

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001159	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2013
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NAME OF PROVIDER OR SUPPLIER CENTER FOR ADVANCED LAPAROSCOPIC & BARIATRIC SUR	STREET ADDRESS, CITY, STATE, ZIP CODE 506 W 2ND ST BLOOMINGTON, IN 47403
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 011384</p> <p>Survey Date: 7/29/2013 thru 7/30/13</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 08/02/13</p>	S000000		
S000182	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (O)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(O) Annual implementation of internal and external disaster preparedness plans with documentation of outcome.</p>			

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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S000230	<p>Based on documentation review and staff interview, the facility failed to participate in disaster drills per surgery center's policies.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Disaster Preparedness Plan (Last approved 1/7/2013) states, "Disaster Drills will be held twice each year." At 11:00 AM on 7/30/2013, staff member #1 confirmed the surgery center has not participated in a disaster drill. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</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>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on documentation review</p>	S000182	<p>Disaster Preparedness Drills will be practiced 2 times per year. The implementation of our new disaster preparedness drill form will keep this deficiency from reoccurring. Phyllis Haworth, Administrator or Ed Glenn, RN, Nurse Manager, will be responsible for organizing the biannual disaster drill. See attachment</p>	08/29/2013			
		S000230	In order to have three	08/29/2013			

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	<p>and staff interview, the facility failed to provide for a periodic review of the center and its operation by three or more licensed physicians with no financial interest in the facility.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The surgery center's Utilization's Review Program (last approved 1/7/2013) notes the patient charts will be reviewed by three physicians with no financial interest in the ambulatory surgery center. The committee will meet quarterly and discuss the review of the patient charts. 2. The Utilization Review minutes were reviewed for 2012 and 2013. The minutes and data provided by the physician reviewer identified that only 2 of 3 appointed Utilization Physician Reviewers were reviewing the surgery center's physician charts. These minutes revealed that the third physician did not attend the 		<p>active Utilization Review Physicians, physician staff member #8 will be replaced by a more accessible physician, willing to participate in reviewing the surgery center's charts. The Medical Staff will recommend and approve the new Utilization Committee member at their next scheduled meeting. Physician staff member #8 is a credentialed anesthesiologist at our facility, but rarely provides services here. By adding a credentialed anesthesiologist that provides regular service to our facility it will facilitate the ease of a chart review and will prevent this deficiency from reoccurring. Phyllis Haworth, Administrator, will make requests to the regular anesthesiologists.</p>		

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S000300	<p>Utilization Review Committee or review any surgery center physician charts.</p> <p>3. At 12:15 PM on 7/30/2013, staff member #1 indicated Utilization Review Physician staff members #6 and #7 routinely review the physician charts quarterly. However, physician staff member #8 has not reviewed the surgery center's physician charts. The staff member confirmed that there were only 2 physicians that were performing Utilization Review of the surgery center.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p>						

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	<p>Based on documentation review and staff interview, the facility failed to have Quality Assurance and Performance Improvement committee meetings to ensure an effective Quality Management/Improvement Program.</p> <p>Findings included:</p> <p>1. Quality Management/Improvement Program policy (Last approved 1/7/2013) indicates all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. The Quality Assurance Committee shall coordinate all activities designed to promote and attain the objectives of the Quality Assurance Plan. The Quality Committee serves as the focal point for integration of the quality activities conducted in the Center. It shall receive sufficient information from all sectors</p>	S000300	The QAPI Committee will have a meeting by 8/29/13 and quarterly thereafter. In order to prevent this deficiency from happening in the future, the QAPI Committee will meet on the same days the Medical Staff and Governing Body meetings occur. Phyllis Haworth, Administrator will oversee the scheduling of these meetings.	08/29/2013			

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	<p>related to patient care and its evaluation to permit intelligent deliberation and to achieve the objectives of the Quality Assurance Plan.</p> <p>2. The Medical Staff Bylaws Article XI section 11.2A (Last approved 1/7/2013) states, "The QAPI Committee shall be a standing committee meeting quarterly or at the call of the Chairman."</p> <p>3. The QAPI Committee minutes were reviewed. The last set of minutes provided was from December 2011. In 2011, the QAPI Committee met 4 times. Since December 2011, the QAPI committee has not met. Therefore, the QAPI Committee did not serve as the focal point for integration of the quality activities conducted in the Center.</p> <p>4. At 1:30 PM on 7/29/2013, staff member #1 indicated the surgery center has not had a QAPI</p>				

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S000310	<p>Committee meeting since 2011.</p> <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.</p> <p>Based on document review and staff interview, the facility failed to ensure 11 services provided by contractors and internal service were included as part of its comprehensive quality assessment and improvement (QA&I) program: Biohazard Waste, Biomedical, Blood Transferred, Housekeeping, Laboratory, Laundry/Linen, Maintenance,</p>	S000310	<p>A Contracted Services Quality Check form was drafted on 8-1-13 and completed on 8-8-13. This form includes specific quality check points for 13 contracted services for this facility. This form will be ongoing and completed and presented quarterly at scheduled QAPI Committee meetings. This form was drafted by Phyllis Haworth, Administrator, and Ed Glenn, Nurse Manager. See attachment.</p>	08/08/2013			

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	<p>Nursing, Pharmacy, Radiology, Security, and Pest Control.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Quality Management/Improvement Program policy (Last approved 1/7/2013) indicates all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. 2. The Center for Advance Laparoscopic and Bariatric Surgery, LLC Quality Assurance Committee quarterly reports were reviewed for 2012. The following eleven contracted services were not evaluated by the surgery center: Biohazard Waste, Biomedical, Blood Transferred, Housekeeping, Laboratory, Laundry/Linen, Maintenance, Pharmacy, Radiology, Security, and Pest Control. Nursing services were not being evaluated by the surgery center. 			

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	<p>3. At 1:21 PM on 7/29/2013, staff member #1 indicated the he/she was providing the data to the Governing Board. The Governing Board selected, at the beginning of each year, the items the facility wants to monitor and evaluate only. In 2012, surgical skin preps and timeout stats were evaluated. In 2013, the medical record consultant and incident reports are being monitored and evaluated only. The staff member indicated he/she thought only selected services are to be monitored ongoing and not all services that are provided.</p>			
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S000320	<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 staff interview, the facility failed to ensure discharges and transfers were made part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Quality Management/Improvement Program policy (Last approved 1/7/2013) indicates all service with direct or indirect impact on patient care quality shall be reviewed under the quality</p>	S000320	All information pertaining to:A) Discharge and transfer.B) Infection control.C) Medication errors.D) Response to patient emergencies.will be disclosed at scheduled, quarterly QAPI Committee Meetings. The next meeting is scheduled for 8/29/13. This information was being reported in Medical Staff Committee meetings, but will now be included in QAPI Committee Meetings. Phyllis Haworth, Administrator, will present this information.	08/29/2013

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S000422	<p>improvement program.</p> <p>2. The Quality Assessment and Performance Improvement data did not evidence discharge and transfers were being monitored and evaluated for 2012 and 2013.</p> <p>3. At 1:30 PM on 7/29/2013, staff member #1 confirmed discharges and transfers are not being monitored by the surgery center.</p> <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 review of product information, employee files review, policy review, and interview, the facility failed to ensure TB testing was performed per policy, manufacturer's recommendations and CDC guidelines for 5 of 12 staff member files reviewed (#N3, N9, N10, N11, and N12).</p>	S000422	<p>1. It has always been the policy and practice at the Center to follow manufacturer's guidelines to read TB test within the post 48 to 72 hour time frame. Our documentation forms have been updated to now reflect the time that results are read. 2. RN noted was contacted and required to submitted a current TB test result before scheduling herself in the</p>	08/23/2013			

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	<p>Findings included:</p> <ol style="list-style-type: none"> 1. The manufacturer's product information for Tubersol, the solution used for TB testing, indicated the tests should be placed and read within 48 to 72 hours for accuracy. 2. The health file for staff member #N3, a prn (as needed) RN (registered nurse) with a hire date of 01/14/10, lacked documentation of any TB testing. 3. The health file for staff member #N9, a nurse tech with a hire date of 09/25/12, indicated a TB test placed on 09/04/12, but with no time noted, and lacked documentation of the date or time read. 4. The health file for staff member #N10, a certified surgical tech with a hire date of 02/07/11, indicated a TB test placed on 03/06/13 and read on 03/08/13, but no times were documented to ensure the test was read between 48 and 72 hours. 5. The health file for staff member #N11, a nurse tech with a hire date of 01/16/08, indicated a TB test placed on 03/06/13 and read on 03/08/13, but no times were documented to ensure the test was read between 48 and 72 hours. 		<p>future. 3-6 These employees are to be retested for TB this week and documented on updated forms. Phyllis Haworth, Administrator and Lorrie Burkhart, CST will be responsible for these credentials.</p>				

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	<p>6. The health file for staff member #N12, a certified surgical tech and administrator with a hire date of 01/15/08, indicated a TB test placed on 02/04/13 and read on 02/06/13, but no times were documented to ensure the test was read between 48 and 72 hours.</p> <p>7. The facility policy "Infection Control for Employee Health", last reviewed 01/07/13, indicated, "b. TST (Tuberculin Skin Testing)- i. TST/evaluation is mandatory for all employees yearly." The policy also indicated the facility followed CDC guidelines which specified tests to be read between 48 and 72 hours.</p> <p>8. At 2:20 PM on 07/30/13, staff members #A1 and A3 confirmed the findings and indicated they were aware of the requirements for timing the tests.</p>						

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S000432	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, policy and procedure review, manufacturer's directions, and interview, the infection control committee failed to ensure the patient care areas were cleaned according to policy to prevent cross-contamination between patients and failed to ensure the appropriate rinsing procedures for high level disinfection were followed in the soiled room.</p> <p>Findings included:</p> <p>1. During the tour of the surgical area at 2:35 PM on 07/29/13, accompanied by staff members #A1, A2, and A4, a plastic container of Cidex OPA for high level disinfection was observed in the soiled room. The housekeeping closet was observed to contain PD-64</p>	S000432	To insure manufacturer's directions are followed for cleaning product, PD-64, an email will be composed and sent to the housekeeper regarding the proper length of kill time for disinfection to occur. This email will also include the observations of the surveyor's regarding dust on suction canisters and widow ledges. To prevent this deficiency from happening in the future, they have been added to the quality check points in the quarterly QAPI report on contracted services. Phyllis Haworth, Administrator, will send the email. According to our facility's policy, manufacturer's directions will be followed regarding the use of High Level Disinfection (CIDEX). It was observed our facility was not using the proper amount of water and the proper amount of separate rinses as recommended	08/29/2013			

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	<p>disinfecting cleaner, Vesphene disinfecting cleaner, and a gallon container of Clorox. Label directions of the PD-64 indicated 2 ounces of the chemical should be mixed with each gallon of water and used on floors and surfaces with a 10 minute kill time.</p> <p>2. At 2:35 PM on 07/29/13, staff member #A2 indicated blades were soaked in the disinfectant, rinsed once in a basin of tap water, and immediately dried. He/she did not describe any specific three separate rinsing procedures when questioned.</p> <p>3. During the tour of the patient bays in the pre-op area at 3:10 PM on 07/29/13, accompanied by staff members #A1 and A4, the ledges and suction canisters were observed with a layer of dust.</p> <p>4. The facility policy "High Level Disinfection", last reviewed 01/07/13, indicated, "A. A high level disinfectant/sterilant (HLD) approved by the Food and Drug Administration (FDA) will be used according to manufacturer's directions. ...G. After high level disinfection, instruments should be rinsed and lumens flushed with sterile water to remove HLD solution (rinse with sterile water as many times as manufacturer's guidelines</p>		<p>by the manufacturer. To keep this from happening again, our facility will post the manufacturer's directions for rinsing in the dirty utility room and this will be discussed at the next monthly nursing staff meeting. Phyllis Haworth, Administrator, will be responsible for this posting. See attachment.</p>	

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	<p>recommend, discard rinse water after each use)."</p> <p>5. The manufacturer's directions for Cidex OPA indicated, "B. Rinsing Procedure: Following removal from Cidex OPA Solution, thoroughly rinse the medical device by immersing it completely in a large volume (e.g. 2 gallons) of water. Use sterile water unless potable water is acceptable. Keep the device totally immersed for a minimum of 1 minute in duration, unless a longer time is specified by the reusable device manufacturer. Manually flush all lumens with large volumes (not less than 100 milliliters) of rinse water unless otherwise noted by the device manufacturer. Remove the device and discard the rinse water. Always use fresh volumes of water for each rinse. Do not reuse the water for rinsing or any other purpose. Repeat the procedure TWO (2) additional times, for a total of THREE (3) RINSES, with large volumes of fresh water to remove Cidex OPA Solution residues. Residues may cause serious side effects. SEE WARNINGS. THREE (3) SEPARATE, LARGE VOLUME WATER IMMERSION RINSES ARE REQUIRED."</p> <p>6. The facility policy "Support Services-</p>						

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	<p>Housekeeping", last reviewed 01/07/13, indicated, "2. Patient Cubicles: Clean and free of marks, kick plate clean and shiny, top of items free of dust and lint. ...4. Dust all surfaces."</p> <p>7. At 11:00 AM on 07/30/13, the contracted cleaning services staff member #A5, was interviewed. He/she indicated all floors and surfaces were cleaned with the chemical PD-64 which he/she mixed using 2 ounces per gallon of water and surfaces were to remain wet for 3 to 4 minutes for effective disinfection.</p> <p>8. At 11:30 AM on 07/30/13, staff member #A1 confirmed the facility policies did not specifically address the 3 separate rinses after soaking in Cidex OPA as specified by the manufacturer. He/she also indicated the dusty areas observed and the inaccurate chemical information given by the contracted cleaner were not according to facility standards or expectations.</p>			

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S000442	<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 employee medical file review and interview, the facility failed to ensure all of their employees had reliable documentation of immunization status in 6 of 12 employee medical files reviewed (N1, N3, N4, N6, N7, and N9).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The medical file for prn (as needed) staff member #N1, an RN (registered nurse) with a hire date of 03/31/08, lacked documentation of immunization to Varicella, Rubeola, or Rubella. The medical file for prn staff member #N3, an RN with a hire date of 01/14/10, 	S000442	The noted employees were contacted and are required to submit updated vaccination records that include missing vaccine information before their next scheduled work day. Lorrie Burkhart, CST was responsible for contacting the employees with missing credentials.	08/30/2013			

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	<p>lacked documentation of immunization to Varicella, Rubeola, or Rubella. The file also lacked any documentation or declination regarding Hepatitis immunity.</p> <p>3. The medical file for staff member #N4, an RN with a hire date of 08/26/11, lacked documentation of immunization to Varicella, Rubeola, or Rubella. The file also lacked any documentation or declination regarding Hepatitis immunity.</p> <p>4. The medical file for staff member #N6, an RN with a hire date of 04/22/10, lacked documentation of immunization to Varicella.</p> <p>5. The medical file for staff member #N7, an RN with a hire date of 09/23/10, lacked documentation of immunization to Varicella, Rubeola, or Rubella. The file also lacked any documentation or declination regarding Hepatitis immunity.</p> <p>6. The medical file for staff member #N9, a nurse tech with a hire date of 09/25/12, lacked documentation of immunization to Varicella, Rubeola, or Rubella. The file also lacked any documentation or declination regarding Hepatitis immunity.</p>			

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S000526	<p>7. At 2:20 PM on 07/30/13, staff members #A1 and A3 confirmed the findings and indicated they were aware of the immunization requirements.</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed. Based on review of employee files and interview, the facility failed to ensure 8 of 8 nurses (# N1- N8), who performed out-of-lab testing on patients of the center, had annual competency for the testing.</p> <p>Findings included:</p> <p>1. The employee files for staff members #N1, hire date 03/31/08, N2, hire date 01/18/08, N3, hire date 01/14/10, N4, hire date 08/26/11, N5, hire date 01/16/08, N6, hire date 04/22/10, N7, hire date 09/23/10, and N8, hire date 09/10/09, lacked documentation of annual glucometer and Hemo-cue competency.</p>	S000526	<p>Annual competencies will be given for all nursing staff regarding the use of Hemo-cue and glucometer. Ed Glenn, RN, Nurse Manager, will be in charge of documentation of annual competencies. These competencies will occur by 8/29/13 this year and will be administered every year after the educational DVD to prevent this deficiency from happening in the future.</p>	08/29/2013

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S000676	<p>2. At 3:10 PM on 07/29/13, staff member #A4 indicated all of the nurses performed the testing with the glucometer and Hemo-cue devices and were trained upon hire, but he/she was not aware of any annual competency.</p> <p>3. At 2:20 PM on 07/30/13, staff members #A1 and A3 confirmed the nurses performed the patient testing with the glucometer and Hemo-cue devices. They indicated the procedures were reviewed annually with an educational DVD, but actual competencies were not performed.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or legally reproduced medical records must be maintained by the center for a period of seven (7) years in accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure.</p> <p>Based on documentation review and staff interview, the facility failed to provide a waiver for</p>	S000676	On 8-19-13 (2:40 pm) a message was left at the office of Ann Hamel, ISDH Nurse Surveyor Supervisor, for instructions to apply for a waiver for the	08/29/2013			

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	<p>storing medical records offsite.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Medical Record Retention policy (Last approved 1/7/2013) states, "The Medical record will be stored to provide protection from loss, damage, or unauthorized access." 2. At 2:15 PM on 7/29/2013, staff member #1 indicated the patient charts are sent to the physician office complex after the procedure to be reviewed quarterly by the medical record consultant. The records could be stored at the office for as long as 4 months. After the records are reviewed by the consultant, the records are brought back to the surgery center and stored in the attic. The staff member confirmed the surgery center does not have a waiver for storing the medical records offsite for a period of time. 		<p>temporary storage of medical records offsite. This phone call was made by Phyllis Haworth, Administrator. As soon as instructions have been received, application for the waiver will be made. 8-26-13 A letter was sent to Randy Snyder at ISDH requesting a waiver for temporary storage of medical records offsite. Please see attached supporting document.</p>				

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S000834	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(iii)</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>(F) The delineation of preanesthesia, intra-operative, and postanesthesia as follows:</p> <p>(iii) The completion of a postanesthetic evaluation for proper anesthesia recovery of each patient prior to discharge in accordance with written policies and procedures approved by the medical staff.</p> <p>Based on review of the medical staff rules and regs, medical record review, and interview, the facility failed to ensure all patients received a complete post-anesthesia evaluation for 7 of 30 patient records reviewed (#P6, P7, P24, P25, P26, P27, and P28).</p> <p>Findings included:</p> <p>1. The medical staff rules and regs, last reviewed 01/07/13, indicated, "D. The patient's Medical Record shall contain anesthesia preoperative and postoperative patient evaluation notes</p>	S000834	<p>A letter is being sent to each Anesthesiologist that has privileges at CALBS. This letter will address the anesthesia record deficiencies that were brought to our attention during the survey. We are requesting that they properly complete their records and also asking for a time of post op vitals to be documented as well. We are now requiring the PACU nurse to review the post op anesthesia evaluation to insure it is complete before patient is transferred into their care. Lorrie Burkhart, CST, is responsible for reviewing the charts to insure proper documentation..</p>	08/30/2013

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	<p>written by the anesthetist. E. The anesthesiologist shall accompany all patients to the postoperative anesthesia recovery room following surgery."</p> <p>2. The medical record for patient #P6, who received anesthesia on 05/31/13, indicated an anesthesia record, signed by the anesthesiologist with "No Anesthetic Complications" checked, but the spaces for blood pressure, heart rate, respiratory rate, and oxygen saturation for the Post Anesthesia evaluation were blank with "VSS" [vital signs stable] written across that area of the form with no time to indicate when the patient was evaluated.</p> <p>3. The medical record for patient #P7, who received anesthesia on 04/12/13, indicated an anesthesia record, signed by the anesthesiologist with "No Anesthetic Complications" checked, but the spaces for blood pressure, heart rate, respiratory rate, and oxygen saturation for the Post Anesthesia evaluation were blank with "VSS" written across that area of the form with no time to indicate when the patient was evaluated.</p> <p>4. The medical record for patient #P24, who received anesthesia on 04/12/13, indicated an anesthesia record, signed by the anesthesiologist with "No Anesthetic Complications" checked, but the spaces</p>			

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	<p>for blood pressure, heart rate, respiratory rate, and oxygen saturation for the Post Anesthesia evaluation were blank with "VSS" written across that area of the form with no time to indicate when the patient was evaluated.</p> <p>5. The medical record for patient #P25, who received anesthesia on 04/12/13, indicated an anesthesia record, signed by the anesthesiologist with "No Anesthetic Complications" checked, but the spaces for blood pressure, heart rate, respiratory rate, and oxygen saturation for the Post Anesthesia evaluation were blank with "VSS" written across that area of the form with no time to indicate when the patient was evaluated.</p> <p>6. The medical record for patient #P26, who received anesthesia on 04/05/13, indicated an anesthesia record, signed by the anesthesiologist with "No Anesthetic Complications" checked, but the spaces for blood pressure, heart rate, respiratory rate, and oxygen saturation for the Post Anesthesia evaluation were blank with "VSS" written across that area of the form with no time to indicate when the patient was evaluated.</p> <p>7. The medical record for patient #P27, who received anesthesia on 04/05/13, indicated an anesthesia record, signed by</p>				

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	<p>the anesthesiologist with "No Anesthetic Complications" checked, but the spaces for blood pressure, heart rate, respiratory rate, and oxygen saturation for the Post Anesthesia evaluation were blank with "VSS" written across that area of the form with no time to indicate when the patient was evaluated.</p> <p>8. The medical record for patient #P28, who received anesthesia on 04/05/13, indicated an anesthesia record, signed by the anesthesiologist with "No Anesthetic Complications" checked, but the spaces for blood pressure, heart rate, respiratory rate, and oxygen saturation for the Post Anesthesia evaluation were blank with "VSS" written across that area of the form with no time to indicate when the patient was evaluated.</p> <p>9. At 3:30 PM on 07/30/13, staff members #A1 and A3 confirmed the medical record findings and confirmed it was unclear what vital signs the physician was referring to and at what time they were checked.</p>			

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S001146	<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 observation, manufacturer's directions and staff interview, the facility failed to maintain the surgery center's attic in such a manner that the safety and well-being of patients, visitors, and/or staff are assured and failed to ensure a safe working environment for staff with regard to chemical use and for patients with regard to warmed fluids.</p> <p>Findings included:</p> <p>1. At 2:15 PM on 7/30/2013, the surgery center's attic was toured. The attic was observed storing</p>	S001146	<p>On 8-19-13 a request was made to maintenance for the addition of two plumbed eye wash stations. One sink was chosen in an area of the facility accessible to patients and family members and one sink was chosen in a restricted, staff only area. It was requested these eye wash stations be installed by 8/29/13 by Phyllis Haworth, Administrator. In order to be in compliance with the manufacturer's recommendations for storing warmed IV fluids, this facility will date fluids for two weeks from the date fluids are put in the warmer. Warmed medications will be stored at their individual manufacturer recommendations. To keep this deficiency from reoccurring, these instructions will be posted on the warmer door by Phyllis Haworth, Administrator. See attachment. An storage room/attic clean up day has been</p>	08/29/2013

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	<p>assorted high-voltage electrical systems, HVAC equipment, Communication equipment, closed medical records, and other miscellaneous items. A metal storage rack was observed in-contacted with 'High-voltage' electrical Transfer Switches. The middle of the room was cluttered with medical records on the cement floor and other miscellaneous items. Metal racks stored with medical records were observed stored in directly in front of a 'high voltage' Kohler electrical free-standing piece of equipment. The distance between the medical records and the electrical equipment was approximately 20 inches. The storage in the attic presented a fire hazard.</p> <p>2. At 2:20 PM on 7/30/3013, staff member #1 confirmed the attic needs to be cleaned and organized.</p> <p>3. During the tour of the surgical area at 2:35 PM on 07/29/13, accompanied by staff members</p>		<p>planned for 8-22-13. General organization and discard of clutter is planned, along with the elimination of the observed metal rack in contact with the transfer switches and moving the medical records away from electrical equipment. Phyllis Haworth and other surgery staff will be responsible for this organization. On 8-30-13 the City of Bloomington Fire Marshall conducted a survey of the surgery center (upper level) and the office (lower level). The building had no fire code violations and the attic storage was approved as a safe, fire restrictive, secure area to store medical charts. Please see attached report.</p>				

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	<p>#A1, A2, and A4, a plastic container of Cidex OPA for high level disinfection was observed in the soiled room. The housekeeping closet was observed to contain PD-64 disinfecting cleaner, Vesphene disinfecting cleaner, and a gallon container of Clorox. Manufacturer's label directions on all of the chemicals indicated eye protection should be worn and eyes should be flushed for at least 15 minutes if any contact or splashing occurred. Directions also indicated medical attention should be sought for any chemical in the eyes. A 32 ounce bottle of flush solution was observed in a wall mounted unit.</p> <p>4. At 2:40 PM on 07/29/13, staff members #A1 and A2 indicated there was no sink mounted or plumbed eye wash station in case of chemical splashes. Staff member #A2 indicated they did have several bottles of the flush solution.</p>						

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	<p>5. At 3:10 PM on 07/29/13, the pre/post areas were toured with staff member #A4 and a Blickman warming cabinet was observed containing eight 1000 milliliter bags of Lactated Ringers IV (intravenous) solution, six 1000 milliliter bags of 0.9% Normal Saline IV solution, and five 1000 milliliter containers of 0.9% Normal Saline irrigation fluid. All of the bags/containers were dated with 08/18/13.</p> <p>6. At 3:10 PM on 07/29/13, staff member #A4 indicated all of the solutions were dated for one month in the warmer. He/she indicated he/she was unsure of where this time frame came from and indicated he/she did not have documentation from the manufacturer regarding the length of time the various solutions could be in the warmer.</p> <p>7. An Internet search from 07/29/13 for fluid manufacturer's recommendations indicated,</p>			

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S001152	<p>"Baxter Healthcare Corporation recommends that IV bags in their plastic overpouches may be warmed no longer than 14 days at a temperature not to exceed 104 degrees F. (Fahrenheit)."</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(B)</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 plan and equipment by qualified personnel as follows:</p> <p>(B) All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on documentation review and staff interview, the facility failed to documented weekly emergency generator inspections.</p>	S001152	On 8-19-13 a request was made to maintenance for weekly preventative maintenance inspections of the emergency generator. To keep this deficiency from reoccurring, new	08/29/2013

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	<p>Findings included:</p> <ol style="list-style-type: none"> Emergency Power System policy (Last approved 1/7/2013) notes the emergency generator was required to have weekly preventive maintenance inspections. The Emergency Power System Log for the generator was reviewed for 2012 and 2013. The log did not evidence weekly preventive maintenance inspections of the emergency generator. At 1:15 PM on 7/30/2013, staff member #1 confirmed the Emergency Power System Log did not document weekly preventive maintenance inspections. The staff member indicated the generator was required to have weekly inspections of the batteries. 		check sheets (including a weekly column) were made for the maintenance staff. This request was made by Phyllis Haworth, Administrator.		