

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2015
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NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
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S 0000 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 011735</p> <p>Dates: 7/7/15 & 7/8/15</p> <p>QA: cjl 08/03/15</p>	S 0000		
S 0110 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the Governing Body (GB) failed to review, at least quarterly, reports of management operations, including quality assessment and improvement programs, within the past 4 quarters.</p>	S 0110	<p>GB meetings will be scheduled and conducted on a quarterly basis. QAPI Studies will be reviewed, as to subject matter, and presented to GB in detail. Medical Director and Administrator responsible</p>	08/11/2015

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

TITLE

(X6) DATE

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

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S 0164	<p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the document titled I. ORGANIZATIONAL FUNCTIONS 2. Governing Body A. Bylaws Rules and Responsibilities, indicated in #15. The GB reviews the QAPI (quality assurance performance improvement) quarterly reports and ... The bylaws were last indicated as approved 8/26/14. 2. Review of the QAPI plan/policy & procedures (P&P) indicated the following: #5. Compliance with the requirements of all federal, state, and accrediting agencies in regard to QAPI. The P&P was approved 10/7/14. 3. Review of the past 4 quarters of GB meeting minutes indicated meetings were held 6/14, 8/26/14, and 6/9/15. Meeting minutes dated 8/26/14 indicated QAPI Studies were reviewed. Meeting dated 6/14 & 6/9/15 lacked documentation of QAPI review. The documents lacked indication of GB meeting minutes for 3rd quarter 2014 and/or 1st quarter 2015. 4. On 7/7/15 at 5:45pm, A1, Administrator, indicated the GB did not hold quarterly meetings. 			

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Bldg. 00	<p>GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program.</p> <p>Based on document review and interview, the Chief Executive Officer (CEO) failed to develop and implement a policy & procedure (P&P) for post offer physical examination for 3 of 7 employees (P5, P6 & P8).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of facility P&P's lacked evidence of a P&P for employee post offer physicals. The P&P manual was last reviewed/revised 10/7/14. 2. Review of employee personnel files (P1, P2, P4, P5, P6, P7 & P8) lacked evidence of a post offer physical examination for P5, P6, & P8. 3. On 7/8/15 at 2:30pm, A1, Administrator, indicated the facility does require a post offer physical for employees. A1 also indicated that post offer physicals were not required early in 	S 0164	All employees that were missed were given physicals. We are now monitoring that each new employee receives physical as they are hired. P&P was developed at time of survey, but post offer physical exam were missed due to not rechecking all items needed. Infection Control LPN is responsible	08/11/2015

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S 0216 Bldg. 00	<p>first few years of the center and does not apply to P1, P2, or P5.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(d)(4)</p> <p>In accordance with center policy, the governing body shall do the following:</p> <p>(4) Ensure that there is a center-wide, quality assessment and improvement program that evaluates the provision of patient care and outcome.</p> <p>Based on document review and interview, the Governing Body (GB) failed to ensure that there was a center-wide quality assessment and performance improvement (QAPI) program within the past year.</p> <p>Findings:</p> <p>1. Review of the document titled I. ORGANIZATIONAL FUNCTIONS 2. Governing Body A. Bylaws Rules and Responsibilities, indicated in #2 of the Preamble. The GB has oversight and accountability for the QAPI program. The bylaws were last indicated as approved 8/26/14.</p>	S 0216	GB agenda will now include the review of all QAPI studies. GB shall review center wide studies and address the evidence gathered for each quarterly. Governing Body members are responsible.	08/11/2015	

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	<p>2. Review of the QAPI plan/policy & procedures (P&P) indicated the following: #5. Compliance with the requirements of all federal, state, and accrediting agencies in regard to QAPI. The P&P was approved 10/7/14.</p> <p>3. Review of the past 4 quarters of GB meeting minutes indicated meetings were held 6/14, 8/26/14, and 6/9/15. Meeting minutes dated 8/26/14 indicated QAPI Studies were reviewed, but lacked evidence of what the studies reviewed. Meetings dated 6/14 & 6/9/15 lacked documentation of QAPI review.</p> <p>4. Review of 2014 and 2015 QAPI documentation indicated a Quality Improvement Study (QIS) titled "Water temperature used in the Center's washing machine" was completed 12/9/14, a QIS titled "Decreased Cost of Supplies" was completed 1/26/15, and a QIS titled "Supporting Post-Op Patients Who are Standing or Walking" was completed for 2015.</p> <p>5. On 7/8/15 at 12:30pm, A1, Administrator, indicated the QAPI conducted only one study at a time and the current study for 2015 was related to supporting post-op patients who are standing or walking. A1 indicated QAPI review was not center-wide.</p>			

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S 0300 Bldg. 00	<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 Quality Assessment and Performance Improvement (QAPI) Program failed to maintain an effective, organized, center-wide, comprehensive program for 2014 or 2015.</p> <p>Findings:</p> <p>1. Review of the QAPI plan/policy & procedures (P&P) indicated the following: #5. Compliance with the requirements of all federal, state, and accrediting agencies in regard to QAPI. The P&P was approved 10/7/14.</p> <p>2. Review of 2014 and 2015 QAPI documentation lacked documentation of QAPI meeting minutes, evaluation of</p>	S 0300	QAPI meetings will be held quarterly. Evaluation of services, medical equipment and/or any events needing attention. Logs have been created for each items to be reviewed. Infection and Safety Co-ordinators and Administrator	08/11/2015

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S 0414 Bldg. 00	<p>services, functions, and/or reportable events.</p> <p>5. On 7/8/15 at 12:30pm, A1, Administrator, indicated the QAPI program was not center-wide and did not have documentation of meetings or reports showing evaluation of services, functions, or reportable events for 2014 or 2015.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p>			

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S 0442 Bldg. 00	<p>(D) Consultants from other appropriate services within the center as needed. Based on document review and interview, the Infection Control Committee failed to meet at least quarterly and failed to include a member of the Medical Staff (MS) in its meetings for 2014 and 2015.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of documents titled Infection Control Meeting Minutes indicated meetings were conducted on the following dates between 1/2014 and 7/2015: 3/12/14, 6/20/14 and 8/29/14. The minutes lacked documentation of attendance by a MS member. On 7/8/15 at 12:00pm, A1, Administrator/Infection Control Officer, indicated the above meeting dates and documentation to be all documentation available. <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</p>	S 0414	Infection Control meetings will be attended by the physician (Medical Staff Member) and the R.N. quarterly. We have had in place, since opening, services furnished from St Mary's Medical Center for Infection Control quarterly R.N. and Medical Director are responsible.	08/11/2015

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	<p>programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on document review and interview, the Infection Control Committee (ICC) failed to ensure maintenance of health records according to their policy and procedure (P&P) for 4 of 7 employees (P4, P6, P7, & P8).</p> <p>Findings:</p> <p>1. Review of facility the P&P titled III. HUMAN RESOURCES 2. Employee Health A. Objectives, indicated, under Responsibilities 1. Maintain current health records of all employees, including health examinations, disease exposure, work injuries, immunizations... The P&P indicated under the Health Maintenance Practices section #1. a 2 step PPD (tuberculosis test) is required for new employees unless they have documentation of a negative PPD within the past 3 months. That same section of the P&P indicated that after initial testing employees should be tested by PPD at least every 12 months. The P&P was last approved 10/7/14.</p>	S 0442	Two step PPD have been conducted on all current employees. All new employees will have the two step PPD. Charts with missing Varicella have been given a lab order to have titer completed. This will update their chart. Varicella missing was due to employees having chicken pox as a child. Infection Control LPN is responsible.	08/11/2015

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S 0472	<p>2. Review of personnel files P1, P2, P4, P5, P6, P7, and P8 indicated the following: Date of hire (DOH) for P4 was 7/30/14, the file contained PPD test documentation that indicated each test should be read between 48 to 72 hours after administration; a test administration was documented 7/29/14 at 8am and indicated as read 7/31/14 at 9am; a second PPD test was indicated to have been administered 8/12/14 at 3:30pm and read 8/14/14 (time not documented). DOH for P6 was 2/10/15; he/she had a PPD test administered 3/9/15 at 2:00pm; the file lacked documentation of the PPD test results being read and lacked documentation of any other PPD within 3 months. DOH for P7 was 10/3/13 the file lacked documentation of Varicella immunization. DOH for P8 was 9/2/14, the file lacked documentation of PPD testing and lacked documentation of Varicella immunization</p> <p>3. On 7/8/15 at 2:30pm, A1, Administrator, indicated the facility does require verification of immunization for Rubella, Rubeola, and Varicella as well as annual PPD testing and confirmed the above as documentation available.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM</p>			

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Bldg. 00	<p>410 IAC 15-2.4-1(2)(h)</p> <p>(h) Environmental surfaces and equipment not requiring sterilization which have been contaminated by blood or other potentially infectious materials shall be cleaned then decontaminated in accordance with acceptable standards of practice and applicable state laws and rules, 410 IAC 1-4.</p> <p>Based on document review, observation and interview, the center failed to maintain equipment which may be contaminated by blood or infectious materials in accordance with manufacturer recommendation for their point of care glucose monitor testing device.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the glucose monitor manufacturer manual indicated the following: The TRUEresults Blood Glucose Monitoring System is for one person use ONLY. DO NOT share your Meter...with anyone. DO NOT use on more than one person. ALL parts of your Blood Glucose Monitoring System could carry blood-borne diseases after use, even after cleaning and disinfection. On 7/8/15 at 12:15pm during review of glucometer documentation with P5, Certified Medical Assistant (CMA), the 	S 0472	Purchased Professional Monitoring Blood Glucose Meter (True Metrix Pro) required for more than one patient. Training on cleaning and competency will be given by the R.N. before use. R.N. and Administrator will be responsible.	08/11/2015

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S 0526 Bldg. 00	<p>following was observed: a McKesson TRUResults glucometer.</p> <p>3. P5 indicated this was the monitor used to test the blood sugar of any/all patients requiring a glucose check.</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed. Based on document review and interview, the center failed to maintain annual competency documentation for 4 personnel performing laboratory testing in 2014 or 2015.</p> <p>Findings:</p> <p>1. Review of facility policies and procedures (P&P) lacked indication of required annual competency testing for personnel performing laboratory testing. The P&P manual was last reviewed 10/7/14.</p> <p>2. On 7/8/15 at 12:15pm, P5, Certified Medical Assistant CMA), indicated that</p>	S 0526	<p>Competency testing will be given on Blood Glucose for staff. Training was done on the one that was in place, but no documentation was made. Documentation will be done on the new monitor. R.N will be responsible.</p>	08/11/2015

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S 0736 Bldg. 00	<p>all patient care staff, including, but not limited to CMAs and registered nurses (RN) may and do perform blood sugar glucose testing.</p> <p>3. Review of patient care personnel records lacked evidence of annual laboratory competency testing for the following: RN P4, CMA P5, CMA P7, & CMA P8.</p> <p>4. On 7/8/15 at 2:30pm, A1, Administrator, confirmed the facility lacked documentation of annual competency evaluations for the above 4 personnel.</p> <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 on document review and interview, the Medical Staff (MS) failed to meet at least quarterly in 2014 or 2015</p>	S 0736	Medical Staff scheduled to meet August 18,2015 and quarterly thereafter. MS will review Staff	08/11/2015

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S 0780 Bldg. 00	<p>and failed to establish attendance requirements of the MS.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of MS Bylaws and Rules and Regulations lacked evidence of a requirement for attendance of the MS meetings by MS members and lacked evidence of a frequency requirement for MS meetings. 2. Review of MS credential files indicated the MS included 1 physician and 1 allied health member (MD#1 and AH#1). 3. Review of facility documentation of MS meeting minutes 2014 and 2015 indicated a MS meeting was held 10/7/14 with MD#1 as the only MS member present. 4. On 7/8/15 at 2:30pm, A1, Administrator, indicated the MS had only conducted only 1 meeting within the past year and that MD#1 was the only MS member in attendance. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p>		<p>Bylaws and Rules. Documentation of all meeting will be kept. One physician and one allied health member will be present. Administrator and Medical Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2015
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	<p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on document review and interview, the Medical Staff (MS) failed to ensure all orders were in writing or acceptable computerized form for 7 of 20 medical records (MR) (Pt#'s 14, 15, 16, 17, 18, 19 & 20).</p> <p>Findings:</p> <p>1. Review of the MS rule titled I. ORGANIZATIONAL FUNCTIONS 6. Medical Staff J. Patient Management, under the section titled Admission and Discharge of Patients, indicated in #5. Patients are discharged only on the order of the attending practitioner. The Rules were last approved 10/7/14.</p> <p>2. Review of 20 patient MRs lacked evidence of a discharge order for the following: Pt# 14, Pt#15, Pt#16, Pt#17, Pt#18, Pt#19, & Pt#20.</p>	S 0780	New post procedure form was created in EHR to show order for discharge. The documentation we had done in chart was not to the extent required. The order will appear in our post procedure note. Medical Director and R.N.	08/11/2015

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S 1010 Bldg. 00	<p>3. On 7/8/15 at 9:25am, A3, Emergency Medical Technician/Nursing, indicated the MRs for Pt#s 14-20 did not contain a written or electronic order to discharge.</p> <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 document review, observation, and interview, the center failed to dispose of expired drugs according to their policy and procedure (P&P) for 3 medications (Epinephrine, Bayer chewable tablets, & NitroStat tablets).</p> <p>Findings:</p> <p>1. Review of facility P&P titled X. ANCILLARY SERVICES 2. Pharmaceutical Services B. Expired Drug Policy, indicated the following: All drugs will be checked on the first of each month for expiration date. Drugs with</p>	S 1010	Log has been created to monitor drug expiration dates. Crash cart is monitored by physician and clinic staff in procedure room. R.N. monitors any other medication area for expiration dates. All expired medications were removed and disposed of utilizing bio-hazard waste service.	08/11/2015

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	<p>expired dates will be disposed utilizing bio-hazardous waste and/or chemical waste management policy. The P&P was last reviewed 10/7/14.</p> <p>2. On 7/8/15 at 10:30am, in the presence of A1, Administrator, during tour of the physical plant, in the crash cart of the Procedure Room, the following was observed: 4 glass ampules of Epinephrine 1:1000 each with an expiration date of 1 Jul 15, a partial bottle of opened Bayer chewable tablets with an expiration date of 3/15, & a vial of NitroStat tablets with an expiration date of 04/15.</p> <p>3. A1 confirmed observation of expired drugs.</p>				