

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001166	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/19/2013
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NAME OF PROVIDER OR SUPPLIER BALL OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 012159</p> <p>Survey Date: 03/18/2013 through 03/19/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 03/25/13</p>	S000000	This is a new plan of correction.	

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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S000100	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)</p> <p>Sec. 1.(a) The governing body shall function as the supreme authority of the center. The governing body shall assume full legal responsibility for determining, implementing, and monitoring policies governing the center's total operation and for ensuring that these policies are followed so as to provide quality health care in a safe environment. The governing body is legally responsible for the conduct of the center as an institution. The governing body shall do the following: Based on documentation review and staff interview, the facility failed to comply with their Risk Management Program.</p> <p>Findings included:</p> <p>1. Risk Management Program policy #QAPI 5.02 (last approval April 2012) states, "The ASC contracts with Indiana University Health to provide Risk Management Services. The services are outlined in the Risk Management services manual. Risk Management Services include:</p>	S000100	The clinical director of the Ball Outpatient Surgery Center is responsible for policies and procedures at the Ball Outpatient Surgery Center. The Clinical Director will ensure that the Risk Management Services manual is available onsite. The manual will be comprised of policy QAPI 5.02 Risk Management Services and Policies ERI 1.00 through ERI 1.06. To prevent the deficiency from recurring the Clinical Director shall monitor the presence of the risk management services manual on a go forward basis.	04/03/2013			

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	<p>Management of patient complaints; Management of patient grievances; Trend analysis of patient complaints; Investigation of medical/clinical errors; Conduction of root cause analysis for potential sentinel and reportable medical events; Trend analysis of medical/clinical errors; Risk reduction strategies to improve patient safety; Disclosure consultation; Investigation/presentation of potential medical claims; peer-review referrals; Organizational consultation for risk mitigation; and Policy review and consultation. Results from risk management activities are included in the quality reporting for the ASC."</p> <p>2. Service Level Agreement between Ball Outpatient Surgery Center and Ball Memorial Hospital (effective October 2009) Responsibility matrix states, "Triage and guidance of Risk Management issues; Conduct root</p>			

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	<p>cause analyses on sentinel and/or state reportable events as needed; Provide facility based support with system interface for the direct processing and reviews management and patient safety issues, and collaborating assistance for patient complaints management including claims management; and Provide support for root cause analyses of patient issues, patient safety related performance improvement activities and education, and patient safety, risk management, and patient complaint data analysis, trending, and related performance improvement activities."</p> <p>3. At 11:30 AM on 3/19/2013, staff member #1 indicated the ASC does not have a Risk Management Manual or documentation supporting the risk management assessment.</p>				

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S000162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on documentation review and staff interview, the facility failed to ensure 1 of 3 Allied Health Staff were cardiopulmonary resuscitation (CPR) competent and 1 of 3 Allied Health Staff was Advanced Cardiac Life Support (ACLS) competent as defined in the facility's policies and procedures (#16 and #17).</p> <p>Findings included:</p> <p>1. ACLS, CPR, and PALS Education Requirements policy #ADM 3.10 (Last approved April 2012) states, "All staff directly involved with patient care must</p>	S000162	The clinical director of the Ball Outpatient Surgery Center is responsible for enforcing policy at the Ball Outpatient Surgery Center. The Clinical Director will ensure that ACLS, CPR & PALS education requirements are maintained per Ball Outpatient Surgery Center Policy. Evidence of compliance will be maintained in employee or allied health professional files. Evidence of current competency has been requested for those allied health providers identified during survey. To prevent the deficiency from recurring the credentialing coordinator and clinical manager shall ensure that all required competencies are up to date and documented.	04/03/2013			

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	<p>successfully complete Basic Life Support. All Registered Nurse Staff must successfully complete ACLS training."</p> <p>2. Cardiopulmonary Resuscitation (CPR) competence for Physicians, Allied Health Professionals, and Supervised Allied Health Professionals policy #MS 2.02 (Last approved April 2012) states, "CPR competence is minimally required for all Allied Health Professionals."</p> <p>3. Allied Health Staff member #16 was a Registered Nurse. Staff member #16 credential file did not evidence an ACLS certification.</p> <p>4. Allied Health Staff member #17 was a Physician Assistant and the staff member's job description notes that the staff member provides direct patient care. The staff member's credential file does not evident he/she was CPR competent.</p>						

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	5. At 11:45 AM on 3/18/2013, staff member #1 indicated staff member #16 did not have an ACLS certification card and staff member #17 did not have a CPR certification card on file in their credential folders.			

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S000224	<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 staff interview, the Governing Body failed to ensure 16 services provided by the contractors were included in its comprehensive quality assessment and improvement (QA&I) program: Anesthesia, Biohazard Waste, Biomedical, Housekeeping, Laboratory, Laundry/Linen, Maintenance, Medical Records, Nursing, Pharmacy, Radiology, Risk Management, Security, Transcription, Infection Control, and Pest Control.</p> <p>Findings included:</p>	S000224	The clinical director of the Ball Outpatient Surgery Center is responsible for administration of the Ball Outpatient Surgery Center Quality Plan. The Clinical Director will ensure that the evaluation of all contracted services shall be reviewed by both the Quality Assurance Committee and Governing Body. Documentation will be maintained with the meeting minutes of both committees. To prevent the deficiency from recurring the Clinical Director shall ensure that the evaluation of all contracted services shall be reviewed by both the Quality Assurance Committee and Governing Body. Documentation will be maintained with the meeting minutes of both committees.	04/03/2013

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	<p>1. The Ball Outpatient Surgery Center (BOSC) Quality Assurance Committee quarterly reports were reviewed for 2012. The following sixteen contracted services were not evaluated by the Governing Board: Anesthesia, Biohazard Waste, Biomedical, Housekeeping, Laboratory, Laundry/Linen, Maintenance, Medical Records, Nursing, Pharmacy, Radiology, Risk Management, Security, Transcription, Infection Control, and Pest Control.</p> <p>2. BOSC contracted services were reviewed with staff member #1 at 1:05 PM on 3/19/2013. Staff member #1 indicated he/she has never sent the evaluation of the contracted services to the Quality Assurance Committee.</p>				

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S000226	<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 documentation review and staff interview, the facility failed to ensure Nursing and Risk Management Services were included in the Ball Outpatient Surgery Center's (BOSC) Contracted Service listing.</p> <p>Findings Included:</p> <p>1. Service Level Agreement between IU Ball Memorial Hospital (Clarian Health Partners) and Ball Outpatient Surgery Center (Agreement was signed 10/1/2009) states, "Clarian Health Partners, Inc. provides the management of Ball Outpatient Surgery Center with risk management services</p>	S000226	<p>The clinical director of the Ball Outpatient Surgery Center is responsible for administration of the Ball Outpatient Surgery Center Quality Plan. The Clinical Director will ensure that the evaluation of all contracted services shall be reviewed by both the Quality Assurance Committee and Governing Body. Contracted services will include Risk Management and Human Resource support. Documentation of the evaluation of both of these services will be maintained with the meeting minutes of both committees. To prevent the deficiency from recurring the Clinical Director shall ensure that the evaluation of all contracted services shall be reviewed by both the Quality Assurance Committee and Governing Body. Contracted services will include Risk Management and Human Resource support.</p>	04/03/2013			

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	<p>under the direction of the risk management department. Ball Memorial Hospital (BMH) agrees to lease to BOSC the services of BMH employees to provide services at BOSC." The employees are listed on Exhibit A of the agreement: Director, Certified Surgical Technicians, Nurse Manager, Registered Nurses, etc.</p> <p>2. BOSC 2012 Contracted Services listing did not include Risk Management and Nursing Contracted Services.</p> <p>3. BOSC contracted services were reviewed with staff member #1 at 1:05 PM on 3/19/2013. Staff member #1 indicated he/she has never listed the Nursing Staff or Risk Management Services on BOSC contractor listing.</p>		Documentation will be maintained with the meeting minutes of both committees.		

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S000310	<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 16 services provided by the contractors as part of it's comprehensive quality assessment and improvement (QA&I) program: Anesthesia, Biohazard Waste, Biomedical, Housekeeping, Laboratory, Laundry/Linen, Maintenance, Medical Records, Nursing, Pharmacy, Radiology, Risk Management, Security, Transcription, Infection Control, and Pest Control.</p> <p>Findings included:</p> <p>1. Quality Management/Improvement Program policy #QAPI 5.00 (Last approved April 2012) indicates all</p>	S000310	<p>The clinical director of the Ball Outpatient Surgery Center is responsible for administration of the Ball Outpatient Surgery Center Quality Plan. The Clinical Director will ensure that the evaluation of all contracted services shall be reviewed by both the Quality Assurance Committee and Governing Body. Documentation of the evaluation of both of these services will be maintained with the meeting minutes of both committees. To prevent the deficiency from recurring the Clinical Director shall ensure that the evaluation of all contracted services shall be reviewed by both the Quality Assurance Committee and Governing Body. Documentation will be maintained with the meeting minutes of both committees.</p>	04/03/2013

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	<p>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 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 Ball Outpatient Surgery Center (BOSC) Quality Assurance Committee quarterly reports were reviewed for 2012. The following sixteen contracted services were not evaluated by the Quality Assurance Committee: Anesthesia, Biohazard Waste, Biomedical, Housekeeping, Laboratory, Laundry/Linen, Maintenance, Medical Records, Nursing, Pharmacy, Radiology,</p>						

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	<p>Risk Management, Security, Transcription, Infection Control, and Pest Control.</p> <p>3. BOSC contracted services were reviewed with staff member #1 at 1:05 PM on 3/19/2013. Staff member #1 indicated he/she has never sent the evaluation of the contracted services to the Quality Assurance Committee. Staff member #1 indicated Nursing and Risk Management Services are contracted services with IU Ball Memorial Hospital. The staff member confirmed those two contracted services are not being monitored and evaluated as the other contracted services are.</p>				

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S000418	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(A)</p> <p>(2) The infection control committee responsibilities must include, but are not limited to the following:</p> <p>(A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the center.</p> <p>Based on policy review and interview, the facility failed to follow their policy regarding identifying infections related to procedures performed at the center.</p> <p>Findings included:</p> <p>1. The facility policy "Infection Prevention and Control Program", effective April 2012, indicated, "4. Reporting and Surveillance: A. The Infection Control Practitioner (ICP) will monitor and track infections. A quarterly report of all infections, recommendations for action, and control measures will be generated for review by the infection control and quality committees. ...i. Physician Communication- The ICP will provide lists to each physician working in the ASC monthly. The responsible physician is expected to confirm the details of any reported infection to the ICP. ii. Hospital admission reports- the ASC patients admitted to the hospital</p>	S000418	The clinical director of the Ball Outpatient Surgery Center is responsible for administration of the Ball Outpatient Surgery Center Infection Control Plan. The Clinical Director will ensure that the Ball Outpatient Surgery Center Infection Control committee establishes techniques and system for identifying, reviewing and reporting infections. The Ball Outpatient Surgery Center Infection Control Plan will be amended to state that the "ICP or contracted designee will provide patient lists to each physician working in the ASC monthly." The results of the physician queries will be reviewed by the Infection Control Committee. A copy of the Ball Outpatient Surgery Center Infection Control Policy has been uploaded with this plan of correction as S444 Infection Control Policy. To prevent the deficiency from recurring the Clinical Director shall amend the Ball Outpatient Surgery Center Infection Control Plan and have it	04/03/2013			

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	<p>within 30 days. iii. Patient follow up. iv. Laboratory Culture Reports."</p> <p>2. At 11:30 AM on 03/18/13, one of the facility's two ICPs, staff member #A3, was interviewed. He/she indicated he/she did not provide monthly lists to the ASC physicians, contact the physicians directly, or receive culture reports directly. He/she indicated he/she relied on the hospital's epidemiology nurse to provide the information regarding any infections related to cases performed at the ASC, then he/she and the other ICP would do the follow-up. He/she provided documentation of the follow-up.</p> <p>3. During the exit conference at 3:15 PM on 03/19/13, staff member #A1 indicated the hospital's epidemiology nurse did send monthly lists to the ASC physicians, but confirmed this tracking was not done by the facility's two ICPs.</p>		approved by the Infection Control Committee and Governing Body.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000444	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks.</p> <p>Findings included:</p> <p>1. While observing in the pre-op area between 10:50 AM and 11:05 AM on 03/19/13, seven different staff members were observed coming out of the surgical area, going to the nurses' station, and talking with patients with their surgical masks either covering their nose and mouth, covering only their mouths, hanging around their necks, or turned backwards on their neck, then returning to the surgical area. At 11:55 AM, two staff members were observed in the pre-op area with masks in their pockets. They</p>	S000444	The Clinical Director and Clinical Manager of the Ball Outpatient Surgery Center are responsible for ensuring that requirements for personal hygiene and attire meet acceptable standards of practice. The Clinical Director and Clinical Manager will ensure that all Ball Outpatient Surgery Center staff follow facility policy for Dress Code in the Perioperative Domain. This includes surgical masks covering their nose and mouth per policy. Surgical masks must be changed between cases and cannot be worn outside the perioperative area. To prevent the deficiency from recurring the Clinical Director and Clinical Manager shall remind all staff of this requirement via electronic communication and at the next staff meetings. Employees who fail to comply with this policy will be subject to disciplinary action.	04/12/2013			

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	<p>returned to the surgical area, pulled the masks out of their pockets, and put them on to go into the operating suites.</p> <p>2. The facility policy "Dress Code: Perioperative Practice Domain", effective April 2012, indicated, "4. Masks are to cover the mouth and nose completely and will be secured to prevent venting from occurring at the sides. Masks will be worn either on or off, rather than hanging around the neck, and must be changed at minimum between cases or more often when soiled. Masks are not to be worn outside the perioperative area."</p> <p>3. At 2:30 PM on 03/19/13, staff member #A2 confirmed the facility followed AORN recommendations which indicated surgical masks were to be changed between cases and not worn around the neck or stored in pockets.</p>			

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S000672	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(13) A copy of the transfer form, if the patient is referred to a hospital or other facility.</p> <p>Based on policy review, medical record review, and interview, the facility failed to follow their documentation policy for 2 of 3 patients who were transferred from the facility (#N1 and N2).</p> <p>Findings included:</p> <p>1. The facility policy "Transfer of a Patient", effective July 2012, indicated, "IV. Procedures; A. Physician or designee calls admitting facility if applicable. B. Complete the transfer paperwork/form. Place a patient label on each form. 1. The physician will need to complete the 'Request to Transfer' form for all patient transfers. If the physician is not at the facility, the nurse can take a verbal order to transfer the patient and complete as much information as possible. Send one copy with the patient and keep a copy. ...C. Document the general assessment, report called to, mode of transfer, time of transfer and the reason</p>	S000672	The clinical director of the Ball Outpatient Surgery Center is responsible for enforcing policy and procedure at the Ball Outpatient Surgery Center. The Clinical Director and Clinical will ensure that all patient transfers are accompanied by the Request to Transfer form and an authenticated physician order. The form will be completely filled out including destination of transfer, reason for transfer, diagnosis, condition on transfer. To prevent the deficiency from recurring the Clinical Director and Clinical Manager shall review the medical record documentation on patient transfers to ensure that policy is being followed.	04/12/2013			

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	<p>for transfer. Document if the patient's care was transferred to another physician or specialty group."</p> <p>2. The medical record for patient #N1, a 13-year old who had a surgical procedure on 11/09/12, indicated a form titled "Patient Transfer Note" which indicated the patient was being transferred to Peds for decreased oxygen saturation levels after a T&A (tonsillectomy and adenoidectomy). The form also listed orders under the "Plan", but there was no indication of who wrote this information and no designation of verbal orders or any authentications for the entry. The record lacked any other transfer forms.</p> <p>3. The medical record for patient #N2, a 62-year old who had a surgical procedure on 08/07/12, indicated a form titled "Patient Transfer Note" on which was written, "Admit to hospital and have hospitalist to admit" as a verbal order from the surgeon at 1650 on 08/07/12. The order was not authenticated by the surgeon. The portion of the form designating "Destination of Transfer, Reason for Transfer, Diagnosis, Condition on Transfer, Plan" was blank. The record lacked any other transfer forms.</p> <p>4. At 9:50 AM on 03/19/13, staff</p>						

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	member #A2 indicated the "Patient Transfer Note" was the only form completed for a patient transfer and there was no form titled "Request to Transfer" mentioned in the policy. He/she confirmed the transfer documentation was incomplete for patients #N1 and N2.			

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S000780	<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 on policy review, medical record review, and interview, the facility failed to ensure all physician written/standing orders were authenticated according to policy for 7 of 17 patients whose records were reviewed (#N1, N3, N5, N7, N8, N9, and N17).</p> <p>Findings included:</p> <p>1. The facility policy "Content of Medical Records", effective July 2012, indicated, "D. The following apply to authentication of entries: 1. All entries in the medical record must be confirmed by written signatures or computer signature, identifying the credentials of the author. ...3. Orders: b. Diagnostic and therapeutic orders shall be recorded,</p>	S000780	The Clinical Director and Clinical Manager of the Ball Outpatient Surgery Center is responsible for enforcing policy and procedure at the Ball Outpatient Surgery Center. The Clinical Director and Clinical Manager will ensure that all orders are entered and authenticated per policy. Orders will contain record of appropriate authentication. To prevent the deficiency from recurring the Clinical Director and Clinical Manager shall review the results of medical records audits and provide continuing education to staff and physicians regarding the policy.	04/12/2013			

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	<p>dated, and authenticated by the responsible practitioner. ...d. A physician's routine orders shall be entered in the patient's medical record, dated and signed by the staff physician. ...13. Authentication: a. All entries in the medical record must be authenticated and dated within 30 days of the date of the procedure."</p> <p>2. The facility policy "Physician Order Sets and Protocols", effective April 2012, indicated, "IV. Policy Statements: A. Surgeons and anesthesiologists may request the use of preoperative, intraoperative and postoperative order sets and/or protocols. ...D. The orders are reviewed and signed by the individual surgeon for each patient."</p> <p>3. The medical record for patient #N1, who had a procedure on 11/09/12, indicated orders written on the "Patient Transfer Note" form, but lacked any designation of verbal orders or who wrote them and also lacked any signatures of a nurse or physician to indicate authentication and implementation.</p> <p>4. The medical record for patient #N3, who had a procedure on 12/28/12, indicated pre-printed standing orders that lacked any nursing authentication to indicate implementation and verbal orders</p>			

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	<p>written on the "Patient Transfer Note" form that also lacked any nursing authentication.</p> <p>5. The medical record for patient #N5, who had a procedure on 12/27/12, indicated written physician orders that lacked any nursing authentication to indicate implementation.</p> <p>6. The medical record for patient #N7, who had a procedure on 09/25/12, indicated a written physician order that lacked any nursing authentication to indicate implementation.</p> <p>7. The medical record for patient #N8, who had a procedure on 10/23/12, indicated written physician orders that lacked any nursing authentication to indicate implementation.</p> <p>8. The medical record for patient #N9, who had a procedure on 10/09/12, indicated pre-printed standing orders that lacked physician authentication.</p> <p>9. The medical record for patient #N17, who had a procedure on 11/19/12, indicated pre-printed standing orders that lacked physician authentication.</p> <p>10. At 2:30 PM on 03/19/13, staff member #A2 confirmed the medical</p>			

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	record findings and indicated the nurses were to sign any orders to designate they had been implemented or carried out. He/she indicated there were no other policies addressing authentication of orders.			

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S000888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure accurate operative reports were written/dictated immediately following surgery for 5 of 17 medical records reviewed (#N1, N2, N11, N16, and N17).</p> <p>Findings included:</p> <p>1. The facility policy "Content of Medical Records", effective July 2012, indicated, "7. Operative/Procedure Reports: a. Operative reports must be written or dictated immediately following any surgical or invasive procedure that is</p>	S000888	The Clinical Director and Clinical Manager of the Ball Outpatient Surgery Center is responsible for enforcing policy and procedure at the Ball Outpatient Surgery Center. Ball Outpatient Surgery Center policy requires that an operative report be dictated immediately following surgery. Immediately is defined as within twenty four hours after the surgery. Physicians will be reminded of this requirement. To prevent the deficiency from recurring the Clinical Director and Clinical Manager shall review the results of medical records audits and provide continuing education to staff and physicians regarding	04/05/2013			

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	<p>performed under general anesthesia. ...c. The surgeon is responsible for the operative report although he/she may delegate to one of the assistant surgeons. The completed operative note must be authenticated by the surgeon."</p> <p>2. The medical record for patient #N1, a 13-year old who was transferred after having a surgical procedure on 11/09/12, lacked a written or dictated operative report by the surgeon.</p> <p>3. The medical record for patient #N2, who was transferred after having a surgical procedure on 08/07/12, indicated an operative report that was not dictated until 08/18/12 and electronically signed by the physician on 08/22/12.</p> <p>4. The medical record for patient #N11, a 4-year old who had a surgical procedure on 10/12/12, indicated an operative report that was not dictated until 10/23/12 and electronically signed by the physician on 10/24/12.</p> <p>5. The medical record for patient #N16, who had a surgical procedure on 08/07/12, indicated an operative report that was not dictated until 08/23/12 and electronically signed by the physician on 08/24/12.</p>		the policy.	

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	<p>6. The medical record for patient #N17, who had a surgical procedure on 11/19/12, indicated an operative report that was not dictated until 11/21/12 and electronically signed by the physician on 11/23/12.</p> <p>7. At 2:30 PM on 03/19/13, staff member #A2 confirmed the operative reports were not completed according to policy. He/she indicated there were no additional policies regarding operative reports and the physicians counted within 24 hours after surgery as the time frame for immediately completed.</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, facility document review, interview, and policy review, the facility failed to ensure patient safety by maintaining appropriate temperature of the fluids in the warming cabinet in the surgical area.</p> <p>Findings included:</p> <p>1. During the tour of the surgical area at 11:20 AM on 03/19/13, accompanied by staff member #A2, a Castle warmer containing Baxter intravenous (IV) and irrigation fluids was observed in the back hallway. The solutions were date labeled and the temperature of the warmer registered 109 degrees Fahrenheit (F). A sign taped near the warmer indicated IV bags could be in the warmer for 14 days and bottles of solution could be in for 60 days. The sign did not designate</p>	S001146	The Clinical Director and Clinical Manager of the Ball Outpatient Surgery Center is responsible for enforcing policy and procedure at the Ball Outpatient Surgery Center. Ball Outpatient Surgery Center policy PSF 10.19 Blanket and Fluid Warmers has been created to provide documentation of the manufacturer recommended temperatures for the fluid and blanket warmers. The devices will be maintained in the appropriate range. A copy of the policy has been uploaded to this plan of correction as S1146 PSF 10.19 Fluid and Blanket Warmer Policy. A copy of the fluid and blanket warmer log and manufacturer documentation has been uploaded with this plan of correction as S1146 Blanket Warmer Log. To prevent the deficiency from recurring the safety committee will evaluate the temperature of blanket and fluid	04/05/2013			

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	<p>temperatures or the source of the information.</p> <p>2. Review of the facility documentation for January and February 2013 indicated the temperature of the fluid warmer was monitored each day the facility was open and was always 109 degrees F. The monitoring log indicated the acceptable temperature range was between 104 and 110 degrees F.</p> <p>3. At 10:00 AM on 03/19/13, staff member #A3 indicated the facility did not have its own fluid warmer policy, but provided a copy of the hospital's policy that he/she indicated they followed.</p> <p>4. Review of the hospital's policy indicated their references were from AORN and Baxter Healthcare Corporation. The policy indicated fluids could be warmed to a temperature of 110 degrees F. but did not specify any time frame for remaining in the warmer.</p> <p>5. At 11:40 AM on 03/19/13, staff member #A1 indicated the facility did not have any policies regarding the warmers, did not have recommendations of acceptable temperatures from the fluid manufacturer, and did not know what temperatures were recommended by the cabinet manufacturer. He/she also</p>		warmers during their walk throughs.				

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	indicated he/she did not know where the signage regarding the dating came from.			

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NAME OF PROVIDER OR SUPPLIER BALL OUTPATIENT SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE STE 200 OMP MUNCIE, IN 47303			
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S001188	<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 documentation review and staff interview, the facility failed to conduct quarterly fire drills as defined by the facility's policies and procedures.</p> <p>Findings included:</p> <p>1. Fire Alarms and Practice Fire Alarms policy #FP 8.00 (Last approved April 2012) states, "Staff shall be trained in fire response. Fire Alert Drills will occur quarterly. For practice alarms: Fire Department is not contacted;</p>	S001188	The Clinical Director and Clinical Manager of the Ball Outpatient Surgery Center is responsible for enforcing policy and procedure at the Ball Outpatient Surgery Center. Ball Outpatient Surgery Center policy FP 8.00 requires that all staff be trained in fire response, fire drills will be conducted quarterly and that drills be audible. In order to train staff from all shifts Ball Outpatient Surgery Center typically provides two training sessions quarterly. Documentation of fire drills will contain the participants name and actions taken. To prevent the deficiency from recurring the Clinical Director and Clinical Manager shall ensure that all staff members participate in scheduled fire drills and appropriate	04/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001166		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/19/2013	
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	<p>Disconnect gas/oxygen, use of fire extinguishers and movement of patients is simulated; Contact alarm company to schedule practice alarm; Complete Fire Drill Evaluation report form; Take necessary actions to remedy deficiencies including Life Safety Code Issues; Document attendance at practice; Evaluate fire alarm/practice alarm reports; Observe compliance with safety standards; Forward written notices to departments with deficiencies; Evaluate effectiveness of measures taken to correct discrepancies at future alarms."</p> <p>2. Life Safety Code requirement for ASC's Fire Drills are to be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required under varied conditions. The drills are to be audible or conducted by a center-wide paging system.</p> <p>3. The four quarter of fire drills for</p>		documentation is made available for review.				

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	<p>2012 were review. The facility operates with 2 shifts. The fire drills were conducted by the staff of IU Ball Memorial Hospital. The drills were documented on Ball Memorial Hospital Security Case/Incident Report forms and were not on the the Fire Frill Evaluation Report form as defined by policy #FP 8.00. Ball Outpatient Surgery Center (BOSC) documented the following drills for 2012: 1 drill for the first quarter; 2 drills for the second quarter; 2 drills for the third quarter; and 5 drills for the forth quarter. The second and third quarter had 1 of the 2 fire drills documented as "Interview Only". These "Interview Only" drills were not identified on the form as actual fire drills. These were training scenarios, such as explaining how to operate a fire extinguisher. The forth quarter had 3 documented drills on Fire Drill/Alarm Responder Roster forms. These drills only identified whom participated and did not evaluate the fire drills' activities.</p>			

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	<p>The other two fire drills in the forth quarter were identified as "Interview Only" drills. Again, those two drills were not actual fire drills as defined by the facility policy. Therefore, the facility complied with only 3 of 8 fire drills as defined by BOSCO policies and procedures.</p> <p>4. At 2:30 PM on 3/18/2012, staff member #1 indicated the facility schedules staff members for second shift, because the facility does have 23-hour stays. The staff member confirmed that Ball Memorial Hospital staff assist in conducting the fire drills for BOSCO. The staff member confirmed the documentation did not evident the proper amount of fire drills that should of been held for 2012.</p>			
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