

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001131	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/02/2016
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NAME OF PROVIDER OR SUPPLIER  ELKHART CLINIC ENDOSCOPY AND SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2117 W LEXINGTON AVE ELKHART, IN 46514
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S 0000  Bldg. 00	This visit was for a State licensure survey.  Facility Number: 003903  Survey Date: 02-29/03-02-2016  QA: cjl 04/12/16  IDR Committe held on 04-27-16. Tag S1168 deleted. JL	S 0000		
S 0110  Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)  The governing body shall do the following:  (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.  Based on document review and interview, the facility's governing board failed to review reports of the quality assessment performance improvement (QAPI) program for 1 other activity	S 0110	To correct the deficiency, QAPI will now include more than just transfer discharges. QAPI will be done on all patients to verify if discharge instructions have been given, which in turn will be	05/01/2016

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 0153  Bldg. 00	<p>(discharges) during calendar year 2015, as part of the facility's QAPI program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the governing board meeting minutes for calendar year 2015 indicated the governing board failed to review QAPI reports for the activity of discharges.</li> <li>Interview of employee #A1, Manager Regulatory and Compliance, on 03-02-2016 at 2:30 pm, confirmed the above and no other documentation was provided prior to exit.</li> </ol> <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>Based on document review and interview, the facility failed to follow its policy to provide orientation of a</p>			S 0153	<p>reviewed by the Governing Body quarterly. This will be done by the Medical Records personnel and implemented by the Manager of Regulatory and Compliance. This will begin on May 1, 2016. The Manager of Regulatory and Compliance is responsible</p> <p>To correct this deficiency, the radiology technician will have a general orientation to the facility and it will be placed in their</p>		05/01/2016

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	<p>contracted employee to the facility for 1 (radiology tech) of 1 personnel file reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of a facility policy entitled New Employee Orientation, Revision Date: 2/12, indicated "all new employees shall receive a general orientation utilizing the New Team Member checklist on or before their first day of employment ... ." Further review of the policy indicated it made no distinction exception as to whether the employee was a directly-hired employee or a contracted employee.</li> <li>2. Review of 1 personnel file, P1, a contracted radiology tech, indicated the employee was contracted to the facility and the file contained no documentation of a general orientation to the facility utilizing the New Team Member checklist on or before their first day of employment.</li> <li>3. Interview of employee #A1, Manager Regulatory and Compliance, on 03-01-2016 at 3:15 pm, confirmed all the above and no other documentation was provided prior to exit.</li> </ol>		employee file. The Manager of Operations will be responsible and this will be completed by May 1, 2016.		

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S 0156 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to follow its policy to maintain an annual performance evaluation for 1 (P1, radiology tech) of 1 contracted employee.</p> <p>Findings include:</p> <p>1. Review of a facility policy entitled Employment Application, Personnel Record, and Pre-Employment Background Investigation, Revision Date: 11/09, indicated "The personnel record shall include ... other information as deemed appropriate by the Administrator with the following</p>	S 0156	Review of the previous performance review indicates that the ASC administrator did initial the review. To correct this deficiency in the future, the ASC administrator will co-sign her full name on the annual performance review of the radiology technician.	04/25/2016

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	<p>minimum requirements: ... Annual performance evaluation."</p> <p>2. Review of 1 contracted employee personnel files, P1, radiology tech, indicated it contained a document entitled <u>Elkhart Clinic - Performance Review</u>, Review Date: 9-14-15, Job Title: Diagnostic Imaging Tech, signed by a Manager/Evaluator.</p> <p>3. Further review of the above-stated evaluation indicated there was no signature on it indicating when and if an authorized facility individual had reviewed the evaluation.</p> <p>4. Interview of employee #A1, Manager Regulatory and Compliance, on 03-01-2016 at 1:15 pm, indicated the above-stated performance review form was not that of the Elkhart Clinic Endoscopy &amp; Surgery Center, LLC. The employee further indicated the Manager/Evaluator was not an employee nor an authorized individual of the facility to review and sign an evaluation for the facility.</p> <p>5. Employee #A1 on the above-stated date and time, was requested to provide a contract/agreement that indicated the facility agreed to have the contracted employee's company to conduct the</p>			

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S 0162 Bldg. 00	<p>employee's review of the the employee. In interview on the above-stated date and time, employee #A1 indicated there was no such contract/agreement.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(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.</p> <p>Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice for 1 (MD#1) of 7 physician credential files reviewed.</p> <p>Findings include:</p> <p>1. Review of 7 physician credential files indicated MD#1 had a document (card) entitled Pacific Medical Training ACLS Provider. Review of this card indicated</p>	S 0162	The doctor in the citation withdrew her privileges on 4/8/16 effective immediately, thus resolving the deficiency. To prevent future deficiencies, the Manager of Regulatory and Compliance will verify all future ACLS courses and any course deemed to be an online course will require a CPR skills checklist or course by a certified CPR instructor in order for privileges to be valid.	04/08/2016

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S 0166 Bldg. 00	<p>"This card certifies that the individual above has successfully completed the Advanced Cardiovascular Life Support (ACLS) course requirements and cognitive evaluation ... ."</p> <p>2. Review of a document entitled Pacific Medical Training, a description of the course, indicated it provided "... online emergency education ... for Advanced Cardiac Life Support." Further review indicated: <b>"Each course features:</b> professional online training material ... [and an] online exam .... ."</p> <p>3. In interview, on 03-02-2016 T 1:00 PM, employee #A1, Manager Regulatory and Compliance, was requested to provide documentation the above-stated course included ACLS competency (hands-on demonstration). The employee indicated no such documentation could be provided and none was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I)</p>			

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	<p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the facility failed to approve policies and procedures by an authorized individual within the last 3 years in 28 of 42 policies reviewed</p> <p>Findings include:</p> <p>1. Review of 44 facility policies and procedures indicated the following had not been reviewed for more than 3 years:</p> <p>APPROVED ABBREVIATIONS AND SYMBOLS Date: 5/20/04 Verbal and Telephone Orders Effective Date: 5/2004 Deactivating Duplicate Accounts in Advantx Effective Date: 4/2010 Computer System Failure Effective Date: 5/2004 Closure of Incomplete Clinical Records Effective Date: 1/2012 Charting Standards Effective Date: 5/2004 Staff Competency Standards Effective Date: 11/2009 New Employee Orientation</p>	S 0166	The previous triennial review was found after the surveyor's departure (see attachment appendix A). To prevent this deficiency in the future, the triennial review will be kept in the front of the policy and procedure manual and a scanned copy on the electronic drive with the policies and procedures where it is accessible by all. The triennial review was just completed on 4/18/16 (see attachment appendix B). This will be the responsibility of the Manager of Regulatory and Compliance.	04/18/2016

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	<p>Revision Date: 2/12</p> <p>Employee Annual Education and Competency                      Revision Date: 11/09</p> <p>Warming Cabinets     Effective Date: 2/2012</p> <p>Tornado Plan - Code "TW"     Effective Date: 5/2004</p> <p>Security Disturbance Plan - Code "303"     Effective Date: 5/2004</p> <p>Preventive Maintenance     Revision Date: 2/12</p> <p>Malignant Hypothermia Crisis Plan     Effective Date: 5/2004</p> <p>Handling of Suspicious Mail or Packages     Effective Date: 5/2004</p> <p>Safe Use of Glutaraldehyde     Effective Date: 4/2011</p> <p>Gas Cylinder Safety     Effective Date: 5/2004</p> <p>Fire Protective Systems Out of Service     Effective Date: 3/2012</p> <p>Bomb Threat Plan - Code BT     Effective Date: 5/2004</p> <p>Insulin Administration     Effective Date: 4/2011 Medication Management                      Effective Date: 5/2004</p> <p>TUBERCULOSIS INFECTION CONTROL PROGRAM      Date: 5/20/04</p> <p>Surgical Attire     Revision Date: 11/09</p> <p>Reportable Diseases     Effective Date: 10/19/09 Refrigerator</p>			

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S 0228 Bldg. 00	<p>Temperature Monitoring Effective Date: 1/2010</p> <p>Pest Control Effective Date: 7/2011</p> <p>Personal Protective Equipment Effective Date: 7/12</p> <p>Infectious Waste Disposal Effective Date: 5/20/04</p> <p>2. Interview of employee A1, Manager Regulatory and Compliance, on 03-02-2016 at 12:30 pm, confirmed all the above. The employee was asked if there was some other cover sheet or committee minutes which would indicate a review of the above-stated policies within the last 3 years and the employee indicated there was none. No other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</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>			

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	<p>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that 1 of 7 credentialed staff, MD#7, a podiatrist, who performed surgery in the facility, failed to have a properly written agreement, signed by both parties, with another physician who did have admitting privileges at a hospital in the same or adjacent county in which the ambulatory surgery center is located, such that the physician would admit patients to the hospital, if needed.</p> <p>Findings include:</p> <p>1. Review of an Indiana State Department of Health Program Advisory Letter, entitled Standing Waiver for 410 IAC 15-2-2.3-1 (e)(4), effective November 21, 2012, indicated podiatrists must provide documentation to the Ambulatory Surgery Center demonstrating that he/she has an</p>	S 0228	To correct the deficiency, the podiatrist has a signed agreement that satisfies the requirements of the Standing Waiver for 410 IAC 15-2-2.3-1 (e)(4), effective November 21, 2012, demonstrating that he has an agreement with the medical director of the ASC who has admitting privileges at the same hospital in which the podiatrist has surgical privileges (Elkhart General Hospital), who agrees to admit podiatric patients in cases in which a transfer is necessary, and is signed by both parties(see attachment appendix C). The Manager of Regulatory and Compliance is responsible for this.	04/25/2016

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	<p>agreement with one or more physicians, with admitting privileges in which the podiatrist has surgical privileges, agrees to admit podiatric patients in cases in which a transfer is necessary, and must be signed by both parties.</p> <p>2. Review of 7 medical staff credential files indicated MD#7, a podiatrist, did not have a properly written agreement, signed by both parties, with a physician who did have admitting privileges at a hospital in the same or adjacent county in which the ambulatory surgery center is located, such that the physician would admit patients to the hospital, if needed.</p> <p>3. Review of a document (agreement) entitled (Facility #1) <b>PRIVILEGE PROFILE for (MD#7)</b>, indicated:  "<b>Admitting Privileges? Can co-admit with Primary care physician.</b>"</p> <p>4. The agreement did not indicate specifically which physician would be the admitting physician. Also, the agreement did not have signatures of both the admitting physician and MD#7.</p> <p>5. Interview of employee #A1, Regulatory and Compliance, on 02-02-2016 at 12:25 pm, confirmed all the above and no other documentation</p>			

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S 0320 Bldg. 00	<p>was provided prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for the activity of discharge in its quality assessment and performance improvement (QAPI) program for calendar year 2015.</p> <p>Findings include:</p> <p>1. Review of the facility's QAPI program for calendar year 2015 indicated it did not include a monitor and standard for the activity of discharge.</p> <p>2. Interview of employee #A1, Administrator/Director of Nursing, on 03-02-2016 at</p>	S 0320	<p>QAPI will now be modified to include more than just transfer discharges, we will monitor if all patients receive D/C instructions. This will be done by the Medical records personnel and implemented by Manager of Regulatory and Compliance. This will be implemented to begin on May 1, 2016.</p>	05/01/2016

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S 0444 Bldg. 00	<p>1:30 pm, confirmed the above and no other documentation was provided prior to exit.</p> <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 document review, observation and interview, the infection control committee failed to ensure that facility personnel met requirements for personal hygiene and attire that meets acceptable standards of practice as related to not wearing a mask for 1 of 1 Gastroenterologist # 52 and 1 of 1 CSTs (Certified Surgical Technicians) # 51.</p> <p>Findings include:</p> <p>1. Review of policy/procedure Personal Protective Equipment on page 4 indicated</p>	S 0444	The deficiency shall be corrected by re-orienting staff, physicians, and AHPs of the current PPE policies. ASC staff shall be re-oriented to the policies at a staff/unit meeting to be scheduled on 4/29/16. Physicians and AHPs will be notified at the Medical Advisory Committee and Board of Manager's Meetings on 4/18/16 and by follow up email on 4/25/16. All health care workers/providers shall be re-oriented to the policies by May 12, 2016. The Manager of Regulatory and Compliance will be responsible for this. The	05/01/2016

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S 0826 Bldg. 00	<p>the following; H. Respiratory Protection</p> <p>b. Staff shall wear masks to protect the mucous membranes of the nose and mouth during procedures and activities that generate splashes, splatters, sprays, or other aerosols of blood or OPIM (other potentially infectious materials). Masks: This policy/ procedure was last reviewed/ revised on 7/12.</p> <p>2. While in procedure room Endoscopy #2 on 3-1-2016 at 1027 hours, it was observed that Gastroenterologist # 52 and CST # 51 did not wear a mask while performing a colonoscopy procedure.</p> <p>3. Interview with RN (registered nurse) # 50 on 3-1-2016 at 1029 hours confirmed the finding of Gastroenterologist # 52 and CST # 51 not wearing a mask during the procedure.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</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>(E) Safety training required of</p>		<p>deficiency shall be prevented from recurring in the future by conducting random QA audits of compliance with the Infection Control Plan and Surgical Attire policies after re-education to the policies has been completed. Individuals found in non-compliance with the policies shall be corrected; additional education shall be provided where needed. The Infection Control Nurse and Manager of Operations will perform the QA audits and report findings to the Manager of Regulatory and Compliance.</p>				

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	<p>personnel. Based on document review and interview, the facility failed to provide documentation of safety training in areas where anesthetics are used for 7 (MD#1, MD#2, MD#3, MD#4, MD#5, MD#6 and MD#7) of 7 medical staff credential files reviewed and 2 (AH#1 and AH#2) of 2 allied health credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of 7 medical staff credential files indicated files MD#1, anesthesiologist, MD#2, obstetrician/gynecologist, MD#3, urologist, MD#4, osteopath, MD#5, pain management, MD#6, gastroenterologist, and MD#7, podiatrist, did not contain any documentation of safety training in areas where anesthetics are used.</li> <li>Review of 2 allied health credential files indicated files AH#1, a Certified Registered Nurse Anesthetist (CRNA) and AH#2, a Nurse Practitioner, did not contain any documentation of safety training in areas where anesthetics are used.</li> <li>Interview of employee #A1, Manager Regulatory and Compliance, on 0-02-2016 at 12:25 pm, confirmed all the above and no other documentation was</li> </ol>	S 0826	The deficiency will be corrected by having all physicians and allied health providers complete Anesthesia/Waste Gas Safety Training (see attachments appendix E and appendix F). This training will be complete by May 12, 2016. To prevent the deficiency in the future, any new physician or allied health professional will have Anesthesia Waste Gas Safety Training completed as part of their credentialing process. Policy Anesthesia Waste Gas Safety Training for Physicians and Allied Health Personnel was created (see attached appendix D). The Manager of Regulatory and Compliance will be responsible for this.	05/12/2016

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S 0888 Bldg. 00	<p>provided by exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review, observation and interview, the facility failed to ensure that the post operative notes were completed immediately following surgery for 3 of 16 patients, PT #6, PT #10, PT #14.</p> <p>Findings Include:</p> <p>1. Review of policy/procedure Medical Staff Rules and Regulations on page 6 indicates the following; Section 11</p>	S 0888	The deficiency shall be corrected by re-orienting the physicians to policy "Medical Record Content and Requirements," with specific attention to the timeframe required for Op Note completeness. This will be provided to the all physicians and PHPs via email on 4/25/16 after the Medical Advisory Committee meeting on 4/18/16. Random QA audits on medical records shall be performed bythe Medical Records person to ensure physicians are achieving	04/25/2016

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	<p><b>MEDICAL RECORD REQUIREMENTS</b></p> <p>D. The patients medical record shall also contain an operative summary/report with a complete description of the operative procedure, including any complications, indications for surgery, name and signature of the primary surgeon and assistant, findings, technical procedures used, specimens removed and postoperative diagnosis with the surgeon's signature. Operative summaries/ reports shall be dictated within 24 hours of the surgical procedure. This policy/procedure was last reviewed/ revised on 4/13.</p> <p>2. While reviewing patient charts it was observed that the operative notes for patients PT #6, PT #10 and PT #14 were completed 3 days following the surgical procedures.</p> <p>3. Interview on 3-1-2016 at 1600 hours with RN (registered nurse) #50 confirmed the operative notes for PT #6, PT #10 and PT #14 were not completed within 24 hours of the surgical procedures.</p>		<p>thisstandard. Physicians not adhering to the facility policy shall beinformed of the need for correction to comply with policy; the Manager ofRegulatory and Compliance, ASC Administrator, and ASC Medical Director will benotified of results. The MAC and Board shall be informed of QA audit results at the quarterly meetings.</p>	

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S 0906  Bldg. 00	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(a)(2)</p> <p>(a) Patient care services must require the following:</p> <p>(2) That personnel with appropriate training are available at all times to handle possible emergencies involving patients of the center.</p> <p>Based on document review, observation and interview, the center failed to ensure that personnel with appropriate training were available at all times to handle possible emergencies involving patients at the center as related to lack of CPR (Cardiopulmonary Resuscitation) certification for 1 of 1 MA (Medical Assistant), N5.</p> <p>Findings Include:</p> <p>1. Review of policy/procedure New Employee Orientation on page 1 indicates the following; Practices and Procedures A. The orientation of the new employees shall take place within the first week of employment beginning with the first day. The New Team Member Checklist is intended to assure completeness of this process. This checklist is to be included in the personnel file of the employee.</p> <p>2. <u>Job Specific Orientation Checklist</u> The orientation of new employees</p>	S 0906	Deficiency has been corrected, staff member took CPR March 4, 2016. See copy of card attached appendix G. To prevent deficiencies in the future, CPR will be scheduled for all new hires upon hire date by Administrator of Human Resources and all files will be reviewed every two years for renewal. Administrator of Human Resources will be responsible.	03/11/2016

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S 1006	<p>relative to their specific job at the center shall vary somewhat with the job and the training and experience of the employee. The supervisor conducting the orientation is responsible for determining the overall content and depth of the orientation using the appropriate checklist. At a minimum, it shall include:</p> <p>f. Cardiopulmonary Resuscitation for all staff within 30 days of hire. This policy/ procedure was last reviewed/ revised on 2/12.</p> <p>2. Review of Job description: Central Services/Sterile Processing Technician on page 2 indicated the following; Requirements Required</p> <p>5. CPR certification within 30 days of hire</p> <p>3. Review of personnel files showed a lack of CPR certification for MA N5.</p> <p>4. Interview on 3-2-2016 at 1100 hours with RN (registered nurse) # 50, Manager, Regulatory/Compliance, confirmed that MA N5 did not have a CPR certification.</p>			
	410 IAC 15-2.5-6			

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Bldg. 00	<p>PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(2)</p> <p>Pharmaceutical services must have the following:</p> <p>(2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed.</p> <p>Based on document review, observation and interview, Pharmaceutical services failed to ensure proper records of all scheduled substances as related to the ISSUED CONTROLLED SUBSTANCES FORM.</p> <p>Findings Include:</p> <p>1. Review of policy/procedure Management of Controlled Substances on page 6 indicated the following; F. Controlled Substance Administration</p> <p>b. Wastage Documentation. Any controlled substance packaged in an amount larger than the dose being administered shall be wasted immediately.</p> <p>i. Wastage documentation shall be performed by two (2) licensed individuals, one of whom shall be an agent of the center.</p> <p>This policy/procedure was last reviewed/ revised on 2/14.</p> <p>2. While on tour on 3-1-2016 at 1138</p>	S 1006	<p>The deficiency shall be corrected by re-orienting staff to the policy "Medication Management," with specific attention to the Narcotic Inventory Control section, which states that "Narcotics shall be counted and verified by two nurses at the beginning and end of each day that the Center is open for patients. Two nurses shall simultaneously count the quantity of each narcotic medication and initial the count on the Narcotic Inventory Record Form. The disposal of any narcotic medication is also recorded and verified on the form with a co-signature." The deficiency shall be prevented in the future by continuing QAPI on narcotic reconciliation and random QA audits on the narcotic logs. The Manager of Regulatory and Compliance and the Manager of Operations will be responsible for these tasks. ASC staff shall be reoriented to the policy at a staff/unit meeting to be scheduled on 4/29/16 and all staff will be re-oriented by May 1, 2016.</p>	05/01/2016
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S 1170 Bldg. 00	<p>hours with RN (registered nurse) # 50, Manager, Regulatory/Compliance, it was observed that the ISSUED CONTROLLED SUBSTANCE FORM dated 1-28-16 lacked 2 signatures for a wasted dose of a controlled medication.</p> <p>3. Interview on 3-1-2016 at 1138 hours with RN # 50 confirmed that 2 signatures should have been present for the wasted medication.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to document</p>	S 1170	The deficiency has been corrected by changing the Daily Crash Cart Checklist to	05/01/2016

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	<p>defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the M Series defibrillator manual <b>SECTION 9 GENERAL MAINTENANCE, Periodic Testing</b>, indicated "The following operational checks should be performed at the beginning of every shift ... . Refer to the appropriate Operator's Checklist ... ."</li> <li>Review of the Operator's Checklist indicated:  <b>"Multi-function Pad</b>                      1 set pre-connected/ 1 spare"                       " Batteries                      A Fully charged battery in unit                      B Fully charged spare battery available"</li> <li>Review of a facility document entitled <b>DAILY CRASH CART CHECKLIST, MONTH</b> February, <b>YEAR</b> 2016, indicated it did not include checks of the Multi-function Pad, nor checks of the Batteries.</li> <li>In interview, on 03-01-2016 at 1:45 pm, employee #A1, Manager Regulatory and Compliance, confirmed all the above</li> </ol>		specifically include batteries and Multi-function pads. See attached revised checklist labeled appendix H. The new checklist will be put in use on May 1, 2016.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

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