

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001123	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2012
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NAME OF PROVIDER OR SUPPLIER CLI SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7747 W JEFFERSON BLVD STE B FORT WAYNE, IN 46804
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 003375</p> <p>Survey Date: 12-10/11-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/14/12</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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S0153	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Bases on document review and interview, the center failed to follow its policy/procedure and ensure that personnel were oriented to applicable policies and procedures for 2 contracted housekeeping personnel.</p> <p>Findings:</p> <p>1. The policy/procedure Environmental Cleaning (approved 1-12) indicated the following: " Personnel responsible for cleaning the environment and equipment and equipment will receive education and training on proper environmental cleaning and disinfection methods, agent use and selection, and safety precautions. "</p> <p>2. The policy/procedure Cleaning of Surgical Spaces (approved 1-12) indicated the following: " A housekeeping service may be contracted provided they have demonstrated their</p>	S0153	<p>S 153 Office One Cleaning personnel will be in-serviced on the Center's "Environmental Cleaning Policy", referenced in section 15 "Infection Control", page numbers 46 and 47. The current housekeeping personnel and any new housekeeping staff will sign acknowledgment and receipt of the policy by December 20, 2012. The signed acknowledgement will be kept in the facility administrator's office along with their orientation and training records. The Facility Administrator and/or designee will monitor and report observations to the QA&I committee quarterly. Deviations from the policy will be reported and training will follow as needed.</p>	12/20/2012			

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	<p>knowledge and ability to adhere to facility policies and procedures ... "</p> <p>3. Contracted service personnel files for 2 housekeepers (HK1 and HK2) failed to indicate that the personnel received copies of the housekeeping and infection control policy/procedures for cleaning at the center.</p> <p>4. During an interview on 12-11-12 at 1530 hours, staff A1 confirmed that the personnel files lacked documentation of orientation to the center policy/procedures for cleaning and disinfecting at the center.</p>			

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S0212	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(d)(2)(A & B)</p> <p>(d) In accordance with center policy, the governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The center develops, implements, and maintains written medical staff policies and procedures for emergencies, initial treatment, and transfer.</p> <p>(B) The center provides immediate lifesaving measures within the scope of service available, to all persons in the center, to include, but not be limited to, the following:</p> <p>(i) Timely assessment. (ii) Basic life support. (iii) Proper transfer mode.</p> <p>Based on document review and interview, the center failed to develop and maintain its policy/procedures regarding emergencies and immediate lifesaving measures for all persons in the center.</p> <p>Findings:</p> <p>1. The publication 'Highlights of the 2010 American Heart Association Guidelines for CPR and ECC' indicated the following: "Healthcare providers who treat cardiac arrest in hospitals and other</p>	S0212	S 212 Section 13, "Emergencies", Code Blue Responsibilities was revised by the Facility Administrator on December 19, 2012 to follow the American Heart Association Guidelines for CPR and ECC. The revised policy will be sent to the MEC committee to be reviewed and approved on January 17, 2013 and upon approval be sent to the Governing Body on January 18, 2013 for approval. Staff members will be educated on the revised policy by January 31, 2013.	01/31/2013			

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	<p>facilities with on-site AEDs or defibrillators should provide immediate CPR and should use the AED/defibrillator as soon as it is available. These recommendations are designed to support early CPR and early defibrillation, particularly when an AED or defibrillator is available within moments of the onset of sudden cardiac arrest (page 9-10)."</p> <p>2. The policy/procedure Code Blue Responsibilities (approved 1-12) indicated the following:</p> <ul style="list-style-type: none"> - 3. Deliver the code cart - 4. Attach leads from the defibrillator to the patient - 5. Assist with arrhythmia interpretation - 6. Establish peripheral intravenous access - 7. Administer medications and repeat name and dose of all medications to the recorder - 8. Titrate drips according to physician order - 9. Defibrillate the patient as ordered by the physician <p>The policy/procedure failed to indicate that emergency responders should attempt defibrillation as soon as possible when a shockable rhythm is identified.</p> <p>3. During an interview on 12-11-12 at 1520 hours, staff A1 confirmed that the policy/procedure failed to ensure</p>			

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	defibrillation is attempted as soon as possible when a defibrillator is available and a shock is indicated.			

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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 center failed to maintain a list of all contracted services, including the scope and nature of services provided for 7 of 24 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 the following: electrical service, generator, laser, pest control, sterilizer, tissue bank and medical transcription.</p> <p>2. Review of center documentation indicated the following service providers: electrical repair by V1, generator service by V2, laser service by V3, pest control by V4, sterilizer service by V6, tissue bank by V6 and transcription by V7.</p> <p>3. During an interview on 12-11-12 at</p>	S0226	S 226 The master list of agreements was updated on December 19, 2012 to include the scope and nature of the contracted services being provided to the Center. This list will be reviewed and/or updated as part of the QA&I program. Contracted services will be reviewed on an annual basis. The Facility Administrator will be responsible for updating and reviewing this list as needed and annually.	12/19/2012			

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	1540 hours, staff A1 confirmed that the list of contracted services had not been maintained.			

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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. Based on document review and interview, the center failed to ensure that all services performed under contract were evaluated by the Quality Assurance and Improvement (QA&I) program for 12 of 24 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance and Improvement Program (approved 1-12) failed to indicate that all contracted services would be monitored and reviewed through the QA&I program.</p> <p>2. Review of the Quality Assurance and Improvement committee minutes dated 1-12-12, 4-22-12, 9-13-12 and 10-18-12 failed to indicate that 12 services [alarm monitoring, anesthesia equipment, electrical repair, fire extinguisher, heating/air conditioning, laboratory/pathology, laser service, lens provider, medical gas, medical</p>	S0310	<p>S 310 December 19, 2012 the Facility Administrator created a QA&I tracking spreadsheet to be reviewed and approved by the QA&I/MEC committee on January 17, 2013. Indicators have been identified based on the service provided in order to monitor the quality of each contracted service. These indicators are objective, measurable and based on current knowledge and clinical experience. Upon the recommendation of the QA&I and MEC this spreadsheet will be reviewed by the Governing Body on January 18, 2013 to be utilized beginning the first quarter of 2013. Contracted services will be reviewed on an annual basis.</p>	01/18/2013

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	<p>transcription, tissue bank and a waste disposal service] had been reviewed by the QA program.</p> <p>3. During an interview on 12-11-12 at 1300 hours, staff A1 confirmed that the QA&I documentation failed to indicate the 12 contracted services had been evaluated in 2012.</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 policy and procedure review, employee health file review, and staff interview, the infection control practitioner failed to implement the facility policy related to communicable disease immunity for 1 of 2 surgical tech files reviewed (staff member P4).</p> <p>Findings:</p> <p>1. at 10:35 AM on 12/10/12, review of the facility policy and procedure manual indicated a policy titled "Physical Examination, Tuberculosis Screening and Verification Immunity", with no policy number and last approved on 1/20/12, that indicated:</p> <p>a. on page 5 under "Verification of Immunity or History of Rubella, Rubeola</p>	S0442	S 442 Section 4, "Personnel", Physical Examination, Tuberculosis Screening and Verification of Immunity the purpose is to ensure all healthcare workers and employees are capable of performing jobs safely and are free of communicable diseases. Acceptable documentation of immunity for those who work in a healthcare setting is as follows: Varicella (Chickenpox) 1. Documented positive history of Varicella infection, or Documentation of two doses of varicella vaccine given at least 28 days apart, or laboratory evidence of immunity of persons who have a negative or uncertain history of Varicella. December 11, 2012 staff member was notified and	12/21/2012			

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	<p>(Measles) and Varicella (Chickenpox)", it reads in the "Procedure" area: "...Varicella (Chickenpox): 1. Documented positive history of Varicella infection, or 2. Documentation of 2 doses of varicella vaccine given at least 28 days apart, or 3. Laboratory evidence of immunity of persons who have a negative or uncertain history of Varicella"</p> <p>2. at 2:45 PM on 12/10/12, review of personnel files indicated: a. staff member P4, a surgical tech, had one Varicella immunization documented as being given in 1997 b. lacked documentation of a second injection of Varicella, or any documentation of immunity by titer</p> <p>3. interview with staff member #50, the facility administrator and infection control officer, at 4:30 PM on 12/11/12 indicated: a. it had been thought that staff member P4 had a Varicella titer performed, but after searching, none was found b. only one Varicella immunization was documented in the employee file for staff member P4 c. Varicella documentation in the employee file for staff member P4 is not per facility policy</p>		<p>authorization for titer to be drawn was ordered and a copy placed in employee file. December 21, 2012 staff member will have titer drawn and based upon results of titer a booster will be ordered and paid for by the facility with a subsequent titer drawn to prove immunity. New hires will be required to provide documentation upon hire or sent for preliminary laboratory draws. The Facility Administrator will be responsible for reviewing documentation of immunity for all staff members.</p>				

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S0444	<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 policy and procedure review, observation, and staff interview, the infection control practitioner failed to implement facility policy related to surgical masks about the neck for 1 CRNA (certified registered nurse anesthetist) observed in the recovery area (staff member #54).</p> <p>Findings:</p> <p>1. at 10:35 AM on 12/10/12, review of the facility policy manual indicated a policy titled: "Aseptic Technique", with no policy number and a last approved date of 1/20/12, that read:</p> <p>a. under "Procedure" in item 13., it reads: "Air is contaminated by dust and droplets and must be controlled by the following means: Masks are to be worn over the nose and mouth, are to fit snugly</p>	S0444	S 444 Section 15, "Infection Control", the Aseptic Technique Policy states that "masks are to be worn over the nose and mouth, are to fit snugly and to be changed every case or more often if necessary". "Surgical mask": Surgical masks are worn where open sterile supplies or scrubbed persons are located. Carefully remove masks by handling strings and discard. Do not save for future use. Masks are either worn on or off. It is not acceptable for masks to be hanging from the neck". January 10, 2013 the Facility Administrator will review the Aseptic Technique Policy and the Surgical Attire Policy with staff members present. Those staff members not present will receive a copy of the policy to review and sign stating they have read and understood the policy by January	01/31/2013	

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	<p>and to be changed every case or more often if necessary..."</p> <p>2. at 10:35 AM on 12/10/12, review of the facility policy manual indicated a policy titled: "Surgical Attire", with no policy number and a last approved date of 1/20/12, that read:</p> <p>a. under "Surgical mask:", it reads: "...Masks are either on or off. It is not acceptable for masks to be hanging from the neck."</p> <p>3. at 11:31 AM on 12/11/12, while on tour of the pre/post op area in the company of staff member #50, the facility administrator and infection control officer, it was observed that the CRNA (staff member #54) was seeing patients and entering staff offices with the surgical mask down about the neck.</p> <p>4. interview with staff member #50, the facility administrator and infection control officer, at 11:32 AM on 12/11/12, indicated:</p> <p>a. staff are not to have the surgical mask down about the neck outside the operating suite</p> <p>b. observation of staff, related to surgical mask compliance, is not currently a part of surveillance performed by the infection control officer</p>		31, 2013. The Infection Control Officer will be responsible for monitoring compliance on the quarterly infection control rounds checklist.				

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S0630	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on patient medical record review and staff interview, the medical records staff failed to ensure the accuracy of the medical record for 1 of 1 patient who had a surgical procedure for a "Rebubble of Detached Graft Left Eye" (pt. # 7).</p> <p>Findings:</p> <p>1. at 9:00 AM and 11:40 AM on 12/11/12, review of patient medical records indicated that pt. #7 had inaccurate documentation on the "Anesthesia Record" form with the "Left eye" circled at the top of the page, but "Right Eye" circled in three other areas at the top of the page</p> <p>2. interview with staff member #50, the facility director, at 1:35 PM on 12/11/12 indicated:</p> <p>a. it was confirmed that the "Anesthesia Record" form for pt. #7 had inaccurate documentation related to whether the</p>	S0630	S 630 Section 7, "Medical Records", Page 4 Current policy reads that "C. The medical records will be reviewed for completeness". On December 28, 2012 this policy was amended to state "The medical records will be reviewed for accuracy and completeness. The following is included within each patient's medical record: 1. Patient Identification. 2. Appropriate medical history and chief complaint to support the diagnosis and treatment. 3. A history and physical. 4. Copies of laboratory, x-ray consultations, other pre-operative diagnostic studies, and other special reports or summary of those same findings by the admitting Medical Staff member, which is recorded in the medical record before surgery, if performed. 5. Any allergies or abnormal drug reactions. 6. A signed consent for treatment, to perform surgery, and for anesthesia administration.	01/31/2013			

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	<p>surgical procedure was for the right or the left eye</p> <p>b. after review of the medical records policies and procedures, it was determined that none of the facility policies address that a medical record should be "accurate"</p>		<p>7. Physician orders and progress notes. The QA&I/MEC will review this policy change on January 17, 2013 and upon approval will be sent to the Governing Body for approval on January 18, 2013. Credentialed staff will be trained on the policy by January 31, 2013. As stated in the above policy, "D. Medical record deficiencies are identified and returned to the responsible health care provider for necessary action. E. Health care providers who are identified by medical record review to be delinquent in timely completion of medical records will undergo appropriate corrective action". To prevent further deficiency anesthesia personnel during the first quarter of 2013 will be responsible for checking their Anesthesia Record for accuracy and completion. Any deficiencies noted will be documented in the peer review and corrective action implemented. The Facility Administrator will be responsible for ensuring this is completed.</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. Based on policy and procedure review, patient medical record review, and staff interview, the medical records staff failed to implement facility policies related to completeness of the medical record for 2 of 5 patients with procedures performed by physician # 55 (pts. #7 and #15).</p> <p>Findings: 1. at 10:35 AM on 12/10/12, review of the facility policy and procedure manual indicated a policy titled: "Patient Identification/Site Verification/Marking of the surgical Site/Time Out Verification", with no policy number and a last date of review on 1/20/12, that indicated: a. under "Time Out Verification:", it reads: "...the circulating nurse will document the time out verification on the OR record."</p> <p>2. at 10:35 AM on 12/10/12, review of the facility policy and procedure manual indicated a policy titled: "Informed Consent, Consent to Observe, Photography", with no policy number and</p>	S0640	S 640 The Facility Administrator will re-educate the staff regarding the importance of the medical record accuracy, completeness and legibility. The staff will receive this training on January 10, 2013 and will receive a copy of the following policies to review, acknowledge and sign. The Policies to be reviewed are "Patient Identification/Site Verification/Marking of the Surgical Site/Time Out Verification", "Informed Consent" the "Consent to Observe, Photography, and "Completing the Consent" policy. As stated in the Medical Records Policy, "Medical record deficiencies are identified and returned to the responsible health care provider for necessary action. Section 7, Policy Title: Medical Records states "All medical record entries are reviewed and signed by the author of the entry within thirty (30) days from the day of the procedure. On December 28, 2012 this policy was amended to state "All medical record entries are reviewed, signed and dated by the author of the entry within thirty (30) days from the day of	01/10/2013	

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	<p>a last date of review on 1/20/12, that indicated:</p> <p>a. under "Procedure", in section K., it reads: "The attending physician notes on the patient's medical record what the patient was advised during receipt of informed consent."</p> <p>3. at 10:35 AM on 12/10/12, review of the facility policy and procedure manual indicated a policy titled: "Medical Records", with no policy number and a last date of review on 1/20/12, that indicated:</p> <p>a. on page 3 under section "V. Medical Record Completion", it reads in item C. "The medical records are reviewed for completeness..."</p> <p>4. review of patient medical records at 9:00 AM and 11:40 AM on 12/11/12 indicated:</p> <p>a. pt. #7 lacked:</p> <p>I. a physician signature, date, and time of explanation of the surgical procedure on the informed consent form in the area: "I have explained to the patient for the above procedure, the risk involved, its benefits, its alternative and the possible complications"</p> <p>II. physician authentication of the standing orders for the procedure done 11/28/12</p> <p>III. documentation of the "Surgical</p>		<p>the procedure". Health care providers who are identified by medical record review to be delinquent in timely completion of medical records will undergo appropriate corrective action". These deficiencies will be documented in the peer review and reviewed by the QA&I/MEC committee. The Facility Administrator will be responsible for ensuring re-education of the staff was completed as stated above.</p>				

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	<p>Time out" time on the "Intra-Operative Nursing Record" form</p> <p>b. pt. #17 lacked documentation on the "Intra-Operative Nursing Record" form regarding the "Condition of Patient" upon transfer to the PACU (post anesthesia care unit) (failed to note "Satisfactory, Fair, or Poor condition as prompted on the form)</p> <p>5. interview with staff member #50, the facility administrator, at 1:35 PM on 12/11/12 indicated:</p> <p>a. the forms for patients #7 and #15 are lacking documentation as listed in 4. above</p> <p>b. current facility policies do not address a physician requirement to authenticate standing surgical (pre and post op) orders on the day of the patient's procedure, but that is the expectation per standards of practice and "facility expectations"</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 failed to ensure that all entries in the medical record (MR) were dated when authenticated.</p> <p>Findings:</p> <p>1. The policy/procedure Medical Records (approved 1-12) indicated the following: "All MR entries are reviewed and signed by the author of the entry within thirty (30) days from the day of the procedures." The policy/procedure failed to require that each MR entry was dated when authenticated to validate compliance with center policy.</p> <p>2. During an interview on 12-11-12 at 1610 hours, staff A1 confirmed that the policy/procedure lacked the requirement to date each entry when authenticated.</p>	S0646	<p>S 646 Section 7, Policy Title: Medical Records states "All medical record entries are reviewed and signed by the author of the entry within thirty (30) days from the day of the procedure. On December 28, 2012 this policy was amended to state "All medical record entries are reviewed, signed and dated by the author of the entry within thirty (30) days from the day of the procedure". The QA&I/MEC will review this policy change on January 17, 2013 and upon approval will be sent to the Governing Body for approval on January 18, 2013. The Facility Administrator will re-educate the staff regarding the importance of the medical record entries to be authenticated and dated in accordance with section 4 (b) (3) (N). Credentialed staff will be trained on the policy by January 31, 2013. Deficiencies will be documented in the peer review and reviewed by the QA&I/MEC committee.</p>	01/31/2013			

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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 ensure that its bylaws, rules and regulations were reviewed at least triennially.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-10-12 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. Review of the Medical Staff Bylaws, Rules and Regulations (approved 2-07-03) failed to indicate a provision ensuring that the bylaws would be periodically reviewed by its medical staff at least triennially. The medical staff meeting minutes for 2010, 2011 and 2012 failed to indicate that the medical staff bylaws had been reviewed or revised and approved by the medical staff. 	S0732	<p>S 732 Section 1 Page 9 Article 4.8 "The Governing Body shall ensure that the Medical Staff has adopted and complies with its Medical Staff Bylaws and Rules and Regulations. The Medical Staff By-laws, Rules and Regulations are reviewed and approved triennially". Section 2 Page 38 Article XV. Adoptions and Amendments "These Bylaws shall be effective when approved by the Board. The Board may amend these Bylaws, after consultations with the CEO". On December 28, 2012 this additional statement was added to the bylaws: "These bylaws will be reviewed triennially by the medical staff and governing body". The QA&I /MEC will review this addition on January 17, 2013 and upon adoption, the governing body will approve on January 18, 2013. The QA&I/MEC committee and Medical Director will be responsible for reviewing these bylaws triennially.</p>	01/18/2013			

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	4. During an interview on 12-11-12 at 1530 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.			

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S0736	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based upon document review, the medical staff failed to establish attendance requirements for its quarterly medical staff meetings to assure that the meetings were held with the required attendance.</p> <p>Findings:</p> <p>1. Review of the Medical Staff Bylaws, Rules and Regulations (approved 2-07-03) failed to indicate the minimum attendance requirements for the medical staff to conduct its business.</p> <p>2. The medical staff meeting minutes for 1-12-12, 4-24-12 and 9-13-12 failed to indicate attendance by any credentialed medical staff members except for the medical director A2.</p>	S0736	<p>S 736 (B) Meeting requirement of the medical staff to include, at a minimum, the following: (i) frequency, at least quarterly (ii) attendance. Section 2, Page 38, "Medical Staff Bylaws", states "The Medical Staff shall meet a minimum of once per quarter, and as necessary as determined by the Board, and maintain a permanent written record of its attendance and proceeding". On January 17, 2013, the medical staff members will receive a copy of the bylaws to review and sign stating they have read and understood their requirements. The Medical Director and/or designee will be responsible for ensuring each medical staff member is present for at least quarterly meetings.</p>	01/17/2013			

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S0780	<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 upon document review and interview, the center failed to ensure that all orders were authenticated within the time frame specified by center policy and no more than 30 days.</p> <p>Findings:</p> <p>1. The policy/procedure Pharmaceutical Services (approved 1-12) indicated the following: "...the patient 's physician ...may verbally prescribe the administration of a drug. Such prescription shall be entered on the physician orders and signed by the physician within twenty-four (24) hours. " The policy/procedure failed to require that each verbal order was dated and timed when signed to validate compliance with</p>	S0780	S 780 Section 10 "Pharmaceutical Services" Page 3 Current policy reads: "Verbal Prescriptions- "Based on his judgment, he may verbally prescribe the administration of a drug. Such prescription shall be entered on the physician's orders and signed by the physician within twenty-four (24) hours. On December 27, 2012 this policy was amended to state: "Such prescription shall be entered on the physician's orders, signed,dated and timed by the physician within twenty-four (24) hours". Deficiencies will be documented in the peer review and reviewed by the QA&I/MEC committee. The QA&I/MEC will review the policy changes on January 17, 2013 and upon approval will be reviewed by the	01/31/2013			

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	center policy. 2. During an interview on 12-11-12 at 1610 hours, staff A1 confirmed that the policy/procedure lacked the compliance requirement to date and time each order when authenticated.		Governing Body on January 18, 2013. Once approved, by the committee and board, the credentialed staff will be re-educated on this policy by January 31, 2013. The Facility Administrator will be responsible for ensuring this is completed.	

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S0862	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(C)</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>(C) A provision for the following equipment and supplies to be available to the surgical and recovery areas:</p> <p>(i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff.</p> <p>Based on document review, observation and interview, the center failed to ensure that required emergency equipment was available if needed for 2 of 8 required emergency equipment.</p> <p>Findings:</p> <p>1. The policy/procedure Emergency Crash Cart List page 67 (approved 1-12) and Emergency Equipment Checklist</p>	S0862	S 862 (C) A provision for the following equipment and supplies to be available to the surgical and recovery areas: (i) emergency call system (ii) oxygen (iii) resuscitation equipment (iv) defibrillator (v) cardiac monitors (vi) tracheostomy set (vii) oximeter (viii) suction equipment (ix) other supplies and equipment specified by the medical staff. Portable oximeters and suction equipment were added on December 28, 2012 to pages 67 and 68 for	01/21/2013
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	<p>page 68 (approved 1-12) failed to indicate that an oximeter and a portable suction equipment was available for use in the event of an emergency.</p> <p>2. During a tour of the center on 12-10-12 at 1720 hours, no available oximeter or portable suction equipment was observed with the crash cart in the pre and post-op nursing unit.</p> <p>3. During an interview on 12-10-12 at 1130 hours, staff A1 confirmed that the policy/procedures failed to indicate the required equipment and confirmed that portable suction equipment was not available if needed.</p>		<p>emergency equipment. The Facility Administrator ordered the portable suction unit from supplier on December 28, 2012. Once delivered it will be placed on the crash cart for immediate use. Portable oximeters are available in the postoperative area for emergency response. Staff will be re-educated on the emergency equipment available by January 21, 2013.</p>		

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S1010	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on policy and procedure review, observation, and staff interview, the facility failed to implement its policy related to the labeling of multi-dose vials in one area toured.</p> <p>Findings:</p> <p>1. at 10:35 AM on 12/10/12, review of the policy and procedure manual indicated a policy titled: "Ordering, handling and storage of medications", with no policy number and a date last approved of 1/20/12, that indicated:</p> <p>a. under "Procedure", it reads: "...Multi-dose vials, once opened, will be marked with the opening date on the bottle and the initial of the person opening..."</p> <p>2. it was observed, while on tour of the medication room in the company of staff member #50, the facility administrator, at</p>	S1010	S 1010 S 444 Section 10, "Pharmaceutical Services", the Ordering, Handling and Storage of Medication Policy states that "Multi-dose vials, once opened, will be marked with the opening date on the bottle and the initial of the person opening. The vials will be discarded for any of the following reasons: manufactures guidelines, after twenty-eight days, and/or suspected contamination". January 10, 2013 the Facility Administrator will review the Ordering, Handling and Storage of Medication Policy with staff members present, they will sign stating they have reviewed and understand the policy. Medical Director will review this policy with the medical staff on January 17, 2013 and each member will receive a copy to review sign acknowledging they understand the policy. Those staff members not present will receive a copy of the policy to	01/31/2013			

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	<p>11:15 AM on 12/11/12, that:</p> <ul style="list-style-type: none"> a. one 50 ml vial of Lidocaine 1% with epi was opened and not dated or initialed b. one 5 ml vial of Robinul 1 mg/5 ml was opened and not dated or initialed c. one 50 ml vial of Lidocaine 2% (20 mg/ml) was opened and not dated or initialed d. one 50 ml vial of Lidocaine 2% with epi was opened and not dated or initialed e. one 30 ml single use vial of Marcaine 0.75% was opened and not dated or initialed <p>3. interview with staff member #50, the facility administrator, at 11:20 AM on 12/11/12, indicated:</p> <ul style="list-style-type: none"> a. it was thought that the physician had opened these vials the morning of 12/11/12 b. the date and initials of the person opening the vials was not written on the vials as required by facility policy 		<p>review and sign stating they have read and understood the policy by January 31, 2013. The Facility Administrator/and or designee will be responsible for this by monitoring this during quarterly inspections.</p>		

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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, observation and interview, the center failed to ensure the immediate availability of eye wash station equipment if needed.</p> <p>Findings:</p> <p>1. Review of the Occupational Safety and Health Administration (OSHA) general requirements for emergency showers and eye wash station equipment in 29 Code of Federal Regulations (CFR) 1910.151(c) indicated the following: " When the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. "</p> <p>2. Center documentation of biweekly</p>	S1146	S 1146 December 21, 2012 The Facility Administrator notified the Property Manager that the eyewash station needed repaired. The Property Manager called the plumber on December 28, 2012 the scheduled repair will be completed by January 31, 2013.	01/31/2013

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	<p>eyewash station checks failed to indicate that the eyewash water flow was sufficient to provide copious irrigation of the eyes if needed.</p> <p>3. During a tour on 12-10-12 at 1730 hours, in the presence of staff A1, the following condition was observed: A sink-mounted eyewash spray in the pre and post-op nursing unit. When activated, the water flow from the spray heads was minimal and failed to provide for quick drenching or flushing of the eyes.</p> <p>4. During an interview on 12-10-12 at 1730 hours, staff A1 confirmed that the eyewash station was not effective in the event of an emergency.</p>			

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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 and interview, the center failed to ensure that a triennial analysis was performed on its operational and maintenance records for the mechanical and physical plant equipment.</p> <p>Findings:</p> <p>1. On 12-10-12 at 1015 hours, staff A1 was requested to provide documentation indicating that a triennial analysis of mechanical equipment and physical plant maintenance records was performed and none was provided prior to exit.</p>	S1154	S1154 On December 28, 2012 the Facility Administrator spoke with Midwest Biomedical Services to discuss the triennially review of the operational and maintenance control records. This facility's records will be reviewed January 02, 2013 and documentation will be provided to the Center by Midwest Biomedical Services. The Facility Administrator will be responsible for ensuring this is completed at least every 3 years and provide documentation to the QA&I/MEC and Governing Body.	01/02/2013			

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	<p>2. Review of the maintenance schedules and equipment maintenance records failed to indicate that the center records were analyzed at least triennially.</p> <p>3. During an interview on 12-11-12 at 1620 hours, staff A1 confirmed that the center lacked documentation of a triennial analysis of the mechanical systems and equipment records.</p>			

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S1164	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</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>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on review of the manufacturer's recommendations, observation, and staff interview, the facility failed to ensure the Getinge blanket warmer was maintained/cleaned as per recommendations.</p> <p>Findings: 1. at 2:25 PM on 12/11/12, review of the Getinge brand warming cabinet/blanket warmer (including model number 5624) indicated: a. in section 3.14 (Maintenance and Repair), it reads: "Regular Cleaning</p>	S1164	S 1164 Getinge blanket warmer according to manufacturer guidelines must be cleaned every six (6) months. On December 26, 2012 the Facility Administrator added this cleaning to the emergency equipment checklist to be completed quarterly. The Facility Administrator will educate the safety committee on January 14, 2013 and the revised checklist will be reviewed by the QA&I/MEC committee on January 17, 2013. The Governing Body will review this checklist on January 18, 2013. The safety committee will train the staff on January 21, 2013	01/21/2013			

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	<p>(Every 6 Months)...section 5. Model 5524 and Models 5618, 5624 Upper compartment: Clean under the plenums as follows..."</p> <p>2. while on tour of the pre/post op area of the facility at 11:25 AM on 12/11/12 in the company of staff member #50, the facility administrator and infection control officer, it was observed that:</p> <p>a. the blanket warmer (Getinge model number 5624) had a large amount of dust and lint (including blue lint from the blue blankets in the cabinet) in the lower cabinet of the warmer under the plenum (bottom shelf)</p> <p>3. interview with staff member #50, the facility administrator and infection control officer, at 2:55 PM on 12/11/12 indicated:</p> <p>a. the blanket warmer had a build up of dust and lint on the bottom shelf of the lower warming cabinet</p> <p>b. it was unknown that the Getinge warming cabinet had manufacturer's recommendations for cleaning</p> <p>c. the blanket warmer is not currently on a cleaning routine or schedule</p>		according to manufacturer recommendations for cleaning the blanket warmer.				

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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 an organized safety management program that included a review of safety functions by a committee appointed by the chief executive officer and included representatives from administration and patient care services.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-10-12 at 1015 hours, staff A1 was requested to provide documentation of a safety management plan including committee responsibilities and membership and none was provided prior to exit. Review of the policy/procedure table of contents (approved 1-12) failed to indicate an entry corresponding to a Safety Program /Plan or Safety Committee within the section for Safety. The Quality Assurance and Improvement Program (approved 1-12) failed to indicate the safety committee requirements and functions to be reviewed through the program. During an interview on 12-11-12 at 1330 hours, staff A1 confirmed that the center lacked a safety management plan including committee responsibilities and membership. 	S1180	<p>S 1180 "A safety management program must include, but not be limited to, the following: (1) A review of safety functions by a committee appointed by the chief executive officer which includes representatives from administration and patient care services".</p> <p>On December 21, 2012 Section 16 Page 1 new policy was written by the Facility Administrator: Safety Policy <i>Purpose:</i> To provide the safest facility possible to the patients, employees, and the public. <i>Policy:</i> It is the policy of the center that all activities be conducted in the safest manner possible to protect our patients, employees and the public. <i>Procedure:</i> Safety always takes precedence over expediency or shortcuts, and every attempt must be made by all employees to remove, correct, and/or report conditions that could cause accidents, if possible. Exercise caution at all times in carrying out</p>	01/31/2013			

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			<p>your duties. As you go about your work, you may observe unsafe conditions in the Center. If you cannot correct them yourself, report what you have seen to you supervisor and see that a warning sign, if necessary, is posted. You must also be on the lookout for fire hazards, which must be reported. In addition, be sure that the Facility Administrator has explained your specific responsibilities in case of fire, fire drill, or any other emergency.</p> <p>We urge employees to work cooperatively to achieve a functioning safety and health program to guard against injury to them and to protect our patients from injury.</p> <p><i>Formation of Safety Committee</i> The Facility Administrator is responsible for monitoring safety within the Center. The Facility Administrator will utilize the expertise of other Center personnel and entities providing contractual services to equipment of the Center as needed to maintain a safe environment within the Center. The Governing Body will appoint the Facility Administrator or other qualified individual. The Facility Administrator will appoint a safety committee, which includes representatives from administration and patient care services. The safety committee will be responsible for the following: 1. Ensuring a process</p>		

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			exists for collecting information about potential hazards and safe practices within the Center; 2. Implementing a safety program that includes, but is not limited to, the following -patient safety - health care worker safety - public and visitor safety; 3. That equipment maintenance, and environmental services are delivered and staffed in relation to services provided by the Center; and 4. Ensuring defibrillators utilized on the Center's crash cart are discharged as required per manufacturer's instructions. The QA&I/MEC will review this policy on January 17, 2013 and upon approval will be sent to the Governing Body for approval on January 18, 2013. The Facility Administrator will re-educate the staff on January 31, 2013. Each staff member will review and sign that they have read and understand this policy.		

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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 maintain its fire control plan ensuring the prompt reporting of fires and evacuation of patients, visitors and staff in the event of an emergency.</p> <p>Findings:</p> <p>1. The policy/procedure Fire Procedures (approved 1-12) indicated the following: " The staff member that notices the fires must determine if the Fire Department should be called and the building evacuated. " The policy/procedure failed to ensure that a fire was promptly reported or clearly indicate when reporting the fire was not required.</p>	S1188	S 1188 Section 17 Page 12, Policy titled "Fire Procedures" item #2 states that "The staff member that notices the fires must determine if the Fire Department should be called and the building evacuated". On December 20, 2012 #2 was revised to read, "Call 911" and to evacuate the building immediately. Once outside, meet on the east side of the building in the grass lot". The Facility Administrator will re-educate the Safety Committee on January 14, 2013. The safety committee will re-educate the staff in a staff meeting on January 31, 2013.	01/31/2013			

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	<p>2. The policy/procedure Fire Safety (approved 1-12) indicated the following: " Personnel not directly involved in patient care should report to the staff lounge or other location as dictated by organization-wide fire policy when the fire alarm sounds. " The policy/procedure failed to ensure that all staff would evacuate the building when a fire alarm sounds and failed to indicate the evacuation destination for staff to assemble outside of the center.</p> <p>3. During an interview on 12-11-12 at 1100 hours, staff A2 confirmed that the policy/procedures fail to ensure that fires were promptly reported and all staff would evacuate the building when the alarm sounds.</p>				