

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001031	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER MARION EYE SPECIALISTS SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 711 W GARDNER DR MARION, IN 46952		
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005975</p> <p>Survey Date: 01-17-12 to 01-18-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 02/24/12</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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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.</p> <p>Based on document review and interview, the center failed to maintain a written quality assurance (QA) plan to include the evaluation of 8 contracted services provided at the facility.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assessment and Risk Management Plan (approved 12-10) failed to indicate a provision for evaluating contracted services (biomedical engineering, clinical laboratory/pathology, fire protection, furnace/humidifier, generator, medical gas, medical records consulting, and pest control services) provided at the center and failed to describe a process for performing, documenting, and reporting the ongoing evaluation.</p> <p>2. Review of the Contract Services Quality Statement documents failed to indicate standards for evaluating each</p>	S0310	<p>The QA/PI monitoring tool was revised to list each contracted service separately with required documentation, standards and evaluation of provider. See attached form QA/PI Monitors. The ASC Patient Care Manager is responsible for completing the form on an on-going basis and providing the information to the QA Committee on a quarterly basis.</p>	03/02/2012			

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	<p>service.</p> <p>3. The QA/PI Monitors Quarterly reports failed to indicate the standards used on the Contract Services Quality Statements for evaluating the providers listed in the Maintenance category and failed to distinguish internal processes.</p> <p>4. During an interview on 1-18-12 at 1715 hours, staff #A1 confirmed that the QA plan lacked a provision and process for evaluating contracted services. Staff #A1 confirmed that the documentation lacked standards and failed to ensure the ongoing review and revision of the standards used for evaluation of biomedical engineering, clinical laboratory/pathology, fire protection, furnace/humidifier, generator, medical gas, medical records consulting, and pest control services.</p>				

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S0332	<p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the center: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained.</p>			

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	<p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to</p>			

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	<p>the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is</p>			

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	<p>progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or (BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the center.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p>			

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	<p>Based on document review and interview, the center quality assessment and improvement program policy Incident Reporting/Adverse Events lacked identification of the events to be reported to the Indiana State Department of Health.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 1-17-12 at 0930 hours, staff #A1 was requested to provide documentation indicating the events to be reported to the Indiana State Department of Health and none was provided prior to exit. 2. The policy/procedure Incident Reporting/Adverse Events (approved 12-10) failed to indicate the events to be reported to the department. 3. During an interview on 1-18-12 at 0905 hours, staff #A1 confirmed that the policy/procedure failed to identify the reportable events indicated by state law. 	S0332	Historically policy 14.02 Incident Reporting/Adverse Incidents indicated a website to reference reportable events. Policy 14.02 was revised to attach the State provided list of required reportable events. See attached Appendix C Ambulatory Surgery Center Reportable Events for 2010. The ASC Patient Care Manager revised the policy, submitted to the appropriate committee. The policy is to be reviewed/approved at the Governing Board meeting on 3-21-12.	03/21/2012	

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S0334	<p>410 IAC 15-2.4-2.2(a)(2) QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) center employee involved; or any other information.</p> <p>(2) A potential reportable event may be identified by a center that:</p>						

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	<p>(A) receives a patient as a transfer; or</p> <p>(b) admits a patient subsequent to discharge; from another health care facility subject to a reportable event requirement. In the event that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually.</p> <p>(e) Any serious reportable listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the center between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)</p> <p>Based on document review and interview,</p>	S0334	Policy 14.02 Incident	03/21/2012			

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	<p>the center failed to include in its Incident Reporting/Adverse Events policy, the requirement that a reportable event be submitted no later than 4 months after the potential reportable event is brought to the program's attention.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Incident Reporting/Adverse Events (approved 12-10) failed to indicate that potential events would be submitted not later than 4 months after the potential reportable event is brought to the attention of the center's quality assessment and improvement program. 2. During an interview on 1-18-12 at 0905 hours, staff #A1 confirmed that the policy/procedure lacked the required timeframe for reporting potential events. 		<p>Reporting/Adverse Incidents was corrected so timeframe for reporting adverse events to the Indiana State Department of Health reflects that the report must be submitted no later than four (4) months after potential event is brought to the Center's attention. See attached policy 14.02. The ASC Patient Care Manager revised the policy, submitted to the appropriate committee and is to be reviewed/approved at the next Governing Board meeting on 3-21-12.</p>		

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S0612	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the implementation of its policy related to accuracy of the medical record for 4 of 30 medical records reviewed. (N1, N3, N4, and N24)</p> <p>Findings:</p> <p>1. review of the policy and procedure "Medical Records - General" (Policy No. 4.01), indicated:</p> <p>a. under "Policy", it reads: "A medical record shall be maintained for each patient, which is accurate, legible, complete and comprehensive..."</p> <p>b. under "Responsibility", it reads: "The Center is responsible to insure that accurate medical records are maintained."</p> <p>c. under "Content", it reads: "Accurate and complete medical records are written for all patients...."</p> <p>2. review of patient medical records through out the survey process of 1/17/12 and 1/18/12 indicated:</p> <p>a. pt. N1 had an allergy to "PCN" (penicillin) noted on the "Pre Op Assessment" form and the "Anesthesia Record" form, but lacked documentation of allergies on the "Transfer</p>	S0612	The ASC Patient Care Manager reviewed policy 4.01 Medical Records with the facility staff and anesthesiologists. The Patient Care Representative in charge of Medical Records will audit the charts for accuracy and return charts to appropriate personnel for corrections as needed. The medical records consultant will continue to complete quarterly chart audits. The ASC Patient Care Manager will conduct a QA project for medical record accuracy to assure compliance.	03/07/2012			

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	<p>Record" form sent to the local ED (emergency department) with the patient upon transfer 6/16/11 (in the "Allergies/Reactions area of the form, "none" was documented)</p> <p>b. pt. N3 had an ASA (American Society of Anesthesiologists) level of 2 marked on the "Anesthesia Evaluation/Orders" form, but had an ASA level of 3 marked on the "Anesthesia Record" form</p> <p>c. pt. N4 had allergies of "Sulfa...PCN...Statins..." on the "Pre Op Assessment" form, but only had documentation of "PCN/Sulfa" on the "Anesthesia Evaluation/Orders" form</p> <p>d. pt. N24 had an ASA level of 2 written on the "Anesthesia Record" form, but the ASA area (in the lower right hand area of the page) on the "Procedural History and Physical" form was left blank</p> <p>3. interview with staff member NA at 2:00 PM on 1/18/12, indicated:</p> <p>a. an ASA level may change if the practitioner gains more information related to a patient's past medical history (regarding pt. N3)</p> <p>b. an anesthesiologist may not list all allergies on the anesthesia records if they don't feel they are "true" allergies</p>			

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S0640	<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.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the legibility of medical records for 7 of 30 patient charts (N1, N11, N12, N26, N28, N29 and N30).</p> <p>Findings:</p> <p>1. review of the policy and procedure "Medical Records - General" (Policy No. 4.01), indicated:</p> <p>a. under "Policy", it reads: "A medical record shall be maintained for each patient, which is accurate, legible, complete and comprehensive..."</p> <p>b. on page 3 under "Legibility", it reads: "...3. If an error is made, draw a single line through the error and initial the entry."</p> <p>2. review of patient medical records through out the survey process of 1/17/12 and 1/18/12 indicated:</p> <p>a. pt. N1 had a write over in the Aldrete scoring area for the 30 minute "LOC" (level of consciousness) area (the record lacked a line drawn through and initials of</p>	S0640	The ASC Patient Care Manager reviewed policy 4.01 Medical Records with the facility staff and anesthesiologists for legibility and appropriate error correction. The Patient Care Representative in charge of Medical Records will audit the charts for legibility and appropriate error correction. The medical records consultant will continue to complete quarterly chart audits. The ASC Patient Care Manager will conduct a QA project for medical record accuracy to assure compliance.	03/07/2012			

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	<p>the staff member who made a correction)</p> <p>b. pt. N11 had illegible notations by the anesthesiologist in the "Post Anesthesia Evaluation" area at the bottom of the "Anesthesia Evaluation/Orders" form and illegible documentation on the same form in the "Allergies" section</p> <p>c. pts. N12, N26, N28 and N29 had illegible notations by the anesthesiologist in the "Post Anesthesia Evaluation" area at the bottom of the "Anesthesia Evaluation/Orders" form</p> <p>d. pt. N30 had a write over/cross out of the "stop time" on the "Anesthesia Record" form that was not initialed as required by facility policy</p> <p>3. interview with staff member NA at 2:00 PM on 1/18/12 indicated:</p> <p>a. most of the staff can interpret the anesthesiologist's documentation so it hadn't been considered illegible by this staff member</p>				

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S0832	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(ii)</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>(ii) The completion by the practitioner administering anesthesia of intra-operative anesthesia monitoring and notations, to include vital signs, on each patient in accordance with the center policy.</p> <p>Based on document review, the center lacked a standard for intra-operative monitoring for anesthesia services at the center.</p> <p>Findings:</p> <p>1. The center policy/procedure Anesthesia Services - Rules & Regulations (approved 12-10) indicated the following: "...during general anesthesia ...vital signs will be monitored and recorded." The policy failed to indicate a minimum standard for ensuring compliance with center policy and current acceptable standards of practice.</p> <p>2. During an interview on 1-18-12 at</p>	S0832	<p>Policy 7.02 Anesthesia Services-Rules and Regulations was revised to add the American Society of Anesthesiologist (ASA) recommendation of monitoring vital signs every 5 minutes during general anesthesia. The Patient Service Representative responsible for medical records will audit the anesthesia record for documentation of vital signs every five minutes. Patient Care Manager revised the policy, submitted to the appropriate committee and is to be reviewed/approved at the next Governing Board meeting on 3-21-12.</p>	03/21/2012			

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	1615 hours, staff #A1 confirmed that the policy/procedure lacked a minimum requirement for documentation of vital signs by the anesthesiologist.				

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S0840	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(2)</p> <p>(c) The anesthesia service is responsible for all anesthesia administered in the center as follows:</p> <p>(2) A requirement that anesthesia equipment must be checked for operational readiness and safety prior to patient administration. Documentation to that effect shall be included in the patient's medical record.</p> <p>Based on document review and interview, the center failed to ensure that anesthesia equipment was checked for operational readiness and safety before each administration with a patient and documented in the patient record.</p> <p>Findings:</p> <ol style="list-style-type: none"> The center policy/procedure Anesthesia Services - Rules & Regulations (approved 12-10) failed to require an equipment check prior to use with each patient and failed to require documentation of the equipment check in the patient medical record. The center document Anesthesia Record failed to indicate a provision that a pre-anesthesia equipment check was performed by the anesthesiologist. During an interview on 1-19-12 at 1615 hours, staff #A1 confirmed that the policy/procedure and 	S0840	<p>Policy 7.02 Anesthesia Services-Rules and Regulations does reflect under F 4 "Prior to administering anesthesia, the anesthesiologist will check the readiness, availability, cleanliness, sterility when required and working condition of all equipment used in the administration of anesthetic agents." See attached policy 7.02. The Anesthesia Record was revised by the ASC Patient Care Manager to add the word "pre" to the "Anesthesia Checklist Complete". See attached form Anesthesia Record.</p>	02/01/2012	

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S1040	<p>Anesthesia Record lacked the required provisions.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAc 15-2.5-6(3)(F)</p> <p>Pharmaceutical service must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(F) Instructions to the patient on the use of take home medication is the responsibility of the prescribing practitioner.</p> <p>Based upon document review and interview, the center policy/procedures lacked a provision indicating the physician responsibility of instructing the patient on the use of take home medication when dispensed.</p> <p>Findings:</p> <p>1. The policy/procedure Pharmaceutical Services (approved 12-10) section 12 regarding dispensing medications to patients failed to indicate the physician responsibility of instructing the patient on the use of take home medication.</p> <p>2. On 1-17-12 at 1615 hours, staff #A1 confirmed the center policy/procedure lacked the indication of physician responsibility for instructing the patient when a medication is dispensed.</p>	S1040	<p>Policy 8.01Pharmacuetical Services was revised to indicate physicians must approve Patient Information Sheets provided to patients with take home medication. All applicable Patient Information Sheets were reviewed and approved by the Medical Staff meeting 2-6-12 and is to be reviewed/approved at the next Governing Board meeting on 3-21-12. Post operative staff is responsible for providing the Patient Information Sheets with the medications to the patient, answer all questions and request clarification from the prescribing physicians as needed.</p>	03/21/2012	

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S1146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</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>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review and interview, the center failed to ensure proper ventilation was safely maintained for patients at the center in compliance with applicable codes.</p> <p>Findings:</p> <ol style="list-style-type: none"> The American Institute of Architects (AIA) 2001 edition, Guidelines for Design and Construction of Hospital and Health Care Facilities indicated the following: "Table 7.2 Operating Room (OR) Minimum total air exchanges per hour : 15." Center documentation of biannual preventive maintenance and certification dated 7-14-11 indicated 12.5 air exchanges per hour for Operating Room 2 and documentation dated 1-09-12 	S1146	<p>The HVAC provider was contacted for service in regards to the inadequate air exchanges in OR 2. The HEPA filters were inspected and replaced. BioMedic Inc, contractor for trace gas analysis, was contacted to re-measure the room air exchanges in OR 2. Measurements will be completed the week of 3-19-12. The vendor was instructed that all abnormal values must be reported verbally to the ASC Patient Care Manager prior to their departure and followed up with a written report. The HVAC provider was reminded that HEPA inspection is to be completed bi-annually during routine PM. The QA/PI monitor was revised to include confirmation and review of the HEPA filters inspection per HVAC contractor semi-annually. See attached QAPI monitor 3-12</p>	03/23/2012			

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	indicated 12.4 air exchanges per hour for Operating Room 2. Both documents indicated that the AIA recommended minimum number of air exchanges per hour for OR and Delivery Rooms was 15 with 3 to be outside air.				

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S1154	<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>(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 document review, the center failed to ensure that a triennial analysis was performed on operational and maintenance records for the mechanical and physical plant equipment at the facility.</p> <p>Findings:</p> <p>1. On 1-17-12 at 0930 hours, staff #A1 was requested to provide documentation indicating a triennial analysis of operational and maintenance control records for heating, ventilation, air conditioning, fire alarm and/or smoke detector system and none was provided prior to exit.</p> <p>2. Review of the maintenance schedules and equipment maintenance records failed to indicate that the center records are analyzed at least triennially.</p>	S1154	Current ownership was established 1-1-2010. Therefore, some of the required triennial review is not obtainable until the completion of inspection, PM and repair for the year 2012. A document was created for review and documenting the required operational and maintenance controls and will be completed by the ASC Patient Care Manager with the assistance of vendor providing PM service. See attached "Operational and Maintenance Control". Review of records 2010-2012 were completed and documented. Information will be submitted to next quarter committee meetings	03/07/2012			

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	3. During an interview on 1-18-12 at 1410 hours, staff #A1 confirmed that the center lacked documentation of a triennial analysis of the mechanical systems and equipment in use at the center.		and ultimately to the Governing Board.		

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S1168	<p>410 IAC 15-2.5-7 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 center failed to ensure that a triennial analysis was performed on all patient care equipment in use at the center.</p> <p>Findings:</p> <p>1. On 1-17-12 at 0930 hours, staff #A1 was requested to provide documentation indicating triennial analysis of patient care equipment preventive maintenance (PM) records and none was provided prior to exit.</p> <p>2. PM records for patient care equipment failed to indicate triennial analysis by either the</p>	S1168	Current ownership was established 1-1-2010. Therefore, some of the required triennial review is not obtainable until the completion of inspection, PM and repair for the year 2012. A document was created for review and documenting the required operational and maintenance controls and will be completed by the ASC Patient Care Manager with the assistance of vendor providing PM service. See attached "Operational and Maintenance Control".	03/07/2012			

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	<p>biomedical engineering services provider for patient care equipment or the center.</p> <p>3. During an interview on 1-18-12 at 1410 hours, staff #A1 confirmed that the center lacked documentation of a triennial analysis of the mechanical systems and equipment in use at the center.</p>				

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S1184	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 2.5-7(c)(3)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(3) The safety program includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety.</p> <p>Based on observation and interview, the safety manager/committee failed to ensure a safe working environment for housekeeping staff by lacking the availability of, and requirement of the use of, goggles in mixing and pouring cleaning chemicals.</p> <p>Findings:</p> <p>1. at 4:15 PM on 1/17/12, while on tour of the surgical hallway in the company of staff member NA, it was observed that the housekeeping/janitorial closet:</p> <p>a. had a chemical, Expose 256, that was to be mixed with water and poured into small, slim bottles that fit on the handle of the mop for floor cleaning (like a swiffer mop)</p> <p>b. lacked goggles for the prevention of eye splash for housekeeping staff</p> <p>2. interview with staff member NB at 3:45 PM on 1/18/12 indicated:</p> <p>a. housekeeping staff mix the Expose 256 in water to fill spray bottles for cleaning surfaces, as well as filling 6 to 7 slim bottles/day for the mopping of floors</p> <p>b. housekeeping staff do not wear goggles to</p>	S1184	The ASC Patient Care Manager contacted the Contracted Service Provider about providing safety eyewear to the housekeeping staff. Safety glasses have been provided and the staff has been instructed to follow their policy of using safety eyewear during mixing of chemicals. The ASC Patient Care Manager will provide ongoing monitoring of contracted services for compliance.	02/29/2012

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	<p>prevent eye splash--"I just turn my head to the side and hope none splashes"</p> <p>3. interview with staff member NA at 4:15 PM on 1/18/12 indicated:</p> <p>a. goggles are available in the facility, if staff wish to wear them</p>				