

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001164	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2016
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NAME OF PROVIDER OR SUPPLIER LAPORTE MEDICAL GROUP SURGICAL CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 900 I STREET, SUITE 1 LA PORTE, IN 46350
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S 0000 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 011718</p> <p>Survey Date: 2/01/2016 through 2/2/2016</p> <p>QA: cjl 02/29/16</p>	S 0000		
S 0162 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES</p> <p>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 chief executive officer failed to ensure 7 (#5, 6, 8, 9, 10, 11 and</p>	S 0162	S-0162-1,2,3 CPR Competency test was given to all physician's on 2/29/2016. CPR Competency test was completed and placed in	02/29/2016

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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S 0310	<p>12) of 8 physicians received annual competency in cardiopulmonary resuscitation (CPR).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of Governing Board Meeting and Medical Staff Committee Minutes of May 19, 2015 stated, "Physicians will be required to have BCLS (basic cardiac life support) written test and competency annually." Review of seven physician (#5, 6, 8, 9, 10, 11 and 12) credential files indicated lack of evidence of CPR competency. In interview at 2:00 PM on 2/2/2016, staff member #1 (Administrator) confirmed the above and no other documentation was provided prior to exit. <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND</p>		<p>their files. CPR competency test have now been added to our yearly competency list to be completed every January of the new year. The BCLS test is also used as their annual competency. The Administrator will be responsible to ensure this is done annually.</p>				

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Bldg. 00	<p>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 facility failed to ensure seven (7) (Bioengineering, Biohazard Waste Hauler, Housekeeping, Laundry/Linen, Maintenance, Pharmacy and Transcription) services provided by contractors were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the Continuous Quality Improvement Program (CQI) indicated all services with direct or indirect impact on patient care quality shall be evaluated for effectiveness. The CQI program was last approved May 4, 2015. Review of the facility's CQI minutes and dashboards indicated seven contracted services (Bioengineering, Biohazard Waste Hauler, Housekeeping, Laundry/Linen, Maintenance, Pharmacy and Transcription) were not evaluated on their effectiveness of the services that 	S 0310	S-0310 A Quality evaluation form has now been implemented for all contracted services and Completed on 2/29/2016. Quality Evaluation's will be completed initially and completed yearly. Quality Evaluation's will be reviewed by CQI and Governing board. The Administrator will ensure that the quality evaluation is completed annually.	02/29/2016	

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S 0404 Bldg. 00	<p>were provided.</p> <p>3. In interview at 10:45 AM on 2/2/2016, staff member #1 (Administrator) confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the facility failed to maintain a written, active, and effective center-wide infection control program related to monitoring of the employee health program and infection control techniques related to cleaning of operating room (OR) suites, failed to ensure an active,</p>	S 0404	S-404-1,2,4,5, Monthly the Certified surgical tech (CST) -Infection Control Liaison will monitor infection control technique of staff cleaning the OR suites and meet with Infection control officer on a Monthly basis to report findings. The CST and Infection control officer will have meeting minutes to take to CQI	02/29/2016	

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	<p>effective center-wide Tuberculosis (TB) infection control program and failed to ensure annual infection control inservices for 3 of 7 (17, 19 and 20) personnel files reviewed.</p> <p>Findings:</p> <p>1. Review of Job Function of Infection Control Officer (ICO) confirmed responsibilities of the ICO include:</p> <p>A. ensuring infection control policies and procedures are properly introduced and followed and for monitoring compliance.</p> <p>B. oversees the implementation and monitoring of the employee health program and compliance to annual testing and/or vaccinations.</p> <p>C. at least yearly and on an as needed basis, will conduct a staff infection control inservice.</p> <p>2. Policy #INFC.06, Infection Prevention & Control Program, revised/reapproved on 5/14/15 indicated on pg.:</p> <p>A. 2, under Purpose section, the infection control program is designed to provide processes for the infection prevention and control program among all areas within the facility and individuals within the organization.</p> <p>B. 3, under Supervision of the Infection Prevention and Control Program, the</p>		<p>for reporting of findings. The infection control job description has been updated. The Infection control officer will no longer oversee employee health program and compliance, annual testing or vaccinations. This has now been added to the director of nursing's job description. It Will be the DON's responsibility to ensure all employee's will have vaccination records upon hire. #4 Infection control in-services have been completed by all employees that were missing in-service and will be conducted for all staff annually in January. The DON will be responsible to ensure this is done annually. S-404-3 CDC TB risk assessment was completed by Infection control officer and will reviewed annually. Low risk was noted on assessment. Infection control officer will be responsible for performing risk assessment annually.</p>				

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	<p>Infection Prevention and Control Officer has been given the authority to implement and enforce the Infection Prevention and Control Program, infection prevention and control policies, coordinate all infection prevention and control within the facility and facilitate ongoing monitoring of the effectiveness of prevention and/or control activities and interventions.</p> <p>C. 9, under Surveillance and Monitoring, conducting or facilitating infection prevention and control rounds or focus reviews.</p> <p>D. 10, under Environmental Assessment/Surveillance, the Infection Prevention and Control Officer and Safety Officer will conduct periodic infection prevention and control rounds with follow-up required by based on the results of the rounds.</p> <p>3. Policy #HRHS.18, Tuberculosis Infection Control Program, revised/reapproved on 5/14/15 indicated, the purpose of the program is to ensure the facility remains a low risk for the transmission of TB.</p> <p>4. Review of personnel files confirmed personnel 17 (Medical Assistant), 19 (Registered Nurse) and 20 (Certified Surgical Technologist) lacked documentation of annual infection</p>			

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S 0420 Bldg. 00	<p>control inservice.</p> <p>5. Staff 3 (Infection Control Officer) was interviewed on 2/1/16 at approximately -1300 hours and confirmed the employee health program and infection control techniques of staff related cleaning of the OR suites is not being monitored by the ICO as required per facility policy and procedure.</p> <p>6. Staff 1 (Administrator) was interviewed on 2/2/16 at approximately -1420 hours and confirmed a TB risk assessment to determine facility is a low risk for transmission of TB was not completed and the above-mentioned personnel do not have documentation of annual infection control inservice as required per facility policy and procedure.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(B)</p> <p>The infection control committee responsibilities must include, but are not limited to, the following:</p> <p>(B) Recommending corrective action plans, reviewing outcomes, and assuring resolution of identified problems.</p> <p>Based on document review and interview, the facility failed to ensure the</p>	S 0420	We have reorganized our CQI meeting to ensure we will be able	02/29/2016	

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	<p>infection control committee responsibilities must include, but are not limited to, the following: recommending corrective action plans, reviewing outcomes and assuring resolution of identified problems for 6 of 6 infection control committee meetings.</p> <p>Findings include:</p> <p>1. Review of policy/procedure INFC.06, Infection Prevention and Control Program, revised/reapproved on 5/14/15 indicated:</p> <p>A. the CQI Committee will review and process surveillance data monitoring for trends in infections, clusters, infections due to unusual pathogens, or any occurrence of healthcare-associated infections that exceed facility expectations.</p> <p>B. the CQI Committee will recommend corrective action(s) and approve all proposals and protocols for special infection control studies.</p> <p>C. outcome and process surveillance data will be used to plan, implement, evaluate and improve infection prevention and control strategies.</p> <p>2. Review of Committee for Quality Improvement (CQI) meeting minutes dated 2/9/15, 4/15/15, 5/19/15, 6/17/15, 8/18/15 and 11/17/15 indicated lack of</p>		<p>review and process surveillance data that is presented to the CQI committee. This information will be used to plan, implement, evaluate, and improve the infection prevention and control process. The following is an Agenda of our CQI meeting to include all required data surveillance. The Administrator will ensure testing and competency is completed annually.</p>				

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S 0422 Bldg. 00	<p>the discussion of recommendations for corrective action plans, review of outcomes and resolutions of identified problems for infection rates and/or issues other than hand hygiene compliance.</p> <p>3. In interview, on 2/1/15 at approximately 1300 hours, staff 3 (Infection Control Officer) confirmed there was no documentation of the above-mentioned infection control committee responsibilities in the CQI meeting minutes dated 2/9/15, 4/15/15, 5/19/15, 6/17/15 and 11/17/15.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk. Based on document review and interview, the infection control committee failed to review employee exposure incidents and make appropriate recommendations to minimize risk for 1 of 1 (staff #21) sharps injury reviewed.</p> <p>Findings include:</p>	S 0422	S-0422-1,2,3,4 We have created a needle stick/exposure handbook. This hand book has policy and procedure for needle sticks/ exposures. The infection control officer will be responsible for this book. All needle stick/exposures will be followed through on and reported to Infection control officer as well as	02/19/2016

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	<p>1. Review of policy/procedure HRHS.14.F1, Individuals Responsible for Illness and Injury Prevention Plan, revised/reapproved on 5/14/15 indicated, the Infection Control Officer shall be responsible for the implementation and oversite review of the employee Illness and Injury Prevention Program for the hazards of the infection and bloodborne pathogen (exposure) control programs.</p> <p>2. Review of policy/procedure INFC.06, Infection Prevention and Control Program, revised/reapproved on 5/14/15 indicated the Infection Prevention and Control Officer:</p> <p>A. has been given the authority to implement and enforce the Infection Prevention and Control Program, infection prevention and control policies, coordinate all infection prevention and control within the facility and facilitate ongoing monitoring of the effectiveness of prevention and/or control activities.</p> <p>B. assists in evaluation of infection-related products and equipment.</p> <p>C. enforces sound infection prevention practices related to reducing potential exposures to blood and body fluids through appropriate use of personal protective equipment.</p> <p>D. outcome and process surveillance data will be used to plan, implement,</p>		<p>being entered into Incident reporting system for reporting and tracking. The infection control officer will document her evaluation and follow-up in the Incident reporting system Infection control officer will review and take any appropriate recommendations to CQI. Needle stick/exposures will also be reviewed by the governing board.</p>				

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S 0432 Bldg. 00	<p>evaluate, and improve infection prevention and control strategies.</p> <p>3. Review of sharps injury log indicated staff #21 (Registered Nurse) experienced a needle stick injury on 6/4/15.</p> <p>4. Committee for Quality Improvement (CQI) meeting minutes dated 6/17/15 documented the needle stick injury and follow up from Employee Health, but lacked documentation of evaluation and follow-up by Infection Control Officer.</p> <p>5. In interview, on 2/1/15 at approximately 1500 hours, staff 3 (Infection Control Officer) confirmed the Infection Control Officer failed to review the employee needle stick injury exposure incident and make appropriate recommendations to minimize risk.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending</p>			

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	<p>changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and interview, the facility failed to maintain a written, active and effective center-wide infection control program related to monitoring of instrument sterilization infection control practices.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of Job Function of Infection Control Officer (ICO) confirmed responsibilities of the ICO include ensuring infection control policies and procedures are properly introduced and followed and for monitoring compliance. Policy #INFC.06, Infection Prevention & Control Program, revised/reapproved on 5/14/15 indicated on pg. 9, under Surveillance and Monitoring, conducting or facilitating infection prevention and control rounds or focus reviews and monitoring sterilization and high level disinfection practices. Staff 3 (Infection Control Officer) was interviewed on 2/1/16 at approximately -1300 hours, and confirmed infection 	S 0432	S-0432-1,2,3 CST-infection control liaison monitors and documents cleaning, disinfection and sterilization. CST-infection control liaison then takes all information to the Infection control office at their monthly meeting. All items are reviewed together. Infection control officer then takes materials to CQI to review. Our governing board also reviews all materials at our board meetings.	02/19/2016

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S 0442 Bldg. 00	<p>control techniques of staff performing sterilization of instruments are not being monitored by the ICO as required per facility policy and procedure.</p> <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 infection control committee failed to ensure documentation of the communicable disease history and/or immunization status related to Tuberculosis (TB) for 7 of 7 (#2, 3, 14, 17, 18, 19 and 20) personnel records reviewed and rubella, rubeola, varicella and hepatitis B for 3 of 7 (#2, 19 and 20) personnel records reviewed.</p>	S 0442	<p>S-0442-1 Infection control officer job description has been revised and the overseeing of employee health files has been removed. The overseeing of employee health files will be overseen by the director of nursing.</p> <p>s-0442-3,4,5,6 New employee check off list are now located in each employees file to ensure all documents and vaccinations are collected for employment. All missing vaccinations have been collected and are in employee</p>	02/19/2016

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	<p>Findings:</p> <p>1. Review of Job Function of Infection Control Officer (ICO) confirmed responsibilities of the ICO include:</p> <p>A. ensuring infection control policies and procedures are properly introduced and followed and for monitoring compliance.</p> <p>B. oversees the implementation and monitoring of the employee health program and compliance to annual testing and/or vaccinations.</p> <p>2. Policy #INFC.06, Infection Prevention & Control Program, revised/reapproved on 5/14/15 indicated on pg.:</p> <p>A. 2, under Purpose section, the infection control program is designed to provide processes for the infection prevention and control program among all individuals within the organization.</p> <p>B. 3, under Supervision of the Infection Prevention and Control Program, the Infection Prevention and Control Officer (IPCO) has been given the authority to implement and enforce the Infection Prevention and Control Program, infection prevention and control policies, coordinate all infection prevention and control within the facility and facilitate ongoing monitoring of the effectiveness of prevention and/or control activities</p>		files. CDC TB risk assessment has been completed and will be completed annually. We are in a low risk area making initial TB test not a requirement. Annual TB questionnaires will be completed by each employee and placed in their employee files. The DON will be responsible for ensuring TB questionnaire done annually for all employees.				

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	<p>and interventions.</p> <p>C. 8, under Employee Health (EH) Program, the EH program involves interventions for reducing the risk of infection transmission, including recommendations for immunizations and testing for immunity. The IPCO will collaborate with the Chief Nursing Officer to implement the program in order to promote employee and patient safety. The program will include TB screening; immunization for hepatitis B and influenza; evaluation of post-exposure assessment to blood/body fluid exposures and/or other communicable diseases. The Centers for Disease Control & Prevention (CDC) Guidelines were used to guide the development of procedures for the Healthcare Worker Safety Guidelines.</p> <p>3. Review of CDC Recommended Adult Immunization Schedule and Guideline for Infection Control in Hospital Personnel indicated on pg. 2:</p> <p>A. point 4, Varicella vaccination: All adults without evidence of immunity to varicella (as defined below) should receive 2 doses of single-antigen varicella vaccine or a second dose if they have received only 1 dose...Evidence of immunity to varicella in adults includes any of the following: documentation of 2 doses of varicella vaccine at least 4</p>			

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	<p>weeks apart; U.S. (United States) born before 1980 except health-care personnel (HCP) and pregnant women; history of varicella based on diagnosis or verification of varicella disease by a health-care provider; history of herpes zoster based on diagnosis or verification of herpes zoster disease by a health-care provider; or laboratory evidence of immunity or laboratory confirmation of disease.</p> <p>B. point 7:</p> <p>a. Measles, mumps, rubella (MMR) vaccination: All adults born in 1957 or later should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, or laboratory evidence of immunity to each of the three diseases. Documentation of provider-diagnosed disease is not considered acceptable evidence of immunity for measles, mumps, or rubella.</p> <p>b. HCP born before 1957: For unvaccinated HCP born before 1957 who lack laboratory evidence of measles, mumps, and/or rubella immunity or laboratory confirmation of disease, health-care facilities should consider vaccinating personnel with 2 doses of MMR vaccine at the appropriate interval for measles and mumps or 1 dose of MMR vaccine for rubella.</p>			

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	<p>4. Policy #HRHS.18, Tuberculosis Infection Control Program, revised/reapproved on 5/14/15 indicated on pg.:</p> <p>A. 1, under Applicants for Employment section, as a condition of employment potential employees will receive TB skin testing or proof of skin testing.</p> <p>B. 2, under Applicants for Employment section, an employee who has proof of TB testing within the last 12 months will be required to complete the TB Skin Test Form annually.</p> <p>5. Review of Committee for Quality Improvement (CQI) meeting minutes dated 4/15/15 confirmed on pg. 2, under Employee Health section, board approved no yearly TB test needed for staff unless known exposure or new hire. Yearly TB questionnaire will be given to each employee in January and placed in their file.</p> <p>6. Review of personnel files confirmed:</p> <p>A. 2 (Registered Nurse [RN]) lacked documentation of annual TB testing; and communicable disease history and/or immunization status related to rubella, rubeola, varicella, and hepatitis B.</p> <p>B. 3 (RN) lacked documentation of annual TB testing.</p> <p>C. 14 (RN) lacked documentation of annual TB testing.</p>			

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	<p>D. 17 (Medical Assistant) lacked documentation of annual TB testing and an Employee Health Evaluation that included a TB questionnaire.</p> <p>E. 18 (RN) lacked documentation of annual TB testing.</p> <p>F. 19 (RN) lacked documentation of annual TB testing and an Employee Health Evaluation that included a TB questionnaire; and communicable disease history and/or immunization status related to rubella, rubeola, varicella, and hepatitis B.</p> <p>G. 20 (Certified Surgical Technologist) lacked documentation of annual TB testing and an Employee Health Evaluation that included a TB questionnaire; and communicable disease history and/or immunization status related to rubella, rubeola, varicella, and hepatitis B.</p> <p>7. Staff 1 (Administrator) was interviewed on 2/2/16 at approximately -1420 hours, and confirmed the TB infection control program policy states employees must show proof of TB testing to be able to complete the annual TB questionnaire. The above-mentioned employees do not have documentation of annual TB testing and/or communicable disease history or immunization status for rubella, rubeola, varicella, and hepatitis B as required per facility policy and</p>			

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S 0772 Bldg. 00	<p>procedure. The Board's decision on 4/15/15 to no longer require annual TB testing contradicts the TB Infection Control Program policy revised/reapproved 5/14/15 because the policy requires TB testing as a condition of employment, as well as requiring proof of TB testing prior to completing the annual TB questionnaire.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record</p>			

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	<p>with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review and interview, the facility failed to ensure a history and physical examination was performed in accordance with center policy related to documentation of current allergies for 3 of 20 (#7, 14 and 16) patient medical records reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Policy PMPA.05, History and Physical Requirements, revised/reapproved on 5/14/15 indicated, a history and physical examination must be done on every patient by an independent licensed practitioner and must include current allergies. 2. Review of patient medical records (MRs) confirmed patient #: <ol style="list-style-type: none"> A. 7 had a history and physical updated on day of surgical procedure 7/20/15 documenting allergy to Vancomycin. Front of patient's MR had no known allergies documented and allergy to Vancomycin directly above that. B. 14 had a history and physical updated on day of surgical procedure 11/10/15 documenting no known allergies. Front of patient's MR documented allergy to Sulfa. Pre-Op 	S 0772	S-0772-1,2,3 Allergies will be verified during pre op call and when patient is being checked in by pre op nurse. During these two episodes of care the nurse will confirm with patient, H&P, and chart that all allergies are consistent. If there is a discrepancy the nurse will notify the physician whom will confirm with patient. History and physical will be updated by physician and all documentation in chart will be updated to agree with history and physical. DON will be responsible for randomly pulling 20 charts per month for 6 months to verify allergies are correct. Data will be monitored by CQI committee.	02/20/2016			

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S 1024 Bldg. 00	<p>Calls/Screening form stated allergy to shellfish, but did not mention Sulfa allergy. Preoperative Assessment Form was blank for placement of allergy band.</p> <p>C. 16 had a history and physical updated on day of surgical procedure 12/2/15 documenting allergies not on file. Front of patient's MR, Pre-Operative Screening Form, and Recovery Room Record documented allergy to Codeine and Epinephrine.</p> <p>3. Staff 1 (Administrator) was interviewed on 2/2/16 at approximately -1420 hours, and confirmed patients #7, 14 and 16 had inconsistent documentation of allergies in MR and/or lacked documentation of current allergies on their history and physical prior to their surgical procedure as required per facility policy and procedure.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)</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>(E) Drugs must be accurately and</p>						

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	<p>clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following: Based on document review, observation and interview, the pharmaceutical service failed to implement and/or maintain written policies and procedures related to the safe storage of high risk/high alert medications in 1 of 3 (Post Anesthesia Care Unit [PACU]) areas toured.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of policy/procedure PMME.23, High-Alert Medications, revised/reapproved on 5/14/15 indicated: <ol style="list-style-type: none"> the facility shall monitor for high-alert medications and will follow proactive planning tips for preventing errors associated with the use of these medications. Quelicin, labeled as a paralyzing agent, has been identified as a "High Alert" medication and will be stored as such. While on tour of PACU 2/2/16 at approximately 1030 hours, accompanied by staff 14 (Registered Nurse [RN]), the following was observed in the medication fridge: succinylcholine (Quelicin) was stored along with non-high alert medications and not labeled as a high risk/high alert medication. This 	S 1024	S-1024-1,2,3 All high alert medications will be labeled upon putting the medication in the refrigerator after being checked in. This will ensure all high alert medicines will be labeled upon storage. Each item will be labeled not just container. The OR team lead is the designee. The director of nursing will do spot checks.	02/03/2016

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S 1188 Bldg. 00	<p>medication was also lacking a high-alert stop sign shaped sticker on the outside of the storage container.</p> <p>3. In interview, on 2/2/16 at approximately 1320 hours, staff 14 (RN) confirmed the above-mentioned Quelicin vials were stored in the medication refrigerator along with non-high alert medications and not designated as a high alert medication.</p> <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 facility failed to ensure fire drills were conducted 1 per quarter.</p>			S 1188	S-1188-1 We are currently working with Wayne Seymour, Fire inspector from La Porte Fire Department to have quarterly fire drills. Wayne will be		02/24/2016

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	<p>The findings include:</p> <ol style="list-style-type: none"> 1. In review of La Porte Medical Group Surgical Center Fire Drill Procedure stated, "A fire drill will be held quarterly for personnel present that day to attend. Safety Officer or designee notifies the monitoring company and the fire department that a drill is about to be conducted." The Fire Drill Procedure was last approved May 4, 2015. 2. Review of the documented fire drills for 2015 indicated table top exercises and not actual fire drills that required activating the fire alarm. The tabletop exercises only had 1 or 2 staff members per exercise. 3. In interview at 1:05 PM on 2/2/2016, staff member #1 (Administrator) confirmed all the above and no other documentation was provided prior to exit. 		<p>here during our quarterly fire drills prior to pulling the alarm to observe, time and critique. We will have full response from the fire department annually. We will also have a building wide fire drill with our tenant annually. The Administrator will ensure that quarterly fire drills happen per policy. S-1188-2 After each drill we will review, document and discus our drill results.</p>		