

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001074		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/14/2012	
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF OPHTHALMOLOGY CONSULTANTS				STREET ADDRESS, CITY, STATE, ZIP CODE 7232 ENGLE RD FORT WAYNE, IN 46804			
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 009567</p> <p>Survey Date: 11-13-12 to 11-14-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 11/20/12</p>			S0000			

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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S0106	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Review the bylaws at least triennially.</p> <p>Based on document review and interview, the governing board failed to review the board bylaws within the past three years.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 11-13-12 at 1030 hours, staff A1 was requested to provide documentation indicating when the governing board bylaws were last reviewed and none was provided prior to exit. The governing board meeting minutes for 2010, 2011 and 2012 failed to indicate that a review of the bylaws had been performed. During an interview on 11-14-12 at 1630 hours, staff A1 confirmed that no documentation was available indicating that the governing board had reviewed the bylaws in the past 3 years. 	S0106	<p>Documentation was present in the By-Laws manual that they were reviewed on 3/23/11, however it was not carried forward to the governing board meeting minutes that this review took place. An emergency meeting of the governing board will be called to order on 12/13/12 at which time the By-Laws will be formally reviewed. Close attention will be paid to monitor the review dates and follow up documentation within the governing board minutes from this day forward. 1/29/13 Addendum: Jackie Dayton, RN Supervisor called the meeting to order on 12/13/12. The By-Laws were reviewed by the governing board. Jackie will be responsible for this in future years.</p>	12/13/2012			

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S0122	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body.</p> <p>Based on document review and interview, the governing board failed to review and approve the medical staff bylaws within the past three years.</p> <p>Findings:</p> <p>1. On 11-13-12 at 1030 hours, staff A1 was requested to provide documentation indicating governing board approval of the medical staff bylaws, rules and regulations and none was provided prior to exit.</p> <p>2. The signature page in front of the medical staff bylaws, rules and regulations indicated a date of review (3-23-11) that failed to correspond with a quarterly medical staff or governing board meeting (2-03-11, 5-5-11) and failed to indicate the signature of the responsible person authorized by the medical staff and the governing board.</p>	S0122	<p>This citation is a duplicate of S 0106. Documentation of our By-Laws manual review was carried out on 3/23/11. An emergency meeting of the governing board will be called to order on 12/13/12 to formally accept the review of the By-Laws. Our medical staff and our governing board are one and the same. Jackie Dayton, RN Supervisor will pay close attention to the review dates and see to it that the review is carried forward for the medical staff/governing board to accept. She will also re-do the signature page in the manual to reflect the author/reviewer of the By-Laws and date the review took place and what date it was sent to the governing board.</p>	12/13/2012	

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	<p>3. The governing board meeting minutes for 2010, 2011 and 2012 failed to indicate that the medical staff bylaws had been reviewed and approved by the board.</p> <p>4. During an interview on 11-14-12 at 1630 hours, staff A1 confirmed that no documentation was available indicating board approval of the medical staff bylaws.</p>			

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S0156	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on review of the facility employee handbook, employee personnel file review, and staff interview, the chief executive officer/administrator failed to ensure an annual performance review was completed for the nursing supervisor (staff member P5) and failed to establish and maintain a job description for all personnel and perform an annual performance evaluation for 2 housekeeping personnel (P30 and P31).</p> <p>Findings:</p> <p>1. at 2:00 PM on 11/14/12, review of the Employee Handbook, with a March 2012 date printed at the bottom, indicated:</p> <p>a. on page 6 under the section titled: "Wages and Salaries", it reads: "In order to attract and retain a highly qualified and</p>	S0156	The annual performance review of Jackie Dayton, RN Supervisor was completed in July 2011 and August 2012, however no copies were found. Doug Miller, Practice Administrator will re-produce the missing documents and place in her file. Doug will make sure that future performance reviews are promptly placed in her file. Job descriptions for housekeeping personnel will be written by Jackie Dayton, RN Supervisor and placed in the Policy Manual. Evaluations were done on the housekeeping staff at regular intervals for 2011 and 2012. The surveyor was shown these evaluations but the citation states that they were missing. Jackie will keep these evaluations in their files and create a new performance evaluation based on	12/28/2012			

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	<p>competent work force, Ophthalmology Consultants has instituted a performance-based program to compensate employees...A. After the employee completes his/her initial employment period. B. Annual work and salary reviews thereafter (currently reviews are usually completed in July). Under usual and appropriate circumstances, an employee should receive a performance review annually..."</p> <p>2. at 2:15 PM on 11/13/12, review of staff personnel files indicated that the file for staff member P5 (also #50, the nursing manager), was lacking documentation of an annual performance review since 7/21/10</p> <p>3. at 4:10 PM on 11/14/12, interview with staff member #50, the nursing manager, indicated that a performance review was performed in 2012 and should be in the file</p> <p>4. interview with staff member #51, the administrator, at 5:30 PM on 11/14/12 indicated the performance evaluation for staff member P5 (#50) could not be found prior to surveyor exit from the facility</p> <p>5. During an interview on 11-13-12 at 1030 hours, staff A1 was requested to provide job descriptions for housekeeping personnel and none was provided prior to</p>		their competencies.	

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	<p>exit.</p> <p>6. The policy/procedure table of contents failed to indicate a job description for housekeeping personnel.</p> <p>7. The housekeeping personnel files for staff P30 and P31 lacked a job description and lacked documentation of an annual performance evaluation based on the job description.</p> <p>8. During an interview on 11-14-12 at 1615 hours, staff A1 confirmed that the 2 personnel files lacked a job description or annual evaluation for the employees.</p>				

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S0166	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based upon document review and interview, the center failed to review and update its policies/procedures at least triennially.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 11-13-12 at 1030 hours, staff A1 was requested to provide documentation indicating that its policies/procedures had been updated and reviewed within the past three years and none was provided prior to exit. The policy/procedures provided for review failed to indicate the surgery center name, dates of origin, review, or revision with the name of the responsible person. During an interview on 11-14-12 at 1330 hours, staff A1 indicated that the center policies/procedures were 	S0166	<p>The Policy and Procedure Manual had a review date of 4/12/11 however the review was neglected to be brought forward to the governing board meeting minutes. The governing board will have an emergency meeting called to order on 12/13/12 at which time the Policy and Procedure Manual will be formally reviewed. Per the suggestion of the surveyor, Jackie Dayton, RN Supervisor is rewriting each policy to show ownership at the top of each page with a title, date of origin and dates of review. The signature page in the front of the manual will contain the author/reviewer of the book and date the review took place and date the review was sent to the governing board.</p>	12/13/2012			

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	<p>historically reviewed during the medical credentials committee meeting.</p> <p>4. The signature page in the front of the policies/procedures binder indicated a date of review (4-12-11) that failed to correspond with the most recent credentials committee meeting (8-25-11) and failed to indicate the signature of the responsible person(s) authorized by the governing board to perform the review.</p> <p>5. The credentials committee minutes failed to indicate that a review of the center policies/procedures had been performed since the 4-17-08 committee meeting.</p> <p>6. During an interview on 11-14-12 at 1630 hours, staff A1 confirmed that the center failed to ensure that its policy/procedures were reviewed and updated within the last three years.</p>				

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S0172	<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, center failed to follow its policy/procedure and maintain the housekeeping personnel files regarding documentation of periodic training in environmental infection control and aseptic technique, bloodborne pathogens (BBP) and fire safety training for 2 housekeeping personnel.</p> <p>Findings:</p> <p>1. The policy/procedure Continuing Education/Inservice Training (approved 4-08) indicated the following: " The Nursing Supervisor in conjunction with the Administrator shall develop, implement a program of ongoing education/training for employees...The</p>	S0172	Jackie Dayton, RN Supervisor will instruct the housekeeping staff to complete their infection control training and blood borne pathogen training online as the rest of the nursing staff does on an annual basis. The housekeeping staff from this day forward will be included in our quarterly fire drills. Aseptic technique is not required for housekeeping personnel. Policy will be changed to exempt them from learning aseptic technique. 1/29/13 Addendum: Jackie Dayton, RN Supervisor will include the two housekeeping staff members in the annual infection control and BBP training along with the nursing staff. This training will take place on Wed. February 27, 2013. Jackie will be the responsible person for seeing	12/28/2012			

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	<p>program ...shall include as a minimum: ...Infection control and aseptic techniques - annually and as needed. Fire and disaster drills - quarterly ...A record of both in-service training and formal continuing education shall be maintained for all employees and kept in the employee ' s personnel file. "</p> <p>2. Review of personnel files for staff P30 and P31 failed to indicate that the staff had participated in periodic annual infection control/BBP training since 6-2011 or participated in periodic fire safety training.</p> <p>3. Review of center documentation Environmental Infection Control and Annual BBP Training Records dated 2-15-12 failed to indicate that staff P30 and P31 had participated in the training.</p> <p>4. Review of center documentation dated 2-9-12, 5-3-12, 8-9-12 and 11-8-12 failed to indicate that staff P30 and P31 had participated in the fire drill or inservice training.</p> <p>5. During an interview on 11-14-12 at 1615 hours, staff A1 confirmed that the personnel files lacked documentation of periodic infection control and fire safety training.</p>		<p>this takes place in the future. Documentation will be in each person's personnel file.</p>		

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S0226	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</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>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided, for 6 of 17 services.</p> <p>Findings:</p> <p>1. Review of a list of contracted services provided by staff A1 failed to indicate a service provider for three (3) fire systems and equipment providers, laser, pest control, and waste disposal.</p> <p>2. Review of facility documentation indicated the following service providers: fire alarm monitoring by V1, fire sprinkler service by V2, fire extinguisher service by V3, laser service by V4, pest control service by V5 and waste disposal by V6.</p> <p>3. During an interview on 11-14-12 at</p>	S0226	<p>The fire alarm monitoring system, sprinkler service system, fire extinguisher system, laser maintenance, and pest control will be added to our list of contracted services by Jackie Dayton, RN Supervisor. Our waste management disposal was already on the list. The surveyor must have overlooked this.</p> <p>1/29/2013 Addendum: Jackie Dayton, RN Supervisor will be responsible for adding the additional contracts to our QA checklist. Jackie made a spreadsheet to assist in making sure all vendors are included in quarterly QA meetings. This spreadsheet will be part of the meeting agenda so all vendors are mentioned in the meeting minutes.</p>	12/28/2012			

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	1640 hours, staff A1 confirmed that the center failed to maintain its list of contracted services.			

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S0300	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the center failed to follow its rules and regulations and ensure that the safety management functions were monitored and evaluated through the quality assessment and improvement (QA) program.</p> <p>Findings:</p> <p>1. The Medical Staff Rules and Regulations (no review or approval date) indicated the following: "The duties of the quality assurance committee regarding the ASC shall include: (d) Monitoring, overseeing, evaluating, and coordinating the ASC ' s services to include: ...safety management. "</p> <p>2. The policy/procedure ASC Committees and Their Functions (reviewed 4-17-08) indicated the following: " The QA committee receives</p>	S0300	Jackie Dayton, RN Supervisor will, from now on, make safety issues a part of our quarterly QA topics.	12/28/2012			

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	<p>and reviews all committee reports and minutes, including ...in-service training and safety [and] fire and disaster activities. "</p> <p>3. Review of the QA Committee minutes dated 2-2-12, 4-26-12, 8-2-12 and 11-1-12 failed to indicate that any safety program functions were performed or reviewed by the committee.</p> <p>4. During an interview on 11-14-12 at 1630 hours, staff A1 confirmed that the QA committee failed to monitor or evaluate the safety management functions through the QA program.</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0310	<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. Based on document review and interview, the center failed to follow its rules and regulations and ensure that the services performed under contract were evaluated by the Quality Assurance (QA) committee for 3 direct and 6 contracted services.</p> <p>Findings:</p> <p>1. The Medical Staff Rules and Regulations (no review or approval date) indicated the following: "The duties of the quality assurance committee regarding the ASC shall include: (a) evaluating all services, including services provided by a contractor."</p> <p>2. The policy/procedure ASC Committees and Their Functions (reviewed 4-17-08) failed to indicate the Quality Assurance Committee requirement to evaluate all contracted services through the QA program.</p>	S0310	<p>Jackie Dayton, RN Supervisor will add the following to her list of QA contractors: Housekeeping, Nursing, Transcription, Fire alarm system, Fire extinguisher system, Sprinkler system, laser maintenance, and pest control. Waste disposal was already on the list. In the past, Jackie did a QA review on these services annually, but according to the surveyor, ALL services should be reviewed quarterly. The surveyor gave Jackie an example of a spreadsheet to incorporate all services into the quarterly QA meeting minutes. Jackie will make a similar document to show how she can easily incorporate all the services into her quarterly meeting minutes.</p>	12/28/2012			

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	<p>3. Review of the Quality Improvement Committee minutes dated 2-2-12, 4-26-12, 8-2-12 and 11-1-12 failed to indicate that three (3) direct services consisting of housekeeping, nursing and transcription had been reviewed by the QA program. The minutes failed to indicate that six (6) contracted services consisting of three (3) fire systems and equipment services, a laser service, a pest control service, and a waste disposal service had been reviewed by the QA program.</p> <p>4. During an interview on 11-14-12 at 1640 hours, staff A1 confirmed that the services had not been evaluated through the QA program.</p>			

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S0320	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the center failed to follow its rules and regulations and ensure that the functions of discharge, medication errors, and response to patient emergencies were evaluated by the Quality Assurance (QA) committee.</p> <p>Findings:</p> <p>1. The Medical Staff Rules and Regulations (no review or approval date) indicated the following: "The duties of the quality assurance committee regarding the ASC shall include: (b) Evaluating all functions, including, but not limited to, the following: discharge and transfer, infection control, medication errors, and response to patient emergencies."</p>	S0320	As a general rule, Jackie Dayton, RN Supervisor usually doesn't report on events that didn't occur, such as the deficiencies listed. A. Discharge and transfer, B. Infection Control C. Medication errors, and D. response to patient emergencies. In the past year, our ASC has had no transfers, medication errors, nor patient emergencies. This is why the surveyor neglected to find a report on them. However, per the surveyor's suggestion, Jackie will report on these issues, from now on, on a quarterly basis, even if the events did not occur.	12/28/2012

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	<p>2. The policy/procedure ASC Committees and Their Functions (reviewed 4-17-08) failed to indicate the Quality Assurance Committee requirement to evaluate all functions including discharge, medication errors, and response to patient emergencies through the QA program.</p> <p>3. Review of the Quality Improvement Committee minutes dated 2-2-12, 4-26-12, 8-2-12 and 11-1-12 lacked documentation indicating that the functions of discharge, medication errors, and response to patient emergencies had been reviewed by the QA program.</p> <p>4. During an interview on 11-14-12 at 1630 hours, staff A1 confirmed that the required functions had not been evaluated through the QA program.</p>			

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S0428	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</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>(i) Sanitation.</p> <p>Based on policy and procedure review, observation, and interview, the infection control practitioner failed to ensure the cleanliness of the facility in one pre op area and the laser room.</p> <p>Findings:</p> <p>1. at 12:00 PM on 11/13/12, review of the policy and procedure manual, with a date of review of 2011, indicated:</p> <p>a. the policy titled "Nursing Staff Cleaning Duties", with no policy number, indicated: "1. On Surgical days...Clean carts with approved germicide, clean all equipment with approved germicide..."</p> <p>2. at 10:25 AM on 11/14/12, while on tour of the pre op area of the facility, it was observed that:</p> <p>a. an accumulation of dust was present on the handle and body of the McKesson</p>	S0428	<p>Jackie Dayton, RN Supervisor took notice of the mentioned areas that were unclean. She delegated to the medical assistant to immediately clean the areas with approved germicidal cleaner. Jackie then had an emergency staff meeting to re-instruct all staff members in their responsibilities for cleaning and disinfection of ALL areas of patient care. Jackie also instructed the housekeeping staff to be watchful of areas that the nursing staff might be missing and bring it to her attention. 1/29/2013 Addendum: Jackie Dayton, RN Supervisor will do random housekeeping checks every 2-3 weeks and document in the surveillance logbook what her findings are. The appropriate staff members will be notified immediately if any areas need attention.</p>	12/28/2012			

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	<p>suction machine on top of the code/crash cart</p> <p>b. an accumulation of dust was observed on the back/top of the code/crash cart</p> <p>c. dust was present on the face plate of the nurse call light (mounted on the wall at the head of the stretcher/gurney)</p> <p>3. at 11:50 AM on 11/14/12, it was observed in the laser room that an accumulation of dust was present on the wall mounted switch box</p> <p>4. at 11:10 AM on 11/14/12, interview with staff member #50, the nursing supervisor and infection control nurse, indicated the dusty code cart, suction machine, and face plate were observed by this staff member in the pre op area</p> <p>5. interview with staff member #50, nursing supervisor and infection control nurse, at 11:50 AM on 11/14/12 indicated dust was present on the wall mounted switch box in the laser room</p>			

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S0442	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on review of the infection control plan, policy and procedure review, employee personnel file review, and staff interview, the infection control practitioner failed to ensure that TB (tuberculosis) tests were read between 48 and 72 hours, per facility policy, for 5 of 6 employees (P2 through P6), and failed to ensure the immunity of Rubeola for staff member P2 and the immunity of Varicella for staff member P4.</p> <p>Findings:</p> <p>1. at 12:00 PM on 11/13/12, review of the policy and procedure manual, which included the infection control plan and was dated as reviewed in 2011, indicated:</p> <p>a. in the section "Immunizations and Titers for Healthcare Workers", it reads: "It is the policy of the Surgery Center of Ophthalmology Consultants to hire competent, healthy workers. In order to assure our employees are free of communicable diseases, the Surgery Center follows guidelines</p>	S0442	Jackie Dayton, RN Supervisor has conducted a risk assessment of the ASC for tuberculosis per the CDC guidelines. It was found that our facility in this area of Indiana is at a very low risk for TB. Only 3 cases were diagnosed in Allen County in 2011. For this reason, our policy will be rewritten to exclude us from yearly PPD testing. All staff members will be asked during their yearly physical exams if any symptoms for TB might be present. If any staff member has exhibited any symptoms of TB, further PPD testing will be required. Jackie will also review all staff personnel files for vaccine and titer requirements for MMR and varicella. If any staff member does not meet the requirement,	02/13/2013			

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	<p>and recommendations from the CDC regarding immunizations and post-vaccination titers. Please see the attached articles to support those findings."</p> <p>2. one attachment related to MMR (measles-mumps-rubella) vaccine indicated: a. "How would I follow up with a new health care worker (HCW) who has 2 documented doses of ...(MMR)...Two documented doses of MMR vaccine is considered proof of immunity according to ACIP..."</p> <p>3. the MMWR (Morbidity/Mortality Weekly Report) May 22 1998 attachment indicated: a. on page 10: "...Documentation of Immunity-- -Only doses of vaccine for which written documentation of the date of administration is presented should be considered valid. Neither a self-reported dose nor a history of vaccination provided by a parent is, by itself, considered adequate documentation..." b. on page 11, "Table 1" reads for HCWs related to Measles/Rubeola: "(1) documented administration of 2 doses of live measles..., or (2) laboratory evidence of immunity, or (3) born before 1957...,or (4) documentation of physician-diagnosed measles"</p> <p>4. at 4:15 PM on 11/14/12, review of the policy "Positive TB Results", with no policy number and a date of review in 2011, indicated: a. "It is the policy of Ophthalmology Consultants to provide annual mantoux testing for ALL employees. The intra-dermal test is administered by a certified RN and read within 48-72 hours by the RN..."</p> <p>5. at 2:15 PM on 11/13/12 and 4:10 PM on 11/14/12, review of staff personnel files indicated: a. staff member P2 was given a TB test at 0758 hours on 6/4/12 that was read at 0740 hours on</p>		<p>then they will be sent for titer blood tests. 1/29/2013 Addendum: The formal risk assessment worksheet from the CDC has been filled out and will be updated annually. These guidelines will be adopted by the infection control committee and ultimately approved by the governing board on Feb. 13, 2013</p>				

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	<p>6/6/12</p> <p>b. staff member P3 had a TB test given at 0937 hours on 6/5/12 that was read at 0820 hours on 6/7/12</p> <p>c. staff member P4 had a TB test given at 1300 hours on 6/5/12 that was read at 0820 hours on 6/7/12</p> <p>d. staff member P5 had a TB test given at 0740 hours on 6/4/12 and read at 0730 hours on 6/6/12</p> <p>e. staff member P6 had a TB test given at 0754 hours on 6/4/12 and read at 0730 on 6/6/12</p> <p>f. staff member P2 had documentation of one MMR given 12/8/80</p> <p>g. staff member P4 had verbal/self reporting documentation of having had Chicken Pox (Varicella)</p> <p>6. interview with staff member #50, nursing manager and infection control nurse, at 10:05 AM on 11/14/12 indicated:</p> <p>a. it is hard to find a time to read the TB tests as all staff are PRN (as needed), thus the TB tests were read prior to the 48 hour policy requirement for staff members P2 through P6</p> <p>b. since the MMR for staff member P2 was written twice on the immunization form, it was assumed two separate immunizations were given--</p> <p>c. no titer results, or documentation of a second MMR could be found for P2</p> <p>d. there are no titer results or documentation of immunization for staff member P4 related to Varicella--their Varicella is self reported which is not allowed per facility policy</p>			

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S0646	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(3)</p> <p>All entries in the medical record must be as follows:</p> <p>(3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule.</p> <p>Based upon document review and interview, the center lacked a policy/procedure to ensure all entries in the medical record (MR) were dated when authenticated.</p> <p>Findings:</p> <p>1. Review of the policy/procedure Medical Record Charting (reviewed 4-08) failed to indicate that the author of each entry must date each entry when authenticated.</p> <p>2. During an interview on 11-14-12 at 1640 hours, staff A1 confirmed that the policy/procedure lacked the requirement to date each entry when authenticated.</p>	S0646	<p>Jackie Dayton, RN Supervisor will write a policy to ensure all entries in the medical record will be dated when authenticated. The ASC will be initiating electronic medical records within the next 4-6 months, when at that time, this will be obsolete. 1/29/2013 Addendum: Our internal medical records auditor has been informed of this. She will do the initial audit on every patient record, then a professional auditor looks at a random sampling of the records twice a year.</p>	12/28/2012	

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S0732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based upon document review and interview, the medical staff failed to follow its policy/procedure and ensure that its bylaws, rules and regulations were reviewed at least triennially.</p> <p>Findings:</p> <p>1. On 11-13-12 at 1030 hours, staff A1 was requested to provide documentation indicating that the medical staff had reviewed its medical staff bylaws, rules and regulations within the past 3 years and none was provided prior to exit.</p> <p>2. The policy/procedure ASC Committees and Their Functions (reviewed 4-17-08) indicated the following: " The duties of the Credentials Committee shall be: To review at least biennially the Medical Staff Bylaws, Rules and Regulations and/or Policies of the ASC ... "</p> <p>3. The signature page in front of the</p>	S0732	<p>This citation is a duplicate of S 0106. Jackie Dayton, RN Supervisor will call to order the governing board on 12/13/12 to approve the By-Laws, Rules and Regulations.1/29/2013 Addendum: Our medical staff and governing board consist of the same 3 physicians. Therefore, if the governing board was called to order for a meeting, the medical staff was called to order also. Jackie Dayton, RN Supervisor will be responsible for bringing the By-Laws and Rules and Regulations to the Medical Staff/Governing Board every 3 years for review.</p>	12/13/2012	

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	<p>medical staff bylaws, rules and regulations indicated a date of review (3-23-11) that failed to correspond with a Credentials Committee meeting (4-17-08, 8-25-11) and failed to indicate the signature of a responsible person.</p> <p>4. The medical staff meeting minutes for 2010, 2011 and 2012 failed to indicate that the medical staff bylaws had been reviewed and approved by the medical staff.</p> <p>5. During an interview on 11-14-12 at 1630 hours, staff A1 confirmed that the medical staff bylaws, rules and regulations had not been reviewed by the medical staff within the past 3 years.</p>				

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S0888	<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 medical staff rules and regulations review, patient medical record review, and staff interview, the medical staff failed to ensure that an operative report was dictated immediately after the operative procedure for one patient that was not a laser or cataract patient (pt. #13).</p> <p>Findings:</p> <p>1. at 3:15 PM on 11/14/12, review of the facility medical staff rules and regulations, with a most recent "reviewed" date of 3/23/11, indicated:</p> <p>a. in the section titled: "Surgery", it</p>	S0888	Jackie Dayton, RN will call to order the governing board on 12/13/12 and remind its members that surgery dictations MUST be completed on the day of surgery. After the ASC initiates our EMR (electronic medical records) in 4-6 months, this problem will be obsolete. Our EMR program will automatically generate an Op-Report when surgery is complete. 1/29/2013 Addendum: Until our EMR is in place, our internal auditor has been informed to add this to her auditing checklist. She audits every record.	12/13/2012			

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	<p>reads: "...(c) An operative report describing techniques, findings, and tissue removed or altered shall be written or dictated immediately following surgery and authenticated by the surgeon in accordance with ASC policy..."</p> <p>2. review of patient medical records at 11:45 AM on 11/14/12 indicated:</p> <p>a. pt. #13 had an excision and biopsy of an eye lesion on 11/7/12 with an operative report dated as dictated on 11/9/12</p> <p>3. interview with staff member #50 (nursing supervisor) at 3:15 PM on 11/14/12 indicated:</p> <p>a. laser procedures and cataract surgery patients have a "template" that physicians dictate/complete immediately after surgery</p> <p>b. pt. #13 had a procedure performed that does not have a template and the physician had to go to the physician office area (outside the surgery center floor plan) to dictate this report</p> <p>c. in checking with the surgeon, it was thought that this was dictated the day of surgery</p> <p>d. there is staff confusion as to why the dictated date is not congruent with the date of surgery</p> <p>4. the surveyor's copy of the operative report was taken by staff member #50 (to</p>			

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	show the surgeon) and never returned to the surveyor, even after a second request for return of the document				

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S1142	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)</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>(1) No condition in the center or on the grounds may be maintained which may be conducive to the harboring or breeding of insects, rodents, or other vermin.</p> <p>Based on observation and interview, the facility failed to ensure that no condition was created that might jeopardize the health of patients related to one stretcher in the post op area.</p> <p>Findings:</p> <ol style="list-style-type: none"> while touring the post op area at 11:04 AM on 11/14/12, it was observed that the gurney being cleaned by nursing staff was: <ol style="list-style-type: none"> torn on the mattress with the inner foam mattress visible (several small open areas with one about 1 to 1 1/2 inches long and 1/2 inch wide) torn (a 3 inch tear) on the head rest with the inner foam visible interview with staff member #50, the nursing supervisor and infection control 	S1142	<p>Jackie Dayton, RN Supervisor has ordered new mattresses for our Stryker gurneys. It is unclear when this citation will be corrected due to the variability of UPS or Fed-Ex deliveries this time of year. 1/29/2013 Addendum: Upon exploration of further options for mattress replacements, we found that having them professionally reupholstered was the most economical way to go. They will be returned to us on Feb. 1, 2013 better than new.</p>	02/01/2013

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	nurse, at 11:04 AM on 11/14/12, indicated: a. it was known that the mattresses are falling apart from the caustic cleaning agent used at the facility b. the Stryker company has reported that new covers are unavailable, only the purchase of a new mattress and head rest is possible, but they are expensive c. it is a possible infection control hazard to patients with the inner foam visible and unable to be cleaned effectively			

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S1180	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on document review and interview, the center lacked documentation of a functioning safety management program that included a review of safety functions by a committee with representatives from administration and patient care services.</p> <p>Findings:</p> <p>1. The Medical Staff Rules and Regulations (no review or approval date) indicated the following: "The duties of the quality assurance committee regarding the ASC shall include: (d) Monitoring, overseeing, evaluating, and coordinating the ASC 's services to include: ...safety management. "</p> <p>2. The policy/procedure ASC Safety Officer/Safety Program (reviewed 4-17-08) failed to indicate Safety Officer responsibilities or committee membership with representatives from administration</p>	S1180	<p>Jackie Dayton, RN Supervisor has a safety manual in place. It describes in detail the functions and responsibilities of staff members in all safety situations. It was provided by the online website from Stericycle (which we subscribe to). However, the surveyor declined to accept its authenticity since nowhere was it documented within the governing board meeting minutes that the safety manual was formally adopted. Jackie will call to order the governing board on 12/13/12 and formally adopt the safety manual as approved.1/29/2013 Addendum: Jackie Dayton, RN Supervisor serves as the safety officer of the ASC. Safety management has been added to her quarterly QA meeting agendas when she meets with the governing board so that they can approve the functions of the safety committee. The committee consists of the entire staff of the ASC (only 10 people). Jackie is</p>	12/13/2012			

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	<p>and patient care and failed to indicate the safety program functions to be performed and reviewed by the committee.</p> <p>3. Review of the Quality Improvement Committee minutes dated 2-2-12, 4-26-12, 8-2-12 and 11-1-12 failed to indicate that the safety function was performed or reviewed by the committee.</p> <p>4. During an interview on 11-14-12 at 1630 hours, staff A1 confirmed that the center lacked documentation of an active safety management program.</p>		the safety officer who relays issues to the governing board.		

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S1182	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based upon document review and interview, the safety management program lacked an ongoing, center wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Findings:</p> <p>1. On 11-13-12 at 1030 hours, staff A1 was requested to provide documentation of safety rounding or indicate the center process to collect and evaluate information about safety practices and hazards and none was provided prior to exit.</p> <p>2. The policy/procedure ASC Safety Officer/Safety Program (reviewed 4-17-08) failed to indicate a Safety Officer responsibility or safety program process for the ongoing collection of</p>	S1182	Jackie Dayton, RN Supervisor will make a checklist with safety hazards to observe for in the ASC. She will perform periodic checks using this list to make sure the ASC is a safe environment. This results of this checklist will be reported at quarterly QA meetings.	12/28/2012			

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	<p>information about hazards in the workplace to be reviewed by the committee.</p> <p>3. During an interview on 11-14-12 at 1620 hours, staff A1 confirmed that the safety management program failed to document an ongoing process for evaluating and collecting information about safety issues and practices.</p>			

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S1188	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on document review and interview, the center failed to follow its policy/procedure for conducting quarterly fire drills for 3 of 4 required drills.</p> <p>Findings:</p> <p>1. The policy/procedure Steri-Safe OSHA Emergency Preparedness Plan titled Emergency Action Plan - Fire (no approval date) failed to indicate a provision for notifying the alarm monitoring service prior to conducting the fire drill and failed to indicate that an audible fire alarm signal will sound when conducting a fire drill per NFPA 101, 2000 Edition Chapter 21.7.1.2</p>	S1188	Jackie Dayton, RN Supervisor has a new criteria checklist for fire drill participation that meets the conditions of NFPA 101. This checklist will be used from now on for the quarterly fire drills.	12/28/2012

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	<p>NFPA 101, 2000 Edition Chapter 21.7.1.2 indicates the following: [Fire exit drills in ambulatory health care facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. and 6:00 a.m. a coded announcement shall be permitted to be used instead of audible alarms.]</p> <p>2. Fire drill documentation dated 2-9-12, 5-3-12, 8-9-12 and 11-8-12 indicated that the fire alarm system was activated and patients and/or visitors were evacuated as part of the fire drill.</p> <p>3. During an interview on 11-1-12 at 1630 hours, staff A1 confirmed that the center did not activate the fire alarm or evacuate staff/patients and/or visitors with the tabletop fire inservices conducted on 2-3-12, 8-9-12 and 11-8-12 during staff meetings. Staff A1 confirmed that the Fire Drill Observer Checklist documentation dated 2-3-12, 8-9-12 and 11-8-12 failed to accurately document that the fire alarm signal was not activated and a center evacuation was not</p>						

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	performed. Staff A1 confirmed that the Emergency Action Plan - Fire lacked a provision for notifying the alarm monitoring service and lacked a provision for ensuring that the alarm signal was activated with each drill.			