

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001046	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/18/2012
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NAME OF PROVIDER OR SUPPLIER NORTH MERIDIAN SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 13225 N MERIDIAN STREET CARMEL, IN 46032
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 007125</p> <p>Survey Date: 7-16-12 to 7-18-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Karilyn Tretter, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 08/02/12</p> <p>10/24/12 revised due to IDR</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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S0122	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body.</p> <p>Based on document review and interview, it could not be determined the governing board had reviewed and approved the medical staff bylaws within the past three years.</p> <p>Findings:</p> <p>1. On 7-16-12 at 0930 hours, staff A1 was requested to provide documentation indicating when the medical staff bylaws were last approved by the governing board and none was provided prior to exit.</p> <p>2. During an interview on 7-18-12 at 1535 hours, staff A1 confirmed that no documentation was available indicating that the Board of Managers had approved the Medical Staff Bylaws in the past 3 years.</p>	S0122	<p>S 122 The Surgery Center Bylaws are contained in our policy and procedure manuals. Policy and procedure manuals were last reviewed by the governing body on 04/21/10. Please see attachment #2, which is the index for the policy and procedure manuals. Policy #2.01 is the Bylaws of the medical staff. Also see attachment #3, which is a copy of the governing body meeting minutes from 04/21/10. We believe that this response was accidentally overlooked by the surveyor when presented to surveyor prior to summation conference. In order for surveyors to quickly locate the last dates of Bylaws Review, we have copied all related paperwork and created a separate binder named "Bylaw Review" on 07/20/12. It is the responsibility of the Director to ensure that all paperwork be easily accessible to surveyors 24-7.</p>	07/20/2012	

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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 and interview, the center failed to keep current its list of all contracted services including the scope and nature of services provided.</p> <p>Findings:</p> <p>1. Review of a list of contracted services [vendors] provided by staff A1 failed to indicate the current contracted service provider for the following: anesthesia machines, building management, emergency generator, fire systems monitoring and equipment, housekeeping, medical laboratory and pathology, medical gas system testing and certification, medical physicist, microscope, pest control and 2 sterilizer service providers. The list failed to clearly indicate the scope and nature of services provided by several contracted services and included a generator service</p>	S0226	<p>S 226 Our facility is brand new construction and comes with a one-year warranty on all portions of the building. Subsequently, services for the emergency generator, fire systems and medical gases are covered by this warranty, and further contracts are not necessary until the first year is up (which will be November 2012). Pest control and housekeeping services are included in our 20-year lease that was signed in September 2011. Since those services are included, we do not maintain separate contracts with these vendors. However, we do maintain surveillance of all their activities related to the Center, and that was presented to surveyors at time of survey. We also maintain policies and procedures which include maintaining a safe, clean environment. Listed generator contract is for the space we are</p>	08/13/2012			

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	<p>no longer providing services for the center.</p> <p>2. Center documentation indicated the following: anesthesia machine service by V1, building management by V2, emergency generator service by V3, fire systems monitoring and equipment service by V4, housekeeping service by V5, medical laboratory and pathology by V6, medical gas system certification by V7, medical physicist certification by V8, microscope service by V9, pest control by V10 and 2 sterilizer service providers V11 and V12.</p> <p>3. On 7-18-12 at 1145 hours, staff A1 confirmed that the list of contracted services had not been maintained.</p>		<p>subleasing at our old address. Since we still maintain a contract with the old generator service provider, it was still included on our list. Anesthesia machine, sterilizer services, medical lab and pathology services, Physicist, and microscope vendors have been added to our contracted vendor list. See attachment #4. This was done on 08/13/12. It is the responsibility of the Director to ensure that the vendor list is up-to-date.</p>		

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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 follow its policy/procedure and ensure that the services performed under contract were evaluated and approved by the Quality Assurance (QA) committee for 53 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedure Vendor Evaluation/QA (revised 8-11) indicated the following: " All vendors [contracted services] associated directly or indirectly with patient care ...will be evaluated yearly. Vendor [contracted service] evaluations will be presented to the QA Committee. "</p> <p>2. The 2011 and 2012 meeting minutes of the QA Committee, Medical Staff and Board of Managers dated 5-04-11, 8-10-11, 12-12-11 and 3-06-12 failed to indicate that the services provided under</p>	S0310	<p>S 310 Meeting minutes from the QA committee on 05/04/2011, 08/10/2011, and 12/12/2011 indicate that services provided by contracted vendors were reviewed. See attachments #5, 6, & 7 QA meeting minutes. In order for surveyors to quickly locate the last dates of Vendor Contract Review, we have added a section to the front of our maintenance manual named "Vendor Contract Review" on 07/20/12. It is the responsibility of the Director to ensure that all paperwork be easily accessible to surveyors 24-7.</p>	07/20/2012

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	<p>contract were evaluated and approved by the committee, medical staff or board of managers. Staff A1 was requested to provide documentation indicating that an evaluation of contracted services was completed and approved in 2011 or 2012 and none was provided prior to exit.</p> <p>3. During an interview on 7-18-12 at 1247 hours, staff A1 confirmed that no documentation was available to indicate that the contracted services had been evaluated and reapproved since 2010.</p>				

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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.</p> <p>Based on CDC (Centers for Disease Control and Prevention) recommendations and personnel file review, the Infection Control Committee of the ASC failed to monitor the tuberculosis (TB) program at the facility for 6 of 8 (E#2, E#3, E#4, E#5, E#7, and E#8) nursing personnel.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. CDC Fact Sheet "Tuberculin Skin Testing" states "the skin test reaction should be read between 48 and 72 hours after administration... a person who does not return within 72 hours will need to be rescheduled for another test." 2. Personnel file review on 7/16/12 and 7/18/12 indicated: E#2's file (RN) contained a "Patient Immunization Record" which indicated that his/her last TB - Surveillance was done on 6/27/2011 and read on 6/30/2011. Also, no times for administration or reading indicated. E#3's file (RN) contained an "Employee Immunizations" form that indicated the last time he/she completed a TB questionnaire was 4/14/2011. E#4's file (RN) contained a "PPD Skin Test Result Form" that indicated a PPD 	S0422	<p>S 422 TB testing was underway during dates of survey. All staff members have had their TB tests performed and results read as of 07/16/2012. To prevent any gap in future testing, we have designated a fulltime staff RN to monitor these results. This fulltime RN has also completed a recent TB certification course and will ensure that the times of testing/administration/reading be written on the form. A tickler file has also been created and is accessible to all staff. It is the responsibility of the Director to ensure that all staff members have current TB testing on file. This has been corrected as of 07/16/2012</p>	07/18/2012			

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	<p>was given on 1/12/11 and read on 1/14/11 (no times of administration or reading indicated). E#4 also had a "NMSC PPD Skin Test Result Form" that indicated a PPD was given on 7-16-12 and read on 7-18-12 (no times of administration or reading indicated, and the form was not in the file on 7/16/12). E#5's file (RN) contained a "PPD Skin Test Result Form" that indicated a PPD was given on 1/12/11 and read on 1/14/11 (no times of administration or reading). E#7's file (CST) contained a form from a hospital that indicated a TST (tuberculin skin test) was given on 4-18-11 at 845 and read on 4-20-11 at 1000. E#8's file (RN) contained a "PPD Skin Test Result Form" that indicated a PPD was given on 1/12/11 and read on 1/14/11 (no times of administration or reading indicated). E#8 also had a "NMSC PPD Skin Test Result Form" that indicated a PPD was given on 7-16-12 and read on 7-18-12 (no times of administration or reading indicated, and the form was not in the file on 7-16-12).</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 ACIP (Advisory Committee on Immunization Practices) recommendations and personnel file review, the Infection Control Committee of the ASC failed to monitor the varicella history of 4 of 8 (E#1, E#5, E#6, E#7) nursing personnel.</p> <p>Findings include:</p> <p>1. ACIP, with support from HICPAC (the Hospital Infection Control Practices Advisory Committee), recommends that healthcare institutions ensure that all healthcare personnel have evidence of immunity against varicella.</p> <p>2. Personnel file review on 7/16/12 and 7/18/12 indicated that E#1, E#5 and E#6 (RNs) and E#7 (CST) lacked documentation to indicate immunity against varicella.</p>	S0442	<p>S 442 All staff who have utilized self attestation for varicella immunity have had their attestations signed/verified by a physician. In order for surveyors to quickly locate Employee Proof of Varicella Immunity, we have copied all related paperwork and created a separate binder named "Employee Health Immunization Documentation" on 07/20/12. We have also assigned a nurse to separately monitor that all employee immunization data is current and enclosed in this binder. It is the responsibility of the Director to ensure that all immunization documentation is readily available to surveyors.</p>	07/20/2012
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S0526	<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.</p> <p>Based on personnel file review, the ASC failed to ensure that all nursing staff have competency assessed annually in point-of-care testing for 5 of 8 (E#1, E#4, E#5, E#6, E#8) nursing personnel.</p> <p>Findings include: 1. Personnel file review on 7/18/12 indicated that the files of E#1, E#4, E#5, and E#8 lacked documentation of competency assessment for glucometer and urine pregnancy testing and E#6 had documentation of glucometer and urine pregnancy test competencies dated January 2011.</p>	S0526	<p>S 526 All staff members who conduct point-of-care testing have had their education completed. This staff education took place on 08/17/2012. Since the survey, we have transferred all of our mandatory education modules to an online product provided by 'Heathstream'. We believe that by utilizing the online modules, we can ensure that all staff members' education remains up to date. It is the responsibility of the Director to ensure that all staff have current education up-to-date.</p>	08/17/2012			

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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 governing body failed to ensure that the medical staff credential files included a signed statement to abide by the rules of the center for 5 of 5 credentialed staff.</p> <p>Findings:</p> <p>1. Review of 5 credential files failed to indicate a signed statement to abide by the rules and bylaws of the center for the current period of reappointment 8-2011 to 8-2013.</p>	S0710	<p><u>S 710</u> We have corrected the physician reappointment applications to include a statement verifying that the physician reapplying for privileges agrees to abide by the rules of the Center. This correction was made on 08/17/2012. We believe that this will not occur again because the main reappointment template has been permanently changed, and all members of our credentials committee are aware of this change. It is the responsibility of the Director to ensure that all</p>	08/17/2012			

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	2. During interview on 7-18-12 at 1640 hours, staff A1 confirmed that the reappointment applications lacked a signed statement to abide by the rules and bylaws of the center.		reappointed members have their applications completed properly.	

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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 lacked a provision indicating 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 Protocol for Dispensing Prescription Drugs/Take Home Meds (revised 8-11) failed to indicate the physician responsibility of instructing the patient on the use of take home medication.</p> <p>2. On 7-18-12 at 1630 hours, staff A1 confirmed that the policy/procedure failed to indicate the physician responsibility for patient instruction when a medication is</p>	S1040	<p>S 1040 The Center currently has numerous policies which describe the physician's involvement in educating the patient in discharge, prescriptions, and care. Our current policy 8.01 which has been in effect at our facility since 09/1998 states "Take home medications are prescribed by the attending physician and instructions for use of medications is explained to patients by the same physician." This language has been clarified to read "It is the prescribing practitioner's responsibility to explain to the patient the use of any take home medications." It is the responsibility of the Director to ensure that all policies and procedures contained within the Policy & Procedure Manuals are current. We believe that we are</p>	08/20/2012	

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	dispensed.		now in full compliance.	

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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 and maintain the immediate availability of eye wash station equipment if needed.</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 within the work area for immediate emergency use. "</p> <p>2. During a tour on 7-16-12 at 1300</p>	S1146	<p>S 1146</p> <p>An additional eye-wash station has been installed. The current eye-wash station checklist has also been updated to contain both eye-wash stations. We have also assigned our fulltime circulator to oversee the completion of this check-off list on a weekly basis. This deficiency was corrected on August 13, 2012. It is the responsibility of the Director to ensure that this has been accomplished. See attachment #10.</p>	08/13/2012			

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	<p>hours, accompanied by staff A2, the following condition was observed in the gross decontamination room: lack of an available eye wash station.</p> <p>3. During a tour on 7-17-12 at 1330 hours, accompanied by staff A1, the following was observed outside of OR3: documentation indicating that weekly eye wash station checks had not been performed since 10-25-11.</p> <p>4. During interview on 7-17-12 at 1330 hours, staff A4 confirmed that weekly eyewash station testing had not been performed since moving into the new center location.</p> <p>5. During interview on 7-17-12 at 1335 hours, staff A1 confirmed that an eyewash station was not immediately available to staff working in the instrument decontamination area in the event of an emergency.</p>				

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S1162	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(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>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: Based on document review, observation and interview, the center failed to ensure that its patient care equipment was maintained in good working order for 1 of 3 radiology equipment in use at the center.</p> <p>Findings:</p> <p>1. Preventive maintenance documentation for 3 C-arms dated 3-25-12 failed to indicate concerns with power cords.</p> <p>2. During a tour on 7-17-12 at 1335 hours, the following condition was observed in OR 2: the power cord for an OEC 9600 C-arm showed evidence of a torn insulation jacket exposing the</p>	S1162	<p><u>S 1162</u></p> <p>On 07/23/2012, the power cord to the OEC 9600 was repaired. A fulltime staff x-ray technologist has been assigned the duty of assisting Dr.Beltz, our Radiation Safety Officer. It is the responsibility of the Director to ensure that equipment has been properly repaired. See attachment #11.</p>	07/23/2012			

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	<p>individual conductors near the connection of the wiring to the equipment.</p> <p>3. During an interview on 7-17-12 at 1335 hours, staff A1 confirmed that the equipment power cord was damaged and required service prior to use.</p>				

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S1180	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on document review and interview, the center failed to establish a safety management program that included a review of safety functions by a committee appointed by the chief executive officer and included representatives from administration and patient care services.</p> <p>Findings:</p> <p>1. On 7-16-12 at 0930 hours, staff A1 was requested to provide documentation of a safety management program including committee minutes and none was provided prior to exit.</p> <p>2. The policy/procedure Safety Management Plan (revised 8-11) failed to ensure that a committee with representatives from administration and patient care would perform a review of safety functions and failed to indicate a frequency for safety committee meetings.</p>	S1180	<p><u>S 1180</u> Historically, safety committee meeting minutes have been included in the monthly staff meeting minutes, and then forwarded to QA. On 08/13/12, a staff meeting occurred to discuss giving the safety committee a more formal committee structure. This committee will meet at least quarterly and be composed of a minimum of one nurse, one central supply staff member, and one administrative member. The initial meeting took place on 08/13/12, and formal meeting minutes were taken. The safety management plan and QA plan were also revised to include that members from each area (nursing and administration) are included in the safety committee. The safety committee is accountable for patient, public, visitor and healthcare worker safety issues and problems. This revision was completed on</p>	08/13/2012			

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	<p>3. The policy/procedure Committee Members (revised 8-11) failed to indicate a Safety Committee among the listed committees with representatives from administration and patient care.</p> <p>4. During interview on 7-18-12 at 1025 hours, staff A1 confirmed that the center lacked a safety management program that reviewed safety functions and lacked documentation of periodic safety committee meetings with representatives from administration and patient care services.</p>		08/13/12. It is the responsibility of the Director to ensure that the safety committee function properly. See attachment #12.		

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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 upon document review and interview, the safety management program failed to establish an organized committee process to evaluate and collect information about hazards and safety practices.</p> <p>Findings:</p> <p>1. The policy/procedure Safety Management Plan (revised 8-11) failed to ensure that the safety committee process for evaluating hazards and safety practices included the following:</p> <p>A. a discussion of the subject areas reviewed by committee</p> <p>B. committee recommendations for the reported subject areas if indicated</p> <p>C. committee actions to correct and improve center safety if indicated</p> <p>D. follow-up reporting for committee actions</p> <p>E. discussion of center safety</p>	S1182	<p><u>S 1182</u></p> <p>Historically, safety committee meeting minutes have been included in the monthly staff meeting minutes, and then forwarded to QA. On 08/13/12, a staff meeting occurred to discuss giving the safety committee a more formal committee structure. This committee will meet at least quarterly and be composed of a minimum of one nurse, one central supply staff member, and one administrative member. The initial meeting took place on 08/13/12, and formal meeting minutes were taken. The safety management plan and QA plan were also revised to include that members from each area (nursing and administration) are included in the safety committee. The safety committee is accountable for patient, public, visitor and healthcare worker safety issues and problems. This revision was completed on 08/13/12. It is the responsibility of</p>	08/13/2012	

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	<p>assessments with recommendations if indicated</p> <p>2. The Quality Assurance Plan (revised 12-10) failed to incorporate the safety committee functions with accountability for patient, public, visitor and health care worker safety issues and problems. The 2011 Quality Assurance Committee minutes for Maintenance/ Safety Building failed to indicate a group discussion of ongoing patient safety processes and activities.</p> <p>3. During interview on 7-18-12 at 1030 hours, staff A1 confirmed that the Safety Management Plan lacked the indicated provisions.</p>		<p>the Director to ensure that the safety committee function properly. See attachment #12.</p>		

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S1184	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 2.5-7(c)(3)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(3) The safety program includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety.</p> <p>Based on document review and interview, the safety management program failed to address patient safety as a primary element of the program.</p> <p>Findings:</p> <p>1. The policy/procedure Safety Management Plan (revised 8-11) failed to indicate that a primary function of the safety program is to assure patient safety and failed to indicate specific elements for addressing patient safety through the safety program. The Plan failed to address patient safety as well as public and visitor safety.</p> <p>2. During an interview on 7-18-12 at 1050 hours, staff A1 confirmed that the safety management plan failed to address patient safety as a primary element of the safety program.</p>	S1184	<p>S 1184</p> <p>Although our Safety Management Plan covers patient, staff and visitor safety, the surveyor wanted the exact wording "primary function of the safety plan is to assure patient, staff, and visitor safety" to be included in the plan. As of 08/13/12, this wording has been added. It is the responsibility of the Director to ensure that this has been accomplished. See attachment #12.</p> <p>** Please note attachment #12 is actually a copy of two safety policies. Policy #14.01 & 14.15.</p>	08/13/2012	

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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 provisions for a standard response in the event of an emergency.</p> <p>Findings:</p> <p>1. The policy/procedure Fire Safety Plan (no review date) failed to indicate the following:</p> <p>A. a standard process for alerting all staff in the event of a fire or other emergency B. the current fire suppression system provider C. a location for staff and patients to assemble following evacuation D. a provision for conducting fire drills</p>	S1188	<p><u>S 1188</u> On 08/13/12 the current Fire Safety Plan was reviewed and updated to include; a standard process for alerting all staff in the event of a fire (sounding the fire alarm), listing Sonitrol as our current fire suppression system provider, and a more detailed description of the location for staff and patients to assemble following evacuation. A provision for conducting fire drills is currently included in our Fire Safety Plan. Our plan has been updated to include our updated address and the sounding of the fire alarm on a quarterly basis. See attachment #13. It is the responsibility of the Director to ensure that this plan has been</p>	08/13/2012			

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	<p>2. The policy/procedure Disaster Plan (revised 8-11) failed to indicate the current address of the center when contacting the fire dispatcher by telephone and failed to indicate a current location for staff to assemble upon evacuation.</p> <p>3. The policy/procedure Life Safety Management Plan (revised 8-11) failed to ensure that performance of a quarterly fire drill included sounding the fire alarm.</p> <p>4. During an interview on 7-18-12 at 1415 hours, staff A1 confirmed that the fire alarm was not activated during the 1-06-12 fire drill and confirmed that the policy/procedures had not been maintained.</p>		updated.		

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S1210	<p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1)</p> <p>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:</p> <p>(1) Radiology services must be supervised by a radiologist or radiation oncologist.</p> <p>Based upon document review and interview, the center failed to ensure that its radiology services were supervised by a radiologist.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 7-16-12 at 0930 hours, staff A1 was requested to provide documentation indicating that ongoing supervision of the radiologic services was provided by a radiologist credentialed by the medical staff and none was provided prior to exit. Review of 2011 and 2012 radiation dosimetry reports failed to indicate that a review by a radiologist had been performed in 2011 or 2012 and no documentation of radiation monitoring was provided for the period 7-01-11 to 9-30-11 prior to exit. During interview on 7-18-12 at 1325 	S1210	<p>S 1210 The Center's Radiologic Services are supervised by a licensed radiologist, Dr. Homer Beltz. Attachment #14 is proof of his last consultation, which occurred on 08/29/2011. At time of survey, this document was erroneously not presented to surveyors. Surveyors did review the Radiologist contract, physicist reports, radiation dosimetry reports (via Landauer reports Attachment#17), radiology technologist licenses and proof of training. Our Center was very busy on date of survey, thus our fulltime radiology technologist was not immediately available. Dr. Beltz will be conducting another site visit within the next 30 days, as scheduled. In order to prevent missing paperwork in the future, we have assigned an additional x-ray tech to assist in our bookkeeping effort. All paperwork was located and a</p>	07/20/2012			

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	hours, staff A1 confirmed that the center lacked documentation of radiology services supervision by a radiologist.		separate binder was created on 07/20/12. It is the responsibility of the Director to ensure that all paperwork be accessible to surveyors 24-7.		

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S1222	<p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(e)</p> <p>(e) Safeguards for patients, personnel, and public must be specified, including, but not limited to, the following:</p> <p>(1) Proper safety precautions must be maintained against radiation hazards in accordance with the center's radiation and safety program(s).</p> <p>(2) Hazards and faulty equipment identified must be promptly corrected in accordance with current standards of practice and applicable federal and state rules, including, but not limited to, collimation and filtration and evaluations of equipment performance.</p> <p>Based on document review, the center failed to ensure that proper radiation safety precautions were maintained and that services were monitored and reported through the safety program.</p> <p>Findings:</p> <p>1. The policy/procedures Radiologic Services (revised 8-11) lacked the following provisions:</p> <p>A. periodic review of radiation badge reports by the safety committee and the supervising radiologist</p> <p>B. a specific location for wearing radiation monitoring badges on surgical</p>	S1222	<p>S 1222 The Center's Radiologic Services are supervised by a licensed radiologist, Dr. Homer Beltz. Attachment #14 is proof of his last consultation, which occurred on 08/29/2011. At time of survey we were unable to locate this document because we were very busy and our fulltime radiology technologist was not immediately available. Surveyors did review the Radiologist contract, physicist reports, radiation dosimetry reports, and radiology technologist licenses and proof of training. On 07/20/2012 our radiation policy was updated to include; badge location, badge storage and lead testing. Please see attachment</p>	07/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001046	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/18/2012
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	<p>attire when exposure to ionizing radiation is anticipated</p> <p>C. a center location for proper storage of monitoring badges when not in use</p> <p>D. periodic testing of protective lead shielding</p> <p>2. During an interview on 7-18-12 at 1325 hours, staff A1 confirmed that the policy/procedure lacked the indicated safety provisions and failed to ensure that services were monitored and reported through the safety program.</p>		<p>#15. In order to prevent missing paperwork in the future and ensure that our radiation policy remain up-to-date, we have assigned an additional x-ray tech to assist in our bookkeeping effort. It is the responsibility of the Director to ensure that all policies remain current and monitored through the safety program.</p>		