STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001078	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EYECARE CONSULTANTS SURGERY CENTER	101 NW FIRST ST STE 104 EVANSVILLE, IN 47708

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S0000	This visit was for a State licensure survey. Facility Number: 009564 Survey Date: 05/21/2012 through 05/22/2012 Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor Albert Daeger Medical Surveyor QA: claughlin 06/18/12	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	15C0001078		05/22/2012

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S0162	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G) Require that the chief executive officer develop and implement policies and programs for the following: (G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care. Based on review of medical staff bylaws, meeting minutes, credential files, and interview, the facility failed to ensure CPR (cardiopulmonary resuscitation) competency for all health care workers providing direct patient care for 2 of 2 physicians reviewed (#MD1 and MD4). Findings included: 1. The medical staff bylaws form #A2.7, "Application Appointment and Reappointment", last reviewed 02/2011, indicated under the items that must be submitted to the Medical Director/Center Director for appointment, "...r. BLS/ACLS [basic life support/advanced cardiac life support] certification, (if Operating Board approves)." 2. The minutes from the Board of	S0162	S162-410 IAC 15-2.4-1 Governing Body Powers & DutiesPlan of Correcton:The Governing Body will ensure all caregivers have current certifiction in CPR.Systemic Changes: Medical Staff By-Laws have been revised to required all physicians maintain current certificaton in CPR. (Attachment A). Required parties will be offered CPR classes to ensure compliance.Responsible Party/Monitoring: The Center Leader will review all files for medical staff appointees initially and monthly to ensure lapses do not reoccur. Actions taken and results of monitors will be reported at the regularly scheduled QAPI meetings for review and reporting to the Governing Body.	07/02/2012

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	Governors Annual Meeting on May 12, 2011 indicated, "...The board discussed and approved that all anesthesia providers were required to be CPR certified. The board agrees that the medical staff is not required to be ACLS/CPR certified moving forward." 3. The credential file for MD1 indicated ACLS expiration on 06/2008 and CPR expiration on 01/2011, both before the meeting on May 12, 2011. 4. The credential file for MD4 indicated ACLS expiration on 11/2005 and CPR expiration on 01/2011, both before the meeting on May 12, 2011. 5. The credential file for MD2, an anesthesiologist, indicated ACLS expiration on 11/2010 and CPR expiration on 02/2012, but also documentation of a CPR class taken on 02/23/12. 6. The credential file for MD3, an anesthesiologist, indicated CPR expiration on 03/2012, but also documentation of a CPR class taken on 02/09/12. 7. At 1:35 PM on 05/22/12, the facility manager, staff member #P1, indicated all of the registered nurses were CPR and			

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	ACLS certified and approximately half of the anesthesiologists were ACLS certified. He/she confirmed the certifications for the 2 physicians expired prior to the board meeting in May and indicated nothing else was put in place of the certification to determine CPR competency.			

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S0422	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C) The infection control committee responsibilities must include, but are not limited to: (C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.			
	Based on review of product information, facility testing form, employee files, and interview, the facility failed to ensure TB testing was performed accurately for 3 of 3 registered nurses (RNs) (#P1, P3, P4) and 2 of 2 certified surgery techs (CSTs) (#P2 and P5). Findings included: 1. The manufacturer's product information for Tubersol and Aplisol, the solutions used for TB testing, indicated the tests should be placed and read within 48 to 72 hours for accuracy. 2. The facility form "Annual/Tuberculosis Screening Documentation" indicated, "...An RN will read the skin test and check the appropriate box. The skin test must be read 48 to 72 hours after being placed. Employees cannot read their own skin test. If this procedure is not followed, the test is invalid and must be repeated."	S0422	S422 410 IAC 15-2.5-1 Infection Control Program 410 IAC 15-2.5-1 (f) (2) (C) Plan of Correction: All staff and physicians will be tested as appropriate for titers of communicable diseases identified as high risk per requirements and facility policy.Systemic Changes: The documentation form for reviewing and tracking compliance has been revised (attachnment B) to include current informaton and times of adminstration for testing and reading. To ensure correct completon of the forms, employees will now be required to review and sign the form for accuracy. Manufacturer's instructons will always be followed.Responsibility Party/Monitoring: The Center Leader will routinely review employee health files for completion and accuracy. All tests will be interpreted by the Center Leader or other qualified personnel. Actions taken will be presented at the regularly scheduled QAPI meetings for	07/02/2012

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	3. The form for the last TB test for staff member #P1 indicated the test was placed on 05/03/11 and read on 05/05/11, but no times were listed so it could not be determined whether or not it had been at least 48 hours. 4. The form for the last TB test for staff member #P2 indicated the test was placed on 03/06/12 and read on 03/08/12, but no times were listed so it could not be determined whether or not it had been at least 48 hours. 5. The form for the last TB test for staff member #P3 indicated the test was placed on 05/03/11 and read on 05/05/11, but no times were listed so it could not be determined whether or not it had been at least 48 hours. 6. The form for the last TB test for staff member #P4 indicated the test was placed on 05/03/11 and read on 05/03/11, the same day. 7. The form for the last TB test for staff member #P5 indicated the test was placed on 05/03/11 and read on 05/03/11, the same day. 8. At 3:15 PM on 05/22/12, the facility manager, staff member #P1, indicated		review and reporting to the Governing Body.	

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	he/she thought dating the placing and the reading was sufficient. He/she also indicated the readings for staff members #P4 and P5 were errors because he/she knows they were read in 2 days.			

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S0442	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii) The infection control committee responsibilities must include, but are not limited to: (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: (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. Based on policy review, employee file review, and interview, the facility failed to ensure a policy was in place to follow the accepted infection control guidelines regarding immunizations. Findings included: 1. The facility policy #C8.17, "Pre-Employment Health Examination", last reviewed 02/2011, indicated, "...Verification of previous rubella titer screening will be obtained. If results are not obtainable a rubella screen will be done at no cost to the employee (if applicable)." The policy failed to address immunity to Rubeola or Varicella.	S0442	S 442 410IAC 15-2.5-1Infecton Control Program 410 IAC 15-2.5-1 (f)(2)(E)(viii)Plan of Correction: The Governing Body will ensure there is an adequate Employee Health program in place that ensures a determination is made at the initial employment date of the new employees communicable disease history.Systemic Changes: Current policy has been changed to include obtaining history on exposure and immunization history for fubeola, rubella, mumps and varicella. (attachment C). All employees will be required to submit informaton about his/her exposure and/or immunizations for mumps, rubella, rubeola and varicella.Responsible	07/02/2012

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	2. Review of the files for staff members #P1- P5 indicated immunization status for Rubella, Rubeola, and Varicella. 3. At 2:45 PM on 05/22/12, the facility manager and infection control person, staff member #P1, indicated the facility followed CDC and AORN guidelines, but the corporation indicated only Rubella immunity was required. He/she indicated he/she was not aware that the CDC guidelines indicated all health care personnel who work in medical facilities should be immune to measles, mumps, and rubella and recommend immunity to varicella.		Party/Monitoring: The Center Leader/designee will review all new hires for completion and accuracy. Issues will be managed. Results will be reported at the regularly scheduled QAPI meetings for review and reporting to the Governing Body.	

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S0772	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (M) A requirement that a medical history and physical examination be performed as follows: (i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed. (ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff. (iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy. Based on policy review, medical record review, and interview, the facility failed to follow their policy regarding the criteria for patient history and physicals for 5 of 25 records reviewed (#N4, N9, N10, N12, and N15).	S0772	S772 410 IAC 15-2.5-4(b)(3)(M) Medical Staff Anesthesia and Surgical 410 IAC 15-2.5-4 (b)(3)(M)Plan of Correction: The Governing Body will ensure all patients receiving care at the facility will have a current history and physical appropriate for the scope of care received.Systemic	07/02/2012

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	Findings included: 1. The facility policy #C5.20, "History and Physical", last reviewed 02/2100, indicated, "Each patient has a comprehensive medical history and physical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws and standards of practice, no more than 30 days prior to the procedure. ...An appropriate assessment is completed prior to the procedure to update any components of the patient's current medical status that may have changed since the prior H&P and documented in the medical record." 2. The medical record for patient #N4, who had surgery on 01/26/12, indicated a comprehensive history and physical (H&P) from 11/21/11. The record did have documentation of a one page update on the day of surgery. 3. The medical record for patient #N9, who had surgery on 03/01/12, indicated a comprehensive H&P from 01/25/12. The record did have documentation of a one page update on the day of surgery and the notation "reviewed and confirmed 3/1/12" on the original H&P and initialed by the physician.		Changes: Staff and physicians will be in-serviced regarding the information required and the time frames in which it must be performed.(attachment D-Educaton summary and sign in sheet). 100% of medical and clinical staff will be provided the required information.Responsible Party/Monitoring: The Center Leader/designee will audit all medical records for the next 90 days for an appropriate H&P. 100% audits will continue until 100% compliance is obtained. Once 100% compliance is noted, a minimum of thirty randon chart audits will be conducted each month for three consecutive months until 100% is noted. Afterwards, random audits will be conducted to ensure ongoing compliance. Actions taken and results of audits will be reported at the regularly scheduled QAPI meetings for review and reporting to the Governing Body.	

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	4. The medical record for patient #N10, who had surgery on 03/27/12, indicated a comprehensive H&P from 02/22/12. The record did have documentation of a one page update on the day of surgery and the notation "reviewed and confirmed 3/27/12" on the original H&P and initialed by the physician. 5. The medical record for patient #N12, who had surgery on 10/13/11, indicated a comprehensive H&P from 09/02/11. The record did have documentation of a one page update on the day of surgery and the notation "reviewed and confirmed 10/13/11" on the original H&P and initialed by the physician. 6. The medical record for patient #N15, who had surgery on 12/01/11, indicated a comprehensive H&P from 02/18/11, over 9 months prior to surgery. The record did have documentation of a one page update on the day of surgery. 7. At 3:00 PM on 05/22/12, the facility manager, staff member #P1, confirmed the medical record findings, but indicated he/she had been told by previous surveyors that a notation by the physician on the previous H&P would be acceptable. He/she also indicated it would be a hardship for some of their			

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	patients to make an extra trip for a new H&P.			