

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/14/2012	
NAME OF PROVIDER OR SUPPLIER ELKHART DAY SURGERY, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2746 OLD US HIGHWAY 20 WEST ELKHART, IN 46514			
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S0000	<p>The visit was for an initial licensure survey.</p> <p>Facility Number: 012596</p> <p>Survey Dates: 6-12-12 thru 6-14-12</p> <p>Surveyor: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/21/12</p>			S0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on document review and interview, the center failed to follow its policy/procedure ensuring that all direct care staff maintain Cardiopulmonary Resuscitation (CPR) competency for 2 of 7 personnel files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> The Elkhart Day Surgery job descriptions titled Instrument Technician and Preop/PACU RN indicated a requirement for current BLS (Basic Life Support) documentation of CPR competency. Personnel files for staff A5 and staff A9 lacked evidence of current CPR competency. During an interview on 6-13-12 at 	S0162	<p>(G) 1.CPR class will be provided for deficient employees on. Those staff members will not be involved in direct patient care until CPR class completed successfully. CPR provider card have been placed in personnel file.</p> <p>(G) 2. Documentation indicating completed CPR course placed in employees personnel file.</p> <p>(G) 3. Documentation indicating completed CPR course placed in employees personnel file.</p> <p>This deficiency, will be prevented from recurrence with the use of perpetual calendar of all staffs' licensure and certifications.</p> <p><u>Responsibility:</u> Clinical Director</p>	06/29/2012			

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	1645 hours, staff A2 confirmed that the 2 staff files lacked the indicated documentation.				

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S0226	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review, the center failed to maintain a list of all contracted services, including the scope and nature of services provided, for 5 of 24 services.</p> <p>Findings:</p> <p>1. Review of a list of contracted services provided by staff A2 failed to indicate a specific service provider for (2) fire systems and equipment providers, a medical records consultant, a microscope provider and a surgical device provider.</p> <p>2. During an interview on 6-14-12 at 1435 hours, staff A2 confirmed that the list of contracted services lacked the indicated contracted service providers.</p>	S0226	<p>(3)1.List of contracted services compiled including; vendor name, contact name, phone number, issue date,and service schedule, renewal date of services including but not limited to: fire systems, and equipment providers, a medical records consultant, a microscope provider and a surgical device provider.</p> <p>(3) 2. A facility compliance calander has been initiated along with a service schedule that has been established to indicate the frequency to which contracted services will be provide to Elkhart Day Surgery. This will be tracked through a new sign in system monitoring day, date and service. This will include but not limited to: fire sytems, equipment providers, medical record consultants, microscope providers, and surgical device provider. To maintain this calendar, a perpetual list of contracted services, issue dates</p>	07/05/2012			

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			and renewal dates will be kept. Per policy and procedure, all facility contracts are reviewed/approved annually by the Medical Advisory Committee and the Governing Body. Responsible: Clinical Director		

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S0320	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the center failed to ensure that the discharge function was reviewed through its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assessment and Performance Improvement (approved 5-12) failed to indicate that the discharge function would be included in the assessment and evaluation of patient care through the QAPI program.</p> <p>2. During an interview on 6-14-12 at 1640 hours, staff A2 confirmed that the policy/procedure lacked the indicated provision.</p>	S0320	<p>(2) (A) 1. Discharge and transfer are part of the QAPI program. In policies approved by the Governing Body on 5/12/12, the Performance Improvement Measures specify the following as indicators:</p> <ul style="list-style-type: none"> · Number of patients who are transferred or admitted to a hospital prior to discharge from the facility · Percentage of patients served whom receive discharge instructions and education specific to their procedure · Percentage of patient responses which express patient satisfaction with the delivery of service experienced in this facility · Percentage of patients which are assessed and discharged by a physician <p>The QAPI program includes Peer Review. The Peer Review/Utilization Review policy includes review of all emergency transfers. Should an adverse event occur during discharge, an incident report would be completed and included in the QAPI program as outlined in policies.</p> <p>This information was reviewed with the staff, the QAPI Committee and the Governing Body to ensure the understanding of the requirement and policy.</p>	07/02/2012			

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			<p>This deficiency, with respect to the policy, will not recur policies only be revised after review and approval by the Governing Body. The Governing Body is aware of that this policy must be in place and implemented.</p> <p>Responsible: QAPI Coordinator and Governing Body</p> <p>(2) (A) 2. Discharge and Transfer are part of the QAPI program. In policies approved by the Governing Body on 5/12/12, the Performance Improvement Measures specify the following as indicators:</p> <ul style="list-style-type: none"> · Number of patients who transferred or admitted to a hospital prior to discharge from the facility · Percentage of patients served whom receive discharge instructions and education specific to their procedure · Percentage of patient responses which express satisfaction with the delivery of service experienced in this facility · Percentage of patients which are assessed and discharged by a physician <p>The QAPI program includes Peer Review. The Peer Review/Utilization Review policy includes review of all emergency transfers. Should an adverse event occur during discharge, an incident report would be completed and included in the QAPI program as outlined in policies.</p> <p>The information was reviewed with the staff, the QAPI Committee and the Governing Body to ensure the understanding of the requirement and policy.</p> <p>This deficiency, with respect to the policy, will not recur policies will only be revised Cont.S320 after review and approval by the Governing Body. The Governing Body is aware of that this policy must be in place and implemented.</p> <p>Responsible: QAPI Coordinator and Governing Body</p>		

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S0400	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and interview, the center failed to ensure a safe and healthful environment that minimized risk and infection exposure to patients, staff, and visitors for 7 occurrences during one patient tracer observation.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure IV access (approved 5-12) failed to indicate a requirement to perform hand sanitation before applying gloves and promptly upon removal of gloves. During an observation on 6-12-12 at 1320 hours, staff A5 failed to perform hand hygiene prior to attempting IV access. At 1330 hours, staff A5 removed used gloves and applied new gloves without performing hand hygiene. During an observation on 6-12-12 at 1330 hours, staff A6 was observed applying gloves without first performing hand hygiene. 	S0400	<p>Infection Control Program</p> <p>(a)1. The Policy "IV Access" was amended to include the requirement to perform hand hygiene before applying gloves and promptly upon removal of gloves. This policy was reviewed and approved by the Governing Body.</p> <p>The deficiency, with respect to policy, will not recur, as policies will only be revised after review and approval by the Governing Body. The Governing Body is aware that this policy must be in place and implemented.</p> <p>Responsible: Infection Control Coordinator and Governing Body</p> <p>(a)2. Inservice to review hand hygiene policy and procedure.</p> <p>(a)3. Inservice to review hand hygiene procedure.</p> <p>(a)4. Inservice to review hand hygiene procedure.</p> <p>(a)5. "Keep door closed" sign added to door surface. Instructed personnel to keep door closed during cleaning of instrumentation.</p> <p>(a)6. Inservice to review proper disposal of used gloves.</p> <p>(a)7. Alcohol based hand sanitizer without fragrance to be purchased for facility and approved at board meeting on 7/2/12. Non-fragrant hand sanitizer placed in patient care areas as alternative to</p>	07/02/2012			

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	<p>4. During an observation on 6-12-12 at 1435 hours, in the surgical suite, a staff nurse was observed removing their used gloves and applying new gloves without performing hand hygiene.</p> <p>5. During an observation on 6-12-12 at 1440 hours, in the area for instrument cleaning and decontamination, the surgical technician was observed cleaning surgical instruments without first closing the door to the decontamination room.</p> <p>6. During an observation on 6-12-12 at 1540 hours, in the PACU area of the center, a discarded glove was observed on the countertop adjacent to a computer terminal.</p> <p>7. During an interview on 6-12-12 at 1605 hours, staff A6 confirmed that they had not performed hand hygiene prior to applying gloves due to an indication of fragrance in the alcohol-based hand sanitizer available in the center.</p> <p>8. During an interview on 6-12-12 at 1610 hours, staff A2 confirmed that the policy/procedure lacked the indicated hand hygiene provisions and confirmed that the nursing staff had failed to perform the indicated hand hygiene.</p>		<p>regular hand sanitizer.</p> <p>(a)8. The policy "IV Access" was amended to include the requirement to perform hand hygiene before applying gloves and promptly upon removal of gloves. The policy was approved by the Governing Body. The staff were in serviced on proper hand hygiene.</p> <p>Infection Control coordinator will perform undisclosed hand hygiene monitoring surveillance over next 3 weeks for all employees to prevent recurrence of deficiency.</p> <p>The Governing Body is aware that this policy must be in place and implemented.</p> <p>With respect to implementation, the Infection Control Coordinator will conduct periodic hand hygiene surveillance and report results to the QAPI Committee and Governing Body.</p> <p>Responsible: Infection Control Coordinator and Governing Body.</p>				

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S0408	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(d)</p> <p>(d) The center shall designate a person qualified by training or experience as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases.</p> <p>Based on document review and interview, the center failed to designate a person qualified by training or experience in infection control as responsible for the ongoing infection control activities.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the personnel file for staff A2 failed to indicate ongoing training or experience in infection control. 2. During an interview on 6-14-12 at 1020 hours, staff A2 confirmed that they were the infection control officer for the center and confirmed that the personnel file lacked documentation of ongoing training, experience, or certification in infection control. 	S0408	<p>(d) 1. Governing body approval for Infection Control Coordinator to receive further training and maintain CEU's related to infection control. Initial training documentation in personnel file regarding initial infection control training. (d) 2 Governing body approval for Infection Control Coordinator to receive further training and maintain CEU's related to infection control. Initial training documentation in personnel file regarding initial infection control training. The Governing Body reviewed job description of Infection Control Coordinator and will maintain ongoing education and training of infection control. Responsibility: Infection Control Coordinator and Governing Body.</p>	07/02/2012			

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S0428	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation.</p> <p>Based on document review, observation and interview, the infection control (IC) committee failed to maintain its sanitation policy/procedures and failed to ensure that the operating room (OR) cleaning was performed in a safe and effective manner according to generally accepted infection control principles and the policy/procedures of the center.</p> <p>Findings:</p> <p>1. The policy/procedure Environment: Housekeeping Standards (approved 5-12) and Environment: OR Sanitation (approved 5-12) failed to indicate if contracted housekeeping personnel or center staff were responsible for terminal OR room cleaning.</p> <p>2. During an interview on 6-13-12 at 1140 hours, staff A2 confirmed that the</p>	S0428	<p>(E) (i) 1. The policy states "housekeeping personnel" in order to address whomever is performing the housekeeping services at the ASC (employee vs. contracted service). The job description of the OR RN states the responsibility of cleaning the OR. Staff were in serviced on proper performance of OR cleaning.</p> <p>(E) (i) 1. The Governing Body reviewed and approved that the OR staff are currently performing housekeeping services in the OR. This is indicated in the minutes.</p> <p>This deficiency, with respect to the policy, will not recur, as policies will only be changed after review and approval by the Governing Body. The Governing Body is aware this policy must be in place.</p> <p>Responsible: Clinical Director and Governing Body</p> <p>(E) (i) 2. The policy states" housekeeping personnel" in order to address whomever is performing the housekeeping services at the ASC (employee vs. contracted service) . The job description of the OR RN states the responsibility of cleaning the OR. Staff were in serviced on proper performance of OR cleaning.</p> <p>The Governing Body reviewed and</p>	07/02/2012			

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	<p>policy/procedures failed to indicate that center staff were responsible for OR cleaning between cases and terminal OR room cleaning.</p> <p>3. During a tour of the facility on 6-12-12 at 1530 hours, the following was observed in OR 1: several copies of two undated documents titled Between Case Cleaning and Daily Terminal Cleaning were observed on a countertop.</p> <p>4. During an interview on 6-12-12 at 1530 hours, staff A2 confirmed that the two cleaning procedures were being used by center staff as the procedural guide for cleaning the OR between cases and cleaning the OR at the end of the day.</p> <p>5. The policy/procedure Environment: OR Sanitation (approved 5-12) failed to indicate the cleaning processes described on the documents titled Between Case Cleaning and Daily Terminal Cleaning observed on tour.</p> <p>6. During an interview on 6-13-12 at 1140 hours, staff A2 confirmed that the two cleaning procedures titled Between Case Cleaning and Daily Terminal Cleaning failed to indicate approval for use by the IC committee and confirmed that the policy/procedure Environment: OR Sanitation failed to indicate the</p>		<p>approved that the OR staff are currently performing housekeeping services in the OR. This is indicated in the minutes.</p> <p>This deficiency, with respect to the policy, will not recur, as policies will only be changed after review and approval by the Governing Body. The Governing Body is aware this policy must be in place.</p> <p>Responsible: Clinical Director and Governing Body</p> <p>(E) (i) 3. New daily, between cases and end of day cleaning check list have been created to reflect the current P&P. Staff had in serviced on new form and OR cleaning</p> <p>E) (i) 4. New daily, between cases and end of day cleaning check list have been created to reflect the current P&P. Staff had in serviced on new form and OR cleaning</p> <p>(E) (i) 5. New daily, between cases and end of day cleaning check list have been created to reflect the current P&P. Staff had in serviced on new form and OR cleaning</p> <p>(E) (i) 6. The cleaning processes reflect the housekeeping policies that were approved by the QAPI Committee, which includes infection control (as stated in the QAPI program) and acts as "committee of the whole" on 5.12.12. The processes are used as a checklist by staff. The use of checklists and how they relate to policies was reviewed with the staff.</p> <p>This deficiency, with respect to the policy, will not recur as policies will only be changed after review and approval by the Governing Body. The Governing Body is aware that this policy must be in place.</p> <p>Responsible: Clinical Director and Governing Body.</p>				

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	<p>current OR cleaning processes in use at the center.</p> <p>7. The policy/procedure Environment: Housekeeping Standards (approved 5-12) indicated the following: " Operating Room and Procedure Room: End of Day ...the entire OR floor is exposed and mopped ...wipe all furniture and equipment in the OR suite, such as instrument table, kick buckets, mayo stand, trash container, surgery lights ... "</p> <p>8. During an interview on 6-13-12 at 1140 hours, staff A2 confirmed that the policy/procedure had not been maintained and failed to indicate the current process for terminal OR cleaning.</p>		<p>(E) (i) 7 New daily, between cases and end of day cleaning check list have been created to reflect the current P&P. Staff had in serviced on new form and OR cleaning</p> <p>(E) (i) 8. Will use cleaning process for terminal cleaning per policy. Staff were in serviced on proper performance of OR terminal cleaning.</p> <p>This deficiency, with respect to the policy, will not recur as this policy will be reviewed by the Governing Body. The Governing Body is aware that this policy must be in place.</p> <p>Responsible: Clinical Director and Governing Body</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 document review and interview, the employee health program failed to determine the communicable disease status for all new personnel at the center for 4 of 9 personnel.</p> <p>Findings:</p> <p>1. The policy/procedure Employee Health Program (approved 5-12) indicated the following: "New employee health screening will be performed before the employee begins workproof of vaccination or titer for measles, mumps, varicella and rubella ..."</p> <p>2. Personnel health files for staff A7, A9, and A12 lacked documentation regarding</p>	S0442	<p>S442 (E) 1. The policy "Employee Health Program" to include the requirement that all staff requires a doctor's note, proof of vaccination or titer for measles, mumps, varicella, and rubella. This policy was reviewed and approved by the Governing Body. The deficiency, with respect to policy, will not recur, as this policy will be reviewed by the Governing Body. The Governing Body is aware that this policy must be in place and implemented. Responsible: Clinical Director, Medical Director, Governing Body (E) 2. Three employees received titers and immunization for communicable diseases per policy. Results of titers and verification of immunization placed in personnel</p>	07/02/2012			

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	<p>communicable disease status for measles, varicella and rubella and the personnel file for staff A8 lacked documentation regarding measles.</p> <p>3. During an interview on 6-13-12 at 1010 hours, staff A2 confirmed that the health files lacked the required documentation.</p>		<p>files. The deficiency, will not recur, as employee files will be reviewed and approved by the Clinical director at the time of employment. Responsible: Clinical Director, Medical Director, Governing Body(E) 3. Three employees received titers and immunization for communicable diseases per policy. Results of titers and verification of immunization placed in personnel files. The deficiency, will not recur, as employee files will be reviewed and approval by the Clinical director and at the time of employment. Responsible: Clinical Director, Governing Body</p>				

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S0780	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based upon document review and interview, the center lacked a uniform policy/procedure for authenticating verbal orders in the medical record (MR) and lacked a provision ensuring authentication was performed in compliance with center policy.</p> <p>Findings:</p> <p>1. The policy/procedure Verbal and Telephone Orders (approved 5-12) indicated the following: " The prescribing practitioner must sign the written record of the verbal/telephone order within forty-eight (48) hours of giving the order. " The policy/procedure lacked a provision to date and time the</p>	S0780	<p>(3) (N) (1) The policy/procedure "Verbal and Telephone Orders" was amended to include a provision to date and time the entry by the prescribing physician. The Governing Body reviewed and approved the revised policy/procedure. An inservice was given to the staff regarding this revised policy/procedure. This deficiency, with respect to the policy, will not recur as policies will only be changed after review and approval by the Governing Body. The Governing Body is aware that this policy must be in place. Responsible: Clinical Director and Governing Body3)</p> <p>(N) (2) The policy/procedure "Verbal Telephone Orders" was amended to include a provision to date and time the entry by the</p>	07/02/2012			

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	<p>entry by the prescribing practitioner when authenticating the order to validate compliance with the policy/procedure.</p> <p>2. During an interview on 6-14-12 at 1430 hours, staff A2 confirmed that the policy/procedure lacked the indicated provision to validate compliance with center policy.</p>		<p>prescribing physician. The Governing Body reviewed and approved the revised policy/procedure. An inservice was given to the staff regarding this revised policy/procedure. This deficiency, with respect to th policy, will not recur as policies will only be changed after review and approval by the Governing Body. The Governing Body is aware that this policy must be in place. Responsible: Clinical Director and Governing Body</p>				

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S1020	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(D)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(D) Reporting of adverse reactions and medication errors to the practitioner responsible for the patient and the appropriate committee, and documented in the patient's record.</p> <p>Based on document review and interview, the center failed to ensure that medication errors would be documented in the patient record.</p> <p>Findings:</p> <p>1. The policy/procedures Medication Errors (approved 5-12) failed to indicate a requirement to document in the patient record when a medication was administered in error.</p> <p>2. During an interview on 6-14-12 at 1430 hours, staff A2 confirmed the policy/procedures lacked the requirement to document in the patient record.</p>	S1020	<p>S1020 (3) (D) 1. This policy/procedure "Medication Errors" was amended to include documentation in the patient record. The Governing Body reviewed and approved this revision. The staff was inserviced on this revised policy/procedure.</p> <p>This deficiency, with respect to the policy, will not recur as policies will only change after review and approval by the Governing Body. The Governing Body is aware that this policy must be in place.</p> <p>Responsible: Clinical Director and Governing Body</p> <p>S1020 (3) (D) 2. This policy/procedure "Medication Errors" was amended to include documentation in the patient record. The Governing Body reviewed and approved this revision. The staff was inserviced on this revised policy/procedure.</p> <p>This deficiency, with respect to the policy, will not recur as policies will only change after review and approval by the Governing Body. The Governing Body is</p>	07/02/2012			

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			<p>aware that this policy must be in place.</p> <p>Responsible: Clinical Director and Governing Body</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 composed of members appointed by the chief executive officer including representatives from administration and patient care services and ensure that the committee met regularly in accordance with program requirements.</p> <p>Findings:</p> <p>1. On 6-12-12 at 1130 hours, staff A2 was requested to provide documentation of a safety management program and a job description for the safety coordinator/safety officer and none was provided prior to exit.</p> <p>2. The policy/procedure Safety Management and Responsibility (approved 5-12) failed to indicate the</p>	S1180	S1180 (C) (1) 1. A comprehensive safety management program exists and includes security, hazard vulnerability analysis, utility failures and safety, patient safety goals, safety in the OR, fire in the OR, overall fire plan, disaster plan, equipment safety, laser safety, physical plant safety and maintenance, risk assessment specific to safety and security risks, and laser safety. From this deficiency, it became apparent that re-orientation was needed for the designated safety officer. A job description was developed, reviewed and approved by the Governing Body, and presented to the Safety Officer Cont (C) (1) 1. who signed the acknowledgement of the job description. The Safety Officer was re-oriented to the safety management program and her duties. The safety program was amended to include committee membersTo prevent recurrence	07/02/2012			

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	<p>composition of the safety committee and failed to indicate how often the committee would meet to conduct committee business.</p> <p>3. During an interview on 6-13-12 at 1345 hours, staff A4 confirmed that the center lacked a safety management program including the indicated committee membership, meeting provisions, and job description for the safety officer.</p>		<p>of this issue, the Clinical Director will evaluate the safety report given by the safety officer to ensure this individual is fully aware of her responsibilities and is implementing policies/procedures as required. Responsible: Clinical Director and Governing BodyC) (1) 2. The Safety Program state that safety management and reporting are part of the QAPI process and the QAPI Program states that safety will be monitored during it's process. This agenda for a "meeting of a whole" was approved by the Governing Body on 5/12/12. The QAPI committee was approved by the Governing Body on 5/12/12. QAPI will be conducted as a "meeting of the whole" due to the size of the staff and the fact that all staff will be on the same committees. This information was reviewed with the staff, QAPI Committee and Governing Body. Then amendment was made to the safety program to include committee members To prevent recurrence of this issue, the Clinical Director will evaluate the safety report given by the safety officer to ensure this individual is fully aware of her responsibilities and is implementing policies/procedures as required. This will prevent the recurrence of this issue. Responsible: Clinical Director (C) (1) 3. A comprehensive safety management program exists and</p>				

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			includes security, hazard vulnerability analysis, utility failures and safety, patient safety goals, safety in the OR, fire in the OR, overall fire plan, disaster plan, equipment safety, laser safety, physical plant safety and maintenance, risk assessment specific to safety and security risks, and laser safety. From this deficiency, it became apparent that re-orientation was needed for the designated safety officer. A job description was developed, reviewed and approved by the Governing Body, and presented to the Safety Officer who signed the acknowledgement of the job description. This information was reviewed with staff, QAPI Committee and Governing Body. To prevent recurrence of this issue, the Clinical Director will evaluate the safety Cont S1180 report given by the safety officer to ensure this individual is fully aware of her responsibilities and is implementing policies/procedures as required. This will prevent the recurrence of this issue. Responsibility: Clinical Director	

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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 center failed to develop a safety management program that indicated an ongoing, center wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Findings:</p> <p>1. On 6-12-12 at 1030 hours, staff #A4 was requested to provide documentation of a safety management program indicating the committee process to collect and evaluate information about safety practices and hazards and none was provided prior to exit.</p> <p>2. Information provided for survey review failed to indicate a safety program or center-wide plan for evaluating safety practices and hazards by committee. The center failed to establish a formal framework for integrating several center practices into an organized process.</p> <p>3. During an interview on 6-13-12 at 1345 hours, staff A4 confirmed that the center failed to develop a written safety management program that demonstrated an ongoing, organized process for evaluating safety issues and problems to ensure a safe environment for patients,</p>	S1182	S1182 (c) (2) 1. A comprehensive safety management program exists and includes security, hazard vulnerability analysis, utility failures and safety, patient safety goals in the OR, fire in the OR, overall fire plan, disaster plan, equipment safety, laser safety, physical plant safety and maintenance, risk assessment specific to safety and security risks, and laser safety. From this deficiency, it became apparent that a re-orientation was needed for the designated safety officer. Hazards and risks are clearly outlined in the safety and security risk assessment, documented in the QAPI meeting minutes from 5/12/12. From this deficiency, it became apparent that a re-orientation was needed for the designated safety officer. The Safety Officer was re-oriented to the safety management program and her responsibilities. To prevent recurrence of this issue, the Clinical Director will evaluate the safety report given by the	06/18/2012			

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	staff members, and the public.		safety officer to ensure this individual is fully aware of her responsibilities and is implementing policies/procedures as required. Responsibility: Clinical Director (C) (2) 2. The formal framework is through the QAPI process and is documented in the QAPI program. Policies and forms were approved on 5/12/12 that outlined what to observe, how often, and when to report it. From this deficiency, it became apparent that re-orientation was needed for the designated safety officer. The Safety Officer was re-oriented to the safety management program and to her responsibilities. S1182 (c)(2) 2. To prevent recurrence of this issue, the Clinical Director will evaluate the safety report given to the safety officer to ensure this individual is fully aware of her responsibilities and is implementing policies/procedures as required. Responsible: Clinical Director (C)(2)3. A comprehensive safety management program exists and includes security, hazard vulnerability analysis, utility failures and safety, patient safety goals, safety in the OR, fire in the OR, overall fire plan, disaster plan, equipment safety, laser safety, physical plant safety and maintenance, risk assessment specific to safety and security risks and laser safety. The formal framework is through the QAPI process and is documented in the		

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			<p>QAPI program. Policies and forms were approved on 5/12/12 that outlined what to observe, how often, and when to report it. From this deficiency, it became apparent that a re-orientation was needed for the designated safety officer. The Safety Officer was re-oriented to the safety management program and to her responsibilities. To prevent recurrence of this issue, the Clinical Director will evaluate the safety report given by the safety officer to ensure this individual is fully aware of her responsibilities and is implementing policies/procedures as required.</p> <p>Responsible: Clinical Director</p>		