

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001022		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2012	
NAME OF PROVIDER OR SUPPLIER  DIGESTIVE HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 AAA WAY CARMEL, IN 46032			
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005403</p> <p>Survey Date: 5-01-12 to 5-02-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Karilyn Tretter, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/22/12</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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S0148	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c) (4)</p> <p>(c) The governing body shall do the following:</p> <p>(4) Require that the chief executive officer designate in writing an administrative officer to serve during his or her absence.</p> <p>Based on document review and interview, the facility failed to clearly indicate in writing who would be in charge when the chief executive officer was not present.</p> <p>Findings:</p> <p>1. The policy/procedure titled Policy for the Chain of Command in the Administrator 's Absence (reviewed 8-11) indicated that the Administrative Assistant would be in charge in the absence of the Administrator and indicated that in the absence of the Administrative Assistant, the Director of Nursing would be in charge of the nursing staff and the Administrative Secretary would be in charge of the front office staff.</p> <p>2. The policy/procedure The Fire Alarm Signal (no date reviewed) indicated the following: " Chain of Command: Administrative Director - Medical</p>	S0148	<p>The policy/procedure titled Policy for the Chain of Command in the Administrator's Absence will be revised to indicate the chain of command.1. MD (Medical Director)2. DON (Director of Nursing)3. Adminstrative Assistant The policy/procedure titled Policy for The Fire Alarm Signal in the Administrator's Absence will be revised to indicate the chain of command.1. MD (Medical Director)2. DON (Director of Nursing)3. Adminstrative AssistantThe policy/procedure titled Impaired or Incapacitated Physician Policy (created 2010) in the Administrator's Absence will be revised to indicate the chain of command.1. MD (Medical Director)2. DON (Director of Nursing)3. Adminstrative AssistantThe medical secretary is the responsible person for monitoring all of these. Policy Chain of Command will be revised by 08/06/12 and the remaining policies will be done by 09/06/12.Addendum:</p>	09/06/2012	

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	<p>Director - Operating Room Supervisor Until the Fire Department arrives at which time the directive of the ranking Fire Department person will be followed. "</p> <p>3. The policy/procedure titled Impaired or Incapacitated Physician Policy (created 2010) failed to indicate a responsible licensed healthcare professional to direct the emergency procedures for the physician and ensure accountability for patients receiving care at the center or reference the policy/procedure Chain of Command in the event that the physician was incapacitated.</p> <p>4. During an interview on 5-02-12 at 0910 hours, staff A2 confirmed that the center lacked a consistent policy/procedure that indicated who would be in charge when the administrator was not present.</p>		<p>We will be done revising drafts for the Policy titled The Fire Alarm Signal in the Administrator's Absence and the Policy titled The Incapacitated Physician Policy (created 2010) in the Administrator's Absence by 09/06/12.</p>		

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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 ensure that personnel were oriented to applicable policies and procedures for 1 contracted housekeeping personnel.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 5-01-12 at 0920 hours, staff A2 was requested to provide documentation of orientation for the contracted housekeeping personnel (HK3) and none was provided prior to exit.</li> <li>2. During an interview on 5-02-12 at 1510 hours, staff A2 confirmed that no documentation of orientation was available for the current housekeeper.</li> </ol>	S0153	<p>The policy will state upon hire of new contracted cleaning personnel, orientation to be conducted by secretary &amp; date/time provided. For the hiring of each new cleaning personnel, there will also be a file created for our records. We will put those files with our employee files. The person responsible for completing &amp; monitoring this will be the secretary. The orientation is to be completed by 08/06/12. The documentation is to be completed by 09/06/12. The person responsible for completing &amp; monitoring this will be the secretary.</p>	09/06/2012	

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S0166	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I)</p> <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 upon document review and interview, the facility failed to follow its policy/procedures and ensure that all policies/procedures were reviewed at least triennially.</p> <p>Findings:</p> <p>1. The administrative policy/procedure titled Policies and Procedures (reviewed 8-10) indicated the following: " All policies and procedures will be reviewed and revised every two years ... "</p> <p>2. The policy/procedure General Policies of Medical Records Department (originated 4-10) indicated the following: "The Medical Records Policy and Procedure Manual will be reviewed every other year and revised as necessary."</p> <p>3. The cover page entitled Medical Record Manual failed to indicate that all</p>	S0166	<p>The administrative policy/procedure titled Policies &amp; Procedures, General Policies of Medical Records Department, The Cover Page Entitled Medical Records Manual, Infection Control Plan, Expiration Times/Dates (reviewed 4/04), Patient Discharge (reviewed 1/08), Sample Drug Administration (revised 1/08), and Administration of Medications (revised 1-08), and Incapacitated Physician Policy &amp; Procedure Manuals will be reviewed, revised, &amp; adopted every 3 years or as needed by the secretary. When a policy or procedure is revised, the secretary will present the policy/procedure to the governing board for approval. The governing board will state any revision in the minutes. The medical secretary is the responsible person that will complete &amp; monitor these manuals. This part to be done by 08/06/12.By 09/06/12 the</p>	09/06/2012			

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	<p>medical record policy/procedures had been reviewed and approved within the past 4 years per policy requirements.</p> <p>4. The policy/procedure Infection Control Plan (no date revised) indicated the following: "Review and approval of policies by the Infection Control Committee will occur at least every three years." The plan failed to indicate a date of revision to validate compliance with its policy requirements.</p> <p>5. The policy/procedure Expiration Times / Dates (reviewed 4-04), Patient Discharge (reviewed 3-05), Sample Drug Administration (revised 1-08) and Administration of Medications (revised 1-08) failed to ensure that the handwritten changes and alterations were valid revisions and failed to indicate a periodic review and approval per policy requirements.</p> <p>6. The policy/procedure titled Impaired or Incapacitated Physician Policy (prepared 2010) failed to indicate the month of creation to validate a periodic review and approval according to center policy.</p> <p>7. On 5-02-12 at 1530 hours, staff A6 confirmed that the center had failed to review all of its policies/procedures within the past 2 years per center policy,</p>		<p>secretary will go through the The administrative policy/procedure titled Policies &amp; Procedures, General Policies of Medical Records Department, The Cover Page Entitled Medical Records Manual, Infection Control Plan, Expiration Times/Dates (reviewd 4/04), Patient Discharge (reviewed 1/08), Sample Drug Administration (revised 1/08) and Administration of Medications (revised 1/08), and Incapacitated Physician Policy &amp; Procedure Manuals and present any policy/procedure to the governing board that needs revision. The secretary is the person responsible for monitoring these manuals. She will mark her calendar and check all of them every 3 years.</p>				

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	that the center lacked a consistent time interval for performing a review its policy/procedures and that the center lacked a process for ensuring that all its policies/procedures will be maintained per policy in the future.			

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S0176	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on document review and interview, the center lacked documentation of personnel competency for cleaning and disinfecting the operating rooms and patient care areas for 1 contracted housekeeper.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 5-01-12 at 0920 hours, staff A2 was requested to provide documentation of housekeeper competency for cleaning and disinfecting according to the applicable policy/procedures of the center and none was provided prior to exit.</li> <li>2. Review of HK3 's personnel file failed to indicate that cleaning and disinfecting competency was demonstrated and documented by center staff.</li> <li>3. During an interview on 05-02-12 at 1515 hours, staff A2 confirmed the</li> </ol>	S0176	<p>Policy to be written for cleaning service to be monitored and directed for competency of correct cleanliness as directed by Medical Director. There is a cleaning and disinfecting checklist in the housekeepers' file folder that is according to our applicable policy/procedures. This checklist also serves as a competency checklist. This is kept in her personnel file. The medical secretary is the responsible person for monitoring this. Competency checklist accomplished on September 10, 2012. A copy of the competency checklist is in personnel file.</p>	09/10/2012			

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	housekeeping file lacked the indicated documentation.			

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S0224	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(2)</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>(2) Ensure that the services performed under a contract are provided in a safe and effective manner and are included in the center's quality assessment and improvement program.</p> <p>Based on document review and interview, the governing body failed to ensure that services performed under contract were provided in a safe and effective manner and failed to ensure that the contracted services were included in the quality assessment and improvement program for 25 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance (QA) Program (no date reviewed) and Continuous Quality Improvement (CQI) Plan (no date reviewed) failed to indicate a process and format for evaluating its contracted services through the QA program.</p> <p>2. The Quality Assurance/Risk Management (QA/RM) minutes dated</p>	S0224	<p>QA minutes will be revised for evaluating all contract services. QA minutes to be completed by the secretary, then given to the Administrative Assistant for approval by the Governing Board. We have included all 25 provider contracted services in our Quality Program. Manuals will be revised annually as necessary. Environment of Care and Safety Manual to be revised with Statement of Quality Review form for each contracted service. 1. Disposal 2. Oxygen Supply. The responsible person for monitoring the manuals will be the secretary. July to August we revised the list of our contractors. August to September it was presented to the Governing Board. This was needed due to the changing of staff. S 224 Addendum: The contract manual has been updated and reviewed on 7/27/12. Disposal, endoscope</p>	07/27/2012

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	<p>May and June 2011 failed to indicate a review by the committee with recommendations for the contracted service providers prior to the governing board approval.</p> <p>3. The Governing Board minutes dated June 27, 2011 indicated the following: " The contract manual was recently reviewed, revised, and updated. At today ' s meeting, the manual was presented to the Board Members, reviewed and approved by all. "</p> <p>4. The Contract Manual contained Quality Review documentation dated July 15, 2011 for 15 contracted services (alarm monitoring and system service, biomedical engineering, computer support, generator service, heating/air conditioning, housekeeping, information technology, medical gas manifold maintenance, medical record consulting, medical supplies, medical waste disposal, pest control, pharmacy consulting, vacuum pump service, and waste disposal) indicating that the review was conducted after the Governing Board approval for the contracted services and that failed to indicate the outcome (+/--) of the review.</p> <p>5. The Contract Manual failed to identify 6 contracted services (document disposal,</p>		<p>service/repair, medical transcription, oxygen supply, propane supply, and pharmaceutical supply contractors have been added to the contracts manual. The copier service, laboratory services, medical record consulting, and pathology service contracts were reviewed on July 27, 2012. Annual review to be done by the secretary with documentation on the statement of quality review from which will document the scope of service, Description of service, Problems encountered, Action to resolve problems, Outcome of action plan, and Statement of quality. To prevent annual review deadlines, contract services added to QA monthly meeting for any problems prior to the annual review.</p>		

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	<p>endoscope service and repair, medical transcription, oxygen supply, propane supply, and pharmaceutical supply) and failed to indicate that 4 contracted services (copier service, laboratory services, medical record consulting, and pathology services) were reviewed in 2011.</p> <p>6. During an interview on 5-02-12 at 1445 hours, staff A2 confirmed that the documentation failed to establish that the contracted services were provided in a safe and effective manner and that the services were included in the QA program.</p>			

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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 9 of 32 services.</p> <p>Findings:</p> <p>1. The document Indirect Patient Care Contracts, Consultants, and Emergency Medical Coverage failed to remove three providers (CMS, City of Carmel, Emergency Coverage) and failed to include 6 providers (document disposal by V1, endoscope service and repair by V2, medical transcription by V3, oxygen supply by V4, propane supply by V5, and pharmaceutical supply by V6) identified through a document review.</p> <p>2. On 5-02-12 at 1530 hours, staff A2 confirmed that the list of contracted services had not been maintained and</p>	S0226	<p>The three providers (CMS, City of Carmel, &amp; Emer. Coverage) have been removed from the manuals and the six providers have now been included: Stericycle-disposal company, Linda Crowe-medical transcription, Beacon Meades-oxygen supply, and Eastside Petroleum Gas-propane supply are in our Contract Service Manuals and a quality review will be maintained annually. Olympus-Endoscopic Repair, Amperipath &amp; Mid-America Labs-pathology, Ikon Business Solutions-copier services and Various Pharmaceutical Reps for samples have also been added to the manual with annual quality review statements and will be maintained annually as well. The secretary will be the person responsible for making additions, maintaining the Contract Services Manual annually and she will also be the</p>	07/27/2012			

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	lacked the indicated providers.		one monitoring.S 226 Addendum:The contract manual for indirect patient care contracts has been updated and reviewed on 7/27/12. CMS, City of Carmel and Emergency coverage has been removed. Disposal company, endoscope service/repair, medical transcription, oxygen supply, propane supply, and pharmaceutical supply have been added to the contract manual and will be reviewed annually and documented in the QA minutes. Each contract will be reviewed by the secretary with the statement of quality review, scope of service, description of service, expiration, problems encountered, actions to resolve, outcome of action, and statement of quality. To prevent future annual review deadlines, contract services added to QA monthly meeting for any problems prior to the annual review.		

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S0228	<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> <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 body failed to ensure that all medical staff maintains admitting privileges at one or more hospitals in the same county as the center or in an Indiana county adjacent to the center.</p> <p>Findings:</p> <p>1. Review of MD1 's credential file failed to indicate documentation of admitting privileges at a hospital located within the same county or adjacent to the county where the surgery center is located.</p>	S0228	The St. Vincent Central Verification Organization application was submitted on January 11, 2012. The secretary will be responsible for follow up with St. Vincent Carmel for documentation verification. The secretary will be the person responsible for monitoring this. We have this as of 08/03/12. S 228 Addendum:Received authorization from St. Vincent Carmel hospital on 8/3/12 which states that privileges are approved for requested privileges, which includes admitting privileges. St Vincent Carmel Hospital is located in the	08/03/2012			

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	2. During an interview on 5-02-11 at 1500 hours, staff A2 confirmed that the credential file lacked the indicated documentation.		same county as facility. The secretary will be responsible for keeping the credential file current. The contract is for 24 months; therefore, the secretary will be responsible for seeking renewal in two years. To prevent the lack of documentation for admitting privileges, a section will be added to the QA meeting minutes to state under the title Medicare, Licensure and Staff development, and privileges for St Vincent Carmel due January of 2014.				

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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 contracted services were evaluated using specific and objective standards through its quality assurance (QA) program for 15 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance Program (no date reviewed) and Continuous Quality Improvement (CQI) Plan (no date reviewed) failed to indicate a process and format for evaluating the contracted services through the center QA program.</p> <p>2. The Contract Manual contained documentation titled Statement of Quality Review and dated July 15, 2011 for 15 contracted services (alarm monitoring and system service, biomedical engineering, computer support, generator service, heating/air conditioning, housekeeping,</p>	S0310	<p>A written program for implementation that evaluates all services has been completed and includes the following:1. Contract Name2. Contact Name &amp; Phone3. Scope of Service4. Description of Service5. Contract Expiration6. Any Problems Encountered7. Actions to Resolve8. Outcome of Action Plan9. Statement of Quality10. Contract Renewal or Nonrenewal11. Signature Lines For Board of Directors12. Date of ReviewThe person responsible for monitoring this is the secretary.All services are in the contract manual and will be included in the monthly Quality Assurance meeting.</p>	08/06/2012			

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	<p>information technology, medical gas manifold maintenance, medical record consulting, medical supplies, medical waste disposal, pest control, pharmacy consulting, vacuum pump service, and waste disposal) that failed to indicate specific and objective standards for evaluating each service recommended for contract renewal. The reports failed to indicate that each service met each standard (or not) based on the documentation provided for review. Four services (copier service, laboratory, medical records conslting, and pathology) indicated no review since 4-2010.</p> <p>3. Review of the Quality Assurance/Risk Management (QA/RM) minutes for 6-11 to 2-12 failed to indicate that the contracted services were reviewed and recommended for renewal. The QA/RM committee failed to identify and address housekeeping and laundry service concerns through the QA program and failed to document a plan of action and indicate the staff responsible for addressing the service concerns.</p> <p>4. During an interview on 5-02-12 at 1315 hours, staff A2 confirmed that the QA program failed to establish measureable and objective standards for evaluating each service and confirmed that the QA program failed to evaluate</p>						

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	and document the effectiveness of each contracted service.				

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S0320	<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, the center failed to ensure that the function of infection control was reviewed through its quality assurance (QA) program.</p> <p>Findings:</p> <p>1. The Infection Control Plan (no date reviewed) indicated the following: " Infection Control reports are included in the quarterly Medical Advisory Minutes. "</p> <p>2. The policy/procedure Quality Assurance Program (no date reviewed) and Continuous Quality Improvement (CQI) Plan (no date reviewed) failed to indicate that Infection Control functions would be reported through the QA program.</p>	S0320	<p>The Infection Control Plan has been reviewed by the QAPI program and the reports have been included in QA minutes and quarterly medical advisory minutes. An annual infection control plan will continue to be submitted each year for reviewing the infection control activities for the year. The person responsible for monitoring this will be the infection control RN. Infection Control issues will be addressed in the QA report (monthly). S 320 Addendum: Infection control plan was reviewed on July 11, 2012. The Quality Assurance Program and Continuous Quality Improvement Plan were reviewed and updated on July 11, 2012. Infection control functions will be reported through the QA program. Infection Control RN will submit any to secretary for QA meetings. With updating and</p>	07/11/2012			

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			<p>reviewing the Quality Assurance program and Continuous Quality review plan, infection control will continue to be reported through the Quality Assurance meetings. The Infection Contraol RN has a spiral tablet for communication with cleaning personnel. Tablet was put in place by infection control RN on May 3, 2012 for communication documentation which will be ongoing. Any issues will be brought to QA meeting by Infection Control RN. To prevent any future issues, policies/procedures will be reviewed and updated every 3 years or as needed by the Infection Control RN.</p>		

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S0328	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the center failed to document the action taken and evaluation of the action for deficiencies identified by the quality assurance (QA) program for 2 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance Program (no date reviewed) and Continuous Quality Improvement (CQI) Plan (no date reviewed) failed to indicate a process and format for evaluating the contracted services including laundry and housekeeping through the QA program.</p> <p>2. The document Statement of Quality Review for the Laundry Service provider V7 dated 3-08-11 indicated the following</p>	S0328	<p>Statement of Quality Review updated for laundry services by DON on 07/11/2012. Contract to be reviewed on an annual basis. Governing board will review services and with approval change to annually. QA minutes to be submitted by secretary for contract services. There was a shortage of linen and some late pick-ups, which was resolved in a meeting with the manager. The DON is the responsible person for monitoring this. Communication log for cleaning service and staff has been placed in the front office for ongoing communication. The facility's cleaning standards were not being met, therefore in May 2012 a new cleaning service was hired with the governing board's approval. After a new cleaning service was hired, the communication log was put in place. Date of issues marked</p>	08/06/2012
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	<p>under the heading Outcome of Action Plan: " Quarterly review and ongoing communication with service manager. " The (action plan) failed to identify the specific and objective standards for evaluating the service, the sampling frequency for evaluating the provider, and manner for documenting and reporting the quarterly review. No further documentation of ongoing evaluations or quarterly Statement of Quality Review was observed in the Contract Manual for the laundry service V7.</p> <p>3. Review of the Quality Assurance/Risk Management (QA/RM) minutes and the Medical Advisory minutes from 7-2011 to 2-2012 failed to indicate any reference to the periodic evaluation of the laundry service V7.</p> <p>4. During an interview on 5-02-12 at 1445 hours, staff A2 confirmed that the QA program failed to document the ongoing evaluation and committee discussion for the laundry service V7.</p> <p>5. The document Statement of Quality Review dated 4-10 for the Housekeeping Service provider V8 indicated that a new provider would begin service 5-10 and indicated the following: " Reviewed 7-15-11 by staff A5. " The entry failed to indicate the outcome (+/--) of the review.</p>		then resolution of issues dated. Log is ongoing. There is now a log that has now since been placed on 05/03/2012 by DON. The DON is the responsible person for monitoring this.				

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	<p>No additional documentation of ongoing evaluations was observed in the Contract Manual for the housekeeping service V8.</p> <p>6. The January 2012 QA/RM minutes indicated the following under Infection Control Report: " [MD1] had a meeting with housekeeping service V8 regarding the quality of cleanliness ... V8 to bring new crew to clean, starting the first week of April. " Review of older QA/RM minutes failed to indicate any sanitation concerns or committee discussion regarding the housekeeping service V8.</p> <p>7. During an interview on 5-02-12 at 1420 hours, staff A2 indicated that the housekeeping providers had provided unsatisfactory service since 2010 and indicated that daily communication logs were maintained with the providers to address cleaning and disinfecting concerns. Staff A2 was requested to provide documentation of daily logs and all additional documentation regarding the housekeeping provider performance and none was provided prior to exit.</p> <p>8. During an interview on 5-02-12 at 1445 hours, staff A2 confirmed that no additional documentation was available for the housekeeping service V8 and confirmed that the QA program failed to document the ongoing monitoring and</p>			

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	evaluation of the laundry service V7 and housekeeping provider V8 in response to concerns identified through the QA program.				

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

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

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	<p>Based on document review and interview, the center lacked a process for reporting each reportable event that was determined by the quality assurance (QA) program to have occurred at the center.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On 5-01-12 at 0920 hours, staff A2 was requested to provide documentation of the process for reporting events to the Indiana State Department of Health (ISDH) and none was provided prior to exit.</li> <li>2. The policy/procedure Sentinel Event (revised 1-05) and Quality Assurance Program (approved 10-01) lacked a provision indicating the process identified by state law 410 IAC 15-2.4-2.2(a)(2) for reporting events to the ISDH.</li> <li>3. During an interview on 5-02-12 at 1030 hours, staff A2 confirmed that the center lacked a policy/procedure for reporting events to the ISDH.</li> </ol>	S0334	<p>QA and Risk Management book was reviewed. Plan is in place for any reportable event. State form 43823 (R2/11-96) for submission to ISDH. Any reportable event that has not previously been reported within 5 days of the effective date of this rule must be reported. (ISDH; 410 IAC 15-2.4-2.2) The report shall be made to the department, be submitted no later than 15 working days after the reportable event is determined to have occurred by the center's QA &amp; improvement program, be submitted no later than 4 months after the potential reportable event is brought to the program's attention; and identify the reportable event, the quarter occurrence, and the center, but shall not include any indentifying info for any: patient, individual licensed under IC 25; or center employee involved or any other info. The responsible person for monitoring this is the DON. The first part of this to be done 08/06/12. A process for reporting a reportable event has been put into place. The process for reporting a reportable event is a post-op survey assessment and phone call that is made to the patient. This will be reviewed, revised, and updated by the QA program and changes will be made as necessary. The second part to be done by 09/06/12. The facility will use state form 43823 (R 2/11-96)</p>	09/06/2012			

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			to submit a reportable event if determined to be such an event according to policy.		

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S0422	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk. Based on personnel file review and interview, the infection control committee failed to ensure that the employee health program included accurate TB/PPD documentation for 5 of 5 (E#1, E#2, E#3, E#4, and E#5) nursing personnel.</p> <p>Findings include:</p> <p>1. During personnel file review on 5/2/12, it was found that, although PPD tests were up to date, the most recent documentation lacked both PPD administration and reading times for 5 of 5 (P#1, P#2, P#3, P#4, and P#5) nursing personnel.</p> <p>2. During interview with A#2, Infection Control coordinator, he/she stated that only the dates of the TB/PPD skin test were documented, but not the times they were administered or read. A#2 stated that times had previously been documented, but the most current ones were not.</p>	S0422	<p>RN----Personnel files for PPD testing updated. RN personnel files have the form which states date/time given and date/time read. P#1, P#2, P#3, and P#4 are no longer at this facility. There are new nurses at our facility. The DON is the responsible person who will make sure that the TB/PPD are up to date. The secretary will monitor all personnel files to make sure that they are kept up to date and when the nurses need new TB/PPD she will alert the DON.</p>	08/06/2012			

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S0428	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</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>(i) Sanitation.</p> <p>Based on document review and interview, the infection control committee failed to review and recommend changes in sanitation policies and procedures or otherwise ensure that the contracted housekeeping services were provided according to the infection control policy/procedures of the center.</p> <p>Findings:</p> <p>1. During an interview on 5-02-12 at 1450 hours, staff A2 indicated that the current housekeeping provider began providing services in May 2010 and that selection criteria included the available documentation of training content and policy/procedures developed for use by cleaning personnel employed by the service. Staff A2 was requested to provide documentation of housekeeper orientation to center infection control</p>	S0428	<p>Contract manual under title of cleaning service statement Quality Review states the complete description of services are kept on file in the Jani-King Binder. The binder will remain in a central location for all staff. A new housekeeping staff has been hired to begin service on May 3, 2010. It has been reviewed with our Infection Control Committee that they meet our infection control policy &amp; procedures, and it has been put in front of the Governing Board and approved that they meet our infection control standards. Therefore they have been approved by the Governing Board to clean for us. They have documentation proving they have met the requirements of OSHA/universal precautions/product safety. Cleaning products used will meet acceptable standards by indicating effectiveness as germicidal/verucidal. This is per</p>	08/06/2012			

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	<p>policy/procedures or provide documentation of infection control committee review and center approval for use of the provider policy/procedures for cleaning and disinfecting by the contracted housekeeping staff and none was provided prior to exit.</p> <p>2. Review of the Quality Assurance/Risk Management meeting minutes for April, May, and July 2010 under the heading of Infection Control Report failed to indicate committee discussion and approval for incorporating the contracted service infection control policy/procedures for cleaning and disinfecting at the center.</p> <p>3. During an interview on 5-02-12 at 1520 hours, staff A2 confirmed that the center failed to document its review and approval of the contracted service policy/procedures for cleaning and disinfecting by the contracted housekeeping service.</p>		<p>our meeting notes dated April 13, 2010. The person responsible for monitoring the manual &amp; keeping this manual up to date is the secretary. The Governing Board will discuss and approve any additional meeting minutes that may need to be approved regarding the cleaning service. This will be monitored by the Infection Control RN.</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/procedure review, personnel file review, and interview, the infection control committee failed to ensure that the employee health program monitored the immunity status regarding rubella, rubeola, and varicella for 2 of 5 (E#3 and E#4) nursing personnel.</p> <p>Findings included: 1. During policy/procedure review on 5/1/12, it was found that the ASC's "Infection Control Policy for Employee Occupational Health states, under G. Pre-placement health assessment, c. "Rubella immunity is mandatory for all medical employees and must be documented by laboratory evidence of immunity or documented receipt of two doses with live virus vaccine on or after their first birthday..." and d. "Measles immunity</p>	S0442	<p>Personnel files will be updated. If new RN's do not have documentation of evidence of immunity to rubella, rubeola, and varicella, labs will be drawn for verification and placed in files. The Secretary is responsible for reviewing &amp; monitoring the files &amp; the DON is responsible for drawing the labs.S 0442 Addendum:Current medical employee personnel files updated with proper immunization records for Rubella, Rubeola, and Varicella. This documentation was completed by August 6, 2012. On August 31, 2012, Infection Control Policy was reviewed and updated which states: Prior to employment, if immunity for Rubella, Rubeola, and Varicella can not be</p>	08/06/2012			

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	<p>(rubeola) is mandatory for all medical employees and must be documented by physician-diagnosed measles, laboratory evidence of immunity, or documentation of receipt of two doses of live measles vaccine both administered on or after the first birthday", and e. "If there is not a clear history of a clinical case of chickenpox (varicella), then an IgG varicella antibody may be drawn..."</p> <p>2. During personnel file review on 5/1/12, it was found that E#3 (a pre- and post- op and OR nurse) and E#4 (a pre- and post-op nurse) had no laboratory evidence of immunity regarding rubella and rubeola.</p> <p>3. During interview with A#2 (the Infection Control committee chairman) on 5/2/12, he/she confirmed that E#3 and E#4 had no laboratory evidence of immunity to rubella, rubeola, and varicella.</p>		<p>documented, then medical employee will be responsible for obtaining the documentation and/or obtaining immunization from his/her primary care physician, health department, and/or from previous employer. This policy was verbally approved on August 31, 2012 per Medical Director and will be presented at the next quarterly governing meeting for approval, which will take place in September. With new policy in effect, current and new medical staff will have proper documentation for immunity status regarding Rubella, Rubeola, and Varicella. Infection Control RN, Director of Nursing, and Administrative Assistant will be responsible for medical employees' personnel files.</p>		

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S0624	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(7)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(7) The center shall ensure the confidentiality of patient records. The center must develop, implement, and maintain the following:</p> <p>(A) A procedure for releasing information or copies of records only to authorized individuals, in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.</p> <p>Based on observation and interview, the facility failed to ensure that medical records (MR) were not accessible to unauthorized individuals.</p> <p>Findings:</p> <p>1. During a facility tour on 5-01-12 at 1615 hours, MR files in large, open cabinets without locks were observed in several unsecured offices in the administrative area of the center.</p> <p>2. During an interview on 5-01-12 at 1615 hours, staff A2 indicated that the</p>	S0624	<p>Policy to be reviewed and revised for cleaning personnel to have authorization for access to MR areas for cleaning. Cleaning staff are required to read and sign HIPAA rules and regulations to protect patient confidentiality. This HIPAA document to be part of the housekeeping file and kept in the administrative secretary's office. They will also have a name badge that they will wear. The responsible person for monitoring this is the secretary. If there is a change in cleaning personnel the secretary will need to get a new HIPAA signed.</p>	08/06/2012

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	<p>contracted housekeeping staff provided cleaning services in the evening when facility staff was not present. Staff A2 indicated that the housekeepers were not authorized access to MR per center policy.</p> <p>3. During an interview on 5-02-12 at 1520 hours, staff A2 confirmed that the center failed to safeguard its MR from access by unauthorized personnel.</p>			

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S0710	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p>						

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	<p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on document review and interview, the center failed to follow it's policy/procedure and ensure that the medical staff credential files included documentation of current hospital appointment and privileges for 1 credentialed staff at the center.</p> <p>Findings:</p> <p>1. The medical staff policy procedure Medical Staff Application (reviewed 8-11) indicated the following: "Obtain confirmation of hospital medical staff</p>	S0710	MD credentials file to be reviewed and documentation obtained from St. Vincent's Carmel. The person responsible for monitoring this is the secretary. We have this as of 08/03/12.	08/06/2012			

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	<p>affiliation and related privileges from hospitals indicated in the application."</p> <p>2. Review of MD1's credential file failed to indicate documentation of privileges to perform surgical procedures at a hospital located within the same county or adjacent to the county where the Surgery Center is located.</p> <p>3. During an interview on 5-02-11 at 1500 hours, staff A2 confirmed that center failed to follow it's policy and confirmed that the credential file lacked documentation of current hospital privileges.</p>				

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S0772	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(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.</p> <p>(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.</p> <p>Based on policy/procedure review, medical record review, and interview, the medical staff failed to follow its policy regarding authentication of medical record entries for 21 of 21 (P#1, P#2, P#3, P#4, P#5, P#6, P#7, P#8, P#9, P#10, P#11, P#12, P#13, P#14, P#15, P#16, P#17, P#18, P#19, P#20, P#21) medical records reviewed.</p>	S0772	All H & P's to be dated & timed at bottom of medical record by MD signature. Once a week the DON will do a spot check on the charts for the week to make sure they are being signed correctly. The DON is the responsible person who is going to monitor this.	08/06/2012			

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	<p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During review of facility policy on 5/2/12, ASC policy "Policy and Procedure for Identification of Authors and Authentication of Medical Record Entries", states "An entry in the medical record is defined as legible documentation by a physician...who record the patient's history, assessments, progress...These entries are authenticated and dated by the author."</li> <li>2. During medical record review on 5/1/12 and 5/2/12, it was found that all H&amp;Ps were signed by the physician, but were not dated or timed.</li> <li>3. During interview with the Director of Nursing (A#2) on 5/2/12, he/she stated that the printed label from the patient procedure had the date on it and indicated when the H&amp;P was done. He/she did agree that there was no time on the H&amp;Ps.</li> </ol>						

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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 lacked a uniform policy/procedure for authenticating verbal orders in the medical record (MR) and lacked a provision ensuring authentication was performed in compliance with center policy.</p> <p>Findings:</p> <p>1. The policy/procedure Incomplete Medical Record Review (approved 4-10) indicated the following: "Verbal or telephone orders must be signed by the physician within 48 hours, as well as by the nurse taking the order." The policy/procedure lacked a provision to date and time the entry by the nurse receiving the order and by the physician</p>	S0780	<p>Policy is in place for verbal orders in standard of care manual, Section 5. Policy reviewed, by DON. Medical records manual was revised to state within 24 hrs to correspond within standard of care manual. All policies are congruent to indicate 24 hrs to correspond with standard of care manual. There will be a policy added that the RN needs to date/time all verbal/phone orders w/in 24 hrs as well. The responsible person for monitoring this is the DON. The person responsible for making sure all manuals are updated is the secretary.</p>	08/06/2012			

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	<p>authenticating the order to validate compliance with the policy/procedure.</p> <p>2. The policy/procedure titled Policy and Procedure for Identification of Authors and Authentication of Medical Record Entries (reviewed 1-08) indicated the following: "Each verbal order is also dated and authenticated within 30 days by the person who gave it."</p> <p>3. The policy/procedure Administration of Medications (reviewed 1-08) indicated the following: "Verbal orders must be signed by the attending physician within 24 hours. An RN or LPN may take a verbal order." The policy/procedure lacked a provision to date and time the entry by the nurse receiving the order and by the physician authenticating the order to validate compliance with the policy/procedure.</p> <p>4. During an interview on 5-02-12 at 0920 hours, staff A2 confirmed that the policy/procedures were not uniform and lacked the indicated provisions.</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 document review and interview, the center failed to maintain its policy/procedures regarding pharmacy multi-dose vials in accordance with acceptable standards of practice at the facility.</p> <p>Findings:</p> <p>1. The United States Pharmacopeia (USP) General Chapter 797 [16] indicated the following for multi-dose vials of sterile pharmaceuticals: " If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. "</p> <p>2. The policy/procedure Administration of Medications (approved 1-08) indicated</p>	S1010	<p>All medications opened in facility are marked to expire in 28 days. Policy to be reviewed and revised to state 28 days. The responsible person for changing the policy in all the manuals is the secretary. The DON will do spot checks once a week to make sure we are in compliance with this.</p>	08/06/2012			

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	<p>the following: " Each opened multi-dose vial shall be marked with an expiration date which shall be thirty (30) days from the date on which the vial was opened. "</p> <p>The policy/procedure failed to indicate the disposal date of 28 days per the USP Pharmacopeia standards.</p> <p>3. The policy/procedure Expiration Times / Dates (reviewed 4-04) failed to ensure that a handwritten policy change in open multi-dose vial usage from 30 days to 28 days was a valid revision and failed to indicate a periodic review and approval per policy requirements.</p> <p>4. During an interview on 5-02-12 at 0910 hours, staff A2 confirmed that the policy/procedures for multi-dose vials failed to ensure disposal in 28 days or less.</p>				

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S1040	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAc 15-2.5-6(3)(F)</p> <p>Pharmaceutical service must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(F) Instructions to the patient on the use of take home medication is the responsibility of the prescribing practitioner.</p> <p>Based upon document review and interview, the center policy/procedures failed to indicate the physician responsibility of instructing the patient on the use of take home medication when dispensed.</p> <p>Findings:</p> <p>1. The policy/procedure Sample Drug Administration (reviewed 1-08) failed to indicate the physician responsibility of instructing the patient on the use of take home medication.</p> <p>2. During an interview on 5-02-12 at 0910 hours, staff A2 confirmed that the center policy/procedure regarding drug samples lacked the indicated provision.</p>	S1040	Policy revised to state physician verbally instructs patient or responsibly party on the use of take home medicine. The discharge RN is the responsible person for monitoring this. The secretary is responsible person for reviewing and updating the policy.	08/06/2012			

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S1146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation and interview, the center failed to ensure the immediate availability of eye wash station equipment if needed and failed to safely secure and maintain 2 Compressed Propane Cylinders which resulted in a hazard to patients, employees, and the public.</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</p>	S1146	<p>Eye wash station to be replaced on 07/07/2012. MD notified/scheduled. This is now immediately available. It is accessible &amp; effective for use &amp; flushing. It has been replaced. The staff RN is the person responsible for monitoring &amp; weekly water pressure checks. Eastside Gas Company notified for securing propane tanks. MD contaced company and will schedule. These are secured and have been put on our weekly scheudule for rounding checks. The secretary is person responsible for monitoring this on her weekly round checks.</p>	08/06/2012			

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	<p>within the work area for immediate emergency use. "</p> <p>2. During a tour on 5-01-12 at 1605 hours, the following condition was observed: a sink-mounted eyewash spray with heavy mineral scale accumulation present on the connections. When activated, the flow diverter required great effort to operate due to the mineral deposits and the flow was minimal from the spray heads at best. It was observed that the spray heads were directed away from the user and the gooseneck interfered with access in the event that the eyewash station was needed.</p> <p>3. During an interview on 5-01-12 at 1605 hours, staff A2 confirmed that the eyewash station was not accessible and not effective in the event of an emergency.</p> <p>4. Review of the Occupational Safety and Health Administration (OSHA) general requirements for compressed gasses in 29 Code of Federal Regulations (CFR) 1910.101 indicated the following: Per 29 CFR 1910.101(b), the in-plant handling, storage and utilization of all compressed gas cylinders must be in accordance with Compressed Gas Association (CGA) Pamphlet P-1 Safe Handling of Compressed Gas Cylinders. Gas</p>						

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	<p>cylinders should be properly secured at all times to prevent tipping, falling, or rolling. They can be secured with straps or chains connected to a wall bracket or other fixed surface, or by use of a cylinder stand.</p> <p>5. During a tour on 5-01-12 at 1615 hours, the following hazardous condition was observed in an open area by the emergency generator: 2 (100 pound capacity) upright propane cylinders unsecured by chains or straps for supplying the emergency generator.</p> <p>6. During an interview on 5-01-12 at 1615 hours, staff A2 confirmed that the 100 lb. propane cylinders were unsecured.</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 operational and maintenance records for the mechanical and physical plant equipment at the facility.</p> <p>Findings:</p> <p>1. On 5-01-12 at 0920 hours, staff A2 was requested to provide documentation indicating a triennial analysis of operational and maintenance control records for heating, ventilation, air conditioning, fire alarm and/or smoke</p>	S1154	Air conditioning and fire alarm systems logs are located in the environmental care and safety manual. Maintenance schedules and equipment analysis records are in the manual and are maintained in accordance to policy. Every 3 years we will do an analysis of the mechanical systems & equipment records. Documentation is completed on an annual basis, not triannually. The person responsible for monitoring this is the secretary. Equipment analysis conducted on April 2, 2012, as per policy.	08/06/2012			

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	<p>detector system was performed and none was provided prior to exit.</p> <p>2. Review of the maintenance schedules and equipment maintenance records failed to indicate that the center records were analyzed at least triennially.</p> <p>3. During an interview on 5-01-12 at 1510 hours, staff A2 confirmed that the center lacked documentation of a triennial analysis of the mechanical systems and equipment records.</p>				

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S1182	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based on document review and interview, the center failed to establish an ongoing, center-wide process for assessing and evaluating hazards and safety practices by a committee.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Safety committee minutes for 2011 and 2012 failed to indicate the following: <ol style="list-style-type: none"> <li>A. the date and time of each meeting</li> <li>B. staff that attended the meeting</li> <li>C. staff that did not attend the meeting</li> <li>D. discussion of the subject areas reviewed</li> <li>E. recommendations for the reported subject areas</li> <li>F. committee actions to correct and improve center safety</li> <li>G. follow-up reporting for committee actions</li> <li>H. periodic review of center safety policy/procedures</li> <li>I. disaster drills as indicated on the Administrative Calendar</li> <li>J. review of periodic safety hazard assessments</li> </ol> </li> <li>2. The Safety Minutes Jan-March 2012 indicated that a tornado warning was issued on 3-02-12. The minutes failed to indicate that the facility response was an actual event and not a drill as reported.</li> <li>3. The Medical Advisory Minutes March 2012 indicated the following: "Safety Policies and Procedures: See safety minutes 1st quarter for further information." The Safety Minutes Jan-March 2012 failed to validate that any review or discussion of safety</li> </ol>	S1182	<p>Safety minutes and procedures will be revised to include the following:1. Date &amp; time 2. Staff 3. Subject4. Recommendations for the reported subjects5. Committee actions to correct &amp; improve center safety6. Follow-up for committee actions7. Periodic review of center policy/procedures8. Disaster drills9. Review of periodic safety.Minutes will also include any disaster warnings etc. All policies/procedures will be updated and reviewed. Staff to be included in minutes are as follows: MD/administrator, Administrative Assistant, Secretary, DON, &amp; staff RN's. The person responsible for monitoring this is the secretary. The secretary will keep a calendar of when meetings are suppose to occur and this is how it will be monitored. Appointed to serve on the committee are: The Chairman, Medical Director, &amp; all DHC Staff.</p>	08/06/2012			

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	<p>policies and procedures had been performed by the committee.</p> <p>4. During an interview on 5-02-12 at 1430 hours, staff A2 confirmed that the safety minutes failed to indicate a functioning program that evaluates safety issues and practices at the center and confirmed that the minutes lacked the indicated concerns.</p>			

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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 and ensure that staff receives consistent information on facility evacuation in the event of an emergency.</p> <p>Findings:</p> <p>1. The policy/procedure Fire Emergency Action Plan (no review date) indicated the following: "Following an emergency evacuation, all employees must report to this location: The back of the building and the northside of the building. "</p> <p>2. During an interview on 5-02-12 at 1430 hours, staff A2 confirmed that the fire evacuation assembly location was the</p>	S1188	All policy and procedure manuals will be updated to indicate that we are to evacuate to the northeast corner of the building's parking lot. All staff have been verbally told of this change. Fire drills are in the process of being scheduled. The responsible person for monitoring this is the secretary. Fire drill conducted on September 7, 2012 and will continue to have quarterly fire drills.	08/06/2012			

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	<p>northeast corner of the parking area at the facility and confirmed that the policy/procedure failed to indicate the current assembly location for evacuating patients, visitors, and employees at the center.</p> <p>3. The Emergency Action Guide Bomb Threat (no review date) indicated the following: In the event of a bomb threat, all employees will proceed to the emergency Muster Area: Front Main Parking Lot. "</p> <p>4. During an interview on 5-02-12 at 1431 hours, staff A2 confirmed that the fire control plan had not been maintained and confirmed that the center policy/procedures lacked a consistent location for staff, patients, and visitors to assemble and ensure the building was clear in the event of an emergency.</p>				

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S1198	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based upon document review and interview, the center failed to follow its policy/procedure and failed to coordinate its emergency preparedness program and document the center participation with community, state and/or federal emergency and disaster preparedness agencies.</p> <p>Findings:</p> <p>1. On 5-01-12 at 0920 hours, staff A2 was requested to provide documentation of disaster drills and documentation of participation with community, state and/or federal emergency and disaster preparedness agencies and no documentation was provided prior to exit.</p> <p>2. Safety Minutes for 4th Quarter 2010 and 1st, 2nd, 3rd, 4th Quarter 2011 failed to indicate that the center conducted a Tornado, Earthquake, Bomb Threat, or</p>	S1198	<p>Will conduct safety drills triannually and provide minutes of these drills in the safety manuals. A Disaster Preparedness Plan will be reviewed and updated to include coordination of emergency disaster and preparedness with an appropriate local, state, or federal agency. Our safety director is the responsible person that will complete the above deficiency. The Safety Drill which is the first part will be done by 08/06/12. The Disaster Preparedness Plan which is the second part will be done by 09/06/12.</p>	09/06/2012	

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	<p>Civil Disturbance Drill. The Safety Minutes 1st Quarter 2012 indicated that a tornado warning was issued and indicated a facility response. Staff A2 was requested to provide documentation of the event and review of the center response and no documentation was provided prior to exit.</p> <p>3. During an interview on 5-02-12 at 1515 hours, staff A2 confirmed that no documentation was available regarding participation with District 5 disaster management events or district meeting attendance, recent center disaster drills or the facility response to a tornado warning event.</p>				