24/14, indicated in item VII., that all physician entries into the medical record must be dated, timed and signed when the entry is made to verify compliance of chart</p>	S 0860	Per the survey findings and subsequent chart review, the director and quality management coordinator created a checklist containing the items consistently missed by surgeons and anesthesiologists on 12/30/15. The checklist will be placed on the front of each chart starting 1/29/16, and will serve to reinforce topics that include but are not limited to: Proper authentication, timing, dating and legibly signing appropriate medical record entries. The proper method for identifying and managing charting errors. H&P's must be completed,	01/25/2016			

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	<p>completion within thirty (30) days, and in section IX., that a pertinent history and physical examination shall be performed according to the Centers guidelines, and 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. Review of the policy History and Physical, MR 03, last updated 5/5/15, indicated under "Procedure", H &amp; Ps done outside of the facility must be performed within 30 days from the date of surgery. The surgeon must also review and indicate any changes to the patient's status or no change on the date of surgery.</p> <p>3. Review of medical records indicated:</p> <p>A. Patient #1 lacked the documentation of a time that the H &amp; P was completed on 12/1/15.</p> <p>B. Patient #2 had a H &amp; P done 8/17/15 and surgery on 8/19/15 with no update note written on the day of surgery for the H &amp; P done two days prior.</p> <p>C. Pt. #7 had no date and time documented for the H &amp; P done for a surgery date of 10/3/14.</p> <p>D. Pt. #8 lacked the documentation of a time that the H &amp; P was completed on 3/9/15.</p> <p>E. Pt. #16 had an office H &amp; P from</p>		<p>authenticated, and updated per the facility Medical Records Policy. Completion of all times, equipment checks, vital signs, summaries and updates. Correct procedure for timing, managing, and authenticating verbal and standing orders, consents, diagnoses and other entries. Correct procedure for pre and post-procedure evaluations and summaries. A summary reminder was sent to each medical staff member by the medical director reiterating the requirements for documentation practices in the facility on 1/2/16. The director and quality Improvement committee chair conducted re-education for the clinical staff regarding the requirements for proper documentation in the medical record on 1/4/16 and 1/5/2016. The actions will be reviewed by the Medical Executive Committee on 1/21/16. The Peer Review Committee, the medical records manager and third party medical record auditor will monitor documentation going forward to ensure compliance.</p>	

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S 0888 Bldg. 00	<p>4/7/15 for an 11/17/15 date of surgery, which was beyond the 30 day requirement.</p> <p>F. Pt. #19 lacked the documentation of a time that the H &amp; P was completed on 11/19/15.</p> <p>4. At 4:05 PM on 12/7/15, interview with staff member #53, the quality and accreditation staff member, confirmed that the H &amp; Ps listed in 3. above were not per facility policy or medical staff rules and regulations.</p> <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 interview, the facility failed to</p>	S 0888	The Director and medical director	01/25/2016
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S 1154 Bldg. 00	<p>have a policy for the operative report to describe techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in 1 instance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 12-07-2015 at 11:15 am, employee #A1, Director, was requested to provide documentation of a policy for the operative report to describe techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon.</li> <li>Interview of employee #A1 on 12-08-2015 at 1:45 pm indicated there was no policy, as requested above, and no other documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(C)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p>		<p>updated the policy MR 09: Completeness and Legibility of the Medical Record to include specific information required in the operative report, including authentication of information, operative techniques, findings, and tissue removed or altered. The policy will be presented to the Medical Executive committee on 1/21/16 for review and approval and then to the governing board for approval on 1/25/16. The medical director will educate the medical staff. The medical records manager, peer review committee and third-party auditor will monitor the documentation for completeness going forward.</p>	

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S 1168	<p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Operational and maintenance control records must be established and analyzed at least triennially. These records must be readily available on the premises.</p> <p>Based on interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 5 systems of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 12-7-2015 at 11:15 am, employee #A1, Director, was requested to provide documentation of the operational and maintenance control records for the heating, ventilation, cooling, smoke detector, and fire alarm systems having been analyzed at least triennially.</li> <li>In interview on 12-10-2015 at 3:20 pm, employee #A1 confirmed there was no documentation of the triennial review on the above pieces of equipment and no other documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-7</p>	S 1154	<p>Effective 2/10/2016, the facility director added the requirement for the documentation of operational and maintenance control recording and triennial analysis of the heating, cooling, smoke detector, and fire alarm systems to the existing Operational and Maintenance testing and review. This was approved by the Medical Executive Committee on 2/12/2016. Compliance will be monitored and documented by the Safety Officer in the annual equipment inspection and by the Medical Executive Committee at the annual and triennial equipment reviews.</p>	02/29/2016

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Bldg. 00	<p>PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the facility failed to document current leakage checks for 3 (emergency call code system, radiology equipment and sterilizer) of 10 pieces of patient care equipment and failed to conduct triennial analysis of the procedures to conduct preventive maintenance (PM) for 5 (cardiac monitor, overhead operating room lights, suction/vacuum machine, surgical table and wheelchair) of 11 pieces of patient care equipment.</p> <p>Findings:</p>	S 1168	<p>S 1168 Revised</p> <p>Effective 2/10/2016, the facilitydirector added the requirement for checking amperage leak checksfor the emergency call code system, the radiology equipment and sterilizers tothe annual listing of equipment requiring amperage leak testing. This was approvedby the Medical Executive Committee on 2/12/2016. In addition, the process for conducting thepreventative maintenance of equipment including but not limited to: cardiacmonitors, overhead operating room lights, patient stretchers, suction vacuum console,surgical tables</p>	02/29/2016
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S 1170  Bldg. 00	<p>1. Review of documentation of 10 pieces of patient care equipment indicated a current leakage check was not performed on a emergency call code system, radiology equipment and sterilizer.</p> <p>2. Review of documentation for 11 pieces of patient care equipment indicated a triennial analysis of the procedures to conduct PM was not performed on a cardiac monitor, overhead operating room lights, suction/vacuum machine, surgical table and wheelchair.</p> <p>3. In interview, on 12-10-2015 at 3:05 pm, employee #A1, Director, indicated all the above was done by a contractor. No documentation was provided of current leakage checks and triennial analysis on the above-stated equipment having been performed by the contractor and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and</p>		and wheelchairs was reviewed and approved by the Safety Committee on 2/16/16. The review of the preventative maintenance plan will be presented to the Medical Executive Committee on 2/25/16 for formal approval of inclusion into the Center's annual and triennial equipment inspection and review processes. Compliance will be monitored and documented by the Safety Officer in the annual equipment inspection and by the Medical Executive Committee at the annual and triennial equipment reviews.	

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	<p>maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to document defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator.</p> <p>Findings include:</p> <p>1. Review of the LIFEPAK 20 Defibrillator/Monitor Operating Instructions indicated the facility was to perform daily checks per the Operator's Checklist provided by the manufacturer that included, but were not limited to, inspect physical condition for foreign substances, damages or cracks, Inspect power source for broken, loose, or worn power cable, and confirm therapy cable connected to defibrillator and perform cable check.</p>	S 1170	The Safety Committee reviewed and recommended amending the policy: PC 045 Defibrillator Checks to include the incorporation of the Lifepak 20 manufacturer guidelines for daily maintenance on 12/17/15. The group approved the changes. The director and safety officer educated the staff regarding the additional requirements on 12/30/15. The policy will be reviewed by the Medical Executive Committee on 1/21/16. The Pre/Post daily checklist activity by unit staff will ensure ongoing compliance.	01/25/2016

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S 1174 Bldg. 00	<p>2. Review of a document entitled Inverness Surgery Center Emergency Cart Checklist, dated 12-01-2015 through, 12-9-2015, indicated it did not include the above daily checks.</p> <p>3. In interview, on 12-09-2015 at 10:15 am, employee #A1, Director, confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following:</p> <p>(A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(i) Asepsis.</p>				

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	<p>(ii) Cross-contamination prevention. (iii) Safe practice.</p> <p>Based on document review, observation, and interview, the facility failed to ensure that housekeeping services were provided in a manner that maintained cleanliness in two areas toured.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of the policy Clean Environment and Housekeeping, PC 109, last updated 5/5/15, indicated in section 8. "Weekly Cleaning", that air returns are cleaned weekly.</li> <li>While on tour of the surgery suites on 12/8/15 at 10:29 AM in the company of staff member #53, the quality and accreditation specialist, and staff member #56, the housekeeping supervisor, it was observed in OR (operating room) #2 that the wall air vents/returns had an accumulation of dust present.</li> <li>Staff members #53 and #56 confirmed that the wall vents were dusty at 10:29 AM on 12/8/15.</li> <li>While on tour of the facility at 10:35 AM on 12/8/15 in the company of staff members #53 and #56, it was observed in the staff break room that both refrigerators had a large accumulation of dust on the tops of the appliances.</li> </ol>	S 1174	<p>On 12/15/2015 the director informed the cleaning contractor that effective 12/15/15 the housekeeping carts will be stored in the General Supply room. The new storage location of the carts will eliminate the potential of cross contamination from the carts to other areas of the center. The charge nurse will check the location of the carts upon opening each business day going forward. On 12/15/16, the director and infection preventionist reviewed the housekeeping logs and cleaning responsibilities per policy PC 109A - Clean Environment and Housekeeping. The cleaning contracted staff were re-educated to include highdusting and cleaning of the operating rooms, sterile areas, sub-sterile areas, refrigerators, and break room in their daily duties on 12/21/2015. The facility policy, PC 109A Clean Environment and Housekeeping was amended by the director to include the two-minute contact time for Cavicide. The policy was reviewed and approved by the Infection Control committee on 12/29/15 and will be presented to the medical executive committee for review and approval on 1/21/16. The infection preventionist educated the contract cleaners and Facility staff on 1/4/16 and 1/5/16. The director and infection</p>	01/25/2016			

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	5. Staff members #53 and #56 agreed that housekeeping is to clean the tops of the appliances and that it had not been done for some time due to the noted accumulation of dust present.		preventionist will monitor the cleanliness and dry times of the cleaning agents during the monthly and quarterly audits to ensure compliance going forward.		