

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001065		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013	
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER THE				STREET ADDRESS, CITY, STATE, ZIP CODE 7900 W JEFFERSON BOULEVARD, SUITE 102 FORT WAYNE, IN 46804			
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Q000000	<p>The visit was for a re-certification survey.</p> <p>Facility Number: 009566</p> <p>Survey Date: 5-13-13 to 5-15-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 05/23/13</p>	O000000					

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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Q000082	<p>416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.</p> <p>(b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care.</p> <p>(c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.</p> <p>(c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.</p> <p>Based on document review and interview, the center failed to identify and analyze opportunities that could result in improvements in patient safety and improved health outcomes through its quality assessment (QA) program.</p> <p>Findings:</p> <p>1. The Quality Assurance Program (approved 12-11) failed to indicate center priorities for performance improvement activities to demonstrate measureable improvement in patient safety and patient</p>	0000082	The TSC Quality "Assurance" Program was published in 1994, reissued in 1997, Edited in 2009 and last approved by the Governing Board 12/19/2011. This document will be rewritten as "The Quality Assessment Performance Improvement Plan" following AAAHC regulations mirrored with the CMS requirements. The Director will be responsible for authoring this plan. This plan will include but is not limited to 2 performance improvement projects: Post Operative Tonsil Bleed Response Time, and Admitting Diagnosis for	06/26/2013			

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	<p>health outcomes.</p> <p>2. The governing board/QA meeting minutes dated 2-20-13 indicated 6 incident reports, one medication error, 20 patient transfers and one patient emergency occurred in 2012. The minutes lacked quality indicator data from prior years to establish whether the measures were increasing or declining and lacked an indication of how the center will use the information to improve quality and patient safety.</p> <p>3. During an interview on 5-14-2013 at 1540 hours, staff A1 confirmed that the documentation failed to indicate a committee action/improvement process in response to the identified concerns with a method to evaluate the effectiveness of the improvement over time.</p>		<p>Problematic Unforeseen Outpatient Hospital Admissions from PACU. These projects will be reported on quarterly as an agenda item at the TSC Governing Board Meeting. In addition, the TSC will monitor Quality Measures as outlined by the National Quality Forum including patient falls, patient burns, wrong site/wrong side/wrong patient/wrong procedure/wrong implant, prophylactic IV antibiotic timing (within one hour of procedure), appropriate surgical hair removal, and safe surgery checklist utilization. These quality measures will be reported at qualitynet.org as required by this program beginning July1, 2013 through August 15, 2013.</p>		

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Q000083	<p>416.43(d) PERFORMANCE IMPROVEMENT PROJECTS</p> <p>(1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.</p> <p>(2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results Based on document review and interview, the center failed to conduct and document annual performance improvement project(s) including a rationale for the project and an evaluation of the project ' s effectiveness.</p> <p>Findings:</p> <p>1. On 5-13-13 at 1030 hours, staff A1 was requested to provide documentation of a current performance improvement project for improving patient health outcomes or safety in the center as well as a recent project completed in the past year and none was provided prior to exit.</p> <p>2. The Quality Assurance [QA] Program (approved 12-11) failed to indicate that the center would conduct distinct, focused improvement projects annually with documentation of the projects being conducted.</p>	0000083	The QAPI plan will include but is not limited to 2 performance improvement projects: Post Operative Tonsil Bleed Response Time, and Admitting Diagnosis for Problematic Unforeseen Outpatient Hospital Admissions from PACU. These projects will be reported on quarterly as an agenda item at the TSC Governing Board Meeting. The Director is responsible for reporting these statistics In addition, the TSC will monitor Quality Measures as outlined by the National Quality Forum including patient falls, patient burns, wrong site/wrong side/wrong patient/wrong procedure/wrong implant, prophylactic IV antibiotic timing (within one hour of procedure), appropriate surgical hair removal, and safe surgery checklist utilization. These quality measures will be reported at qualitynet.org as required by this program beginning July1, 2013 through August 15, 2013. The	06/26/2013	

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	3. During an interview on 5-14-13 at 1345 hours, staff A1 confirmed that the center lacked documentation of an annual performance improvement project that included the reason for implementing the project, expected outcomes, and an evaluation of the project's effectiveness.		Director is responsible for this reporting.	

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Q000084	<p>416.43(e) GOVERNING BODY RESPONSIBILITIES The governing body must ensure that the QAPI program-</p> <p>(1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.</p> <p>Based on document review and interview, the governing body failed to ensure that the quality assessment / performance improvement (QA) program established standards and expectations for safety and implemented improvement actions for identified deficiencies with assessment of ongoing effectiveness.</p> <p>Findings:</p> <p>1. On 5-14-13 at 1000 hours, staff A1 and A3 were requested to provide documentation of QA program activity including priorities for patient safety and monitoring of improvement actions and none was provided prior to exit.</p> <p>2. The Quality Assurance Program (approved 12-11) failed to indicate center priorities for performance improvement</p>	0000084	<p>The TSC Quality "Assurance" Program was published in 1994, reissued in 1997, Edited in 2009 and last approved by the Governing Board 12/19/2011. This document will be rewritten as "The Quality Assessment Performance Improvement Plan" following AAAHC regulations mirrored with the CMS requirements. The Director will be responsible for authoring this new plan. This plan will include but is not limited to 2 performance improvement projects: Post Operative Tonsil Bleed Response Time, and Admitting Diagnosis for Problematic Unforeseen Outpatient Hospital Admissions from PACU. These projects will be reported on quarterly as an agenda item at the TSC Governing Board Meeting. The exact parameters for the Outpatient Admissions will be</p>	06/26/2013			

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	<p>activities to demonstrate measureable improvement in patient safety and health outcomes.</p> <p>3. The governing board/QA meeting minutes dated 2-20-13 indicated 20 patient transfers including one patient emergency occurred in 2012. The minutes lacked documentation that indicated a committee action/improvement process in response to the patient transfers or other identified safety concern with a method to evaluate the effectiveness of the improvement over time and failed to indicate documentation of any ongoing QA projects.</p> <p>4. On 5-14-13 at 1230 hours, the governing board chairman MD01 indicated that the QA program lacked documentation of a current action in response to the 20 patient transfers.</p> <p>5. On 5-14-13 at 1350 hours, staff A1 confirmed that the center lacked documentation of an improved outcome in response to an identified patient safety concern or patient health outcome and plan of action.</p>		determined and meeting minutes will reflect the evaluation of these parameters and a direction for improvement where appropriate.				

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Q000141	<p>416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. Based on policy and procedure review, personnel file review, and staff interview, the facility failed to ensure current CPR (cardiopulmonary resuscitation) certification for 1 of 5 RNs (registered nurses) as required per facility policy (staff member N8).</p> <p>Findings: 1. at 12:40 PM on 5/13/13, review of the facility policy and procedure manual indicated a policy titled: "Cardio Pulmonary Competency" (dated at the bottom of the page 3/05), which read: a. under "Policy": "All team members providing patient care shall be certified and maintain certification" b. under "Procedure": "A. The surgery center professional staff will be at minimum CPR certified B. All nursing, scrub technicians....will be CPR certified..."</p> <p>2. at 3:35 PM on 5/14/13 and 12:05 PM on 5/15/13, review of the personnel file for RN N8 (hired 7/29/08) indicated their CPR certification had expired 2/13</p>	Q000141	The CPR Certification expiring 08/2014 for N8 was provide to A1 on 5/16/13. A1 forwarded this to Linda Plummer, however, the electronic message did not send correctly. All other RN records were reviewed for completeness and found to be current. The soonest expiration date is 07/2013. This nurse is signed up for recertification in 07/2013. All other RNs records were reviewed and found to be current until 01/2014. The Director will be responsible for knowing who needs recertification.	05/16/2013			

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	3. interview with staff member #50, the facility administrator, indicated current CPR certification documentation for staff member N8 cannot be found at this time			

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Q000162	<p>416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ol style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the completeness of documentation in the medical records for 9 of 22 patient records (Pts. #2, 7, 12, 14, 15, 16, 18, 19, and 20).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. at 12:40 PM on 5/13/13, review of the policy and procedure manual indicated: <ol style="list-style-type: none"> a. a policy titled "Anesthesia Record", with an "originated" date of 12/2012, which reads: <ol style="list-style-type: none"> A. under "Procedure": "...Assessment 	O000162	The Chief of Anesthesia returned from FMLA and met with the Director A1 on 5/17/13. Preliminary survey deficiencies concerning Anesthesia were reviewed including: the omission of ASA status designation, and omission of appropriate criteria documentation for medical discharge from anesthesia services, either Yes or No. A final report concerning all anesthesia deficiencies will be submitted to the Chief of Anesthesia, after which they will address the deficiencies with the anesthesia staff members. The Anesthesia Policy: Anesthesia Provider Responsibilities will be updated	06/28/2013			

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	<p>of adequate recovery from anesthetic prior to discharge. Any pertinent information to assure continuity of care for the patient..."</p> <p>b. a policy titled "Anesthesia Provider Responsibilities", with an "originated" date of 12/2012, which reads:</p> <p>A. under "Policy": "...The anesthesia provider will be responsible for the following:...Assignment of ASA (American Society of Anesthesiologists) status..."</p> <p>2. review of patient medical records on 5/14/13 indicated:</p> <p>a. pts. #2, #7, #18, and #19 lacked completion on the "Operative Record" form of the "Person Exempting" the sending of tissue specimen to the laboratory</p> <p>b. pt. #12 lacked on the "Anesthesia Record" form, an assignment of ASA level for the patient prior to a general anesthesia procedure</p> <p>c. pts. #12, #14, #15, #16, and #20 lacked, on the "Anesthesia Record" form, documentation at the bottom of the page for "Patient has met criteria for medical discharge from anesthesia services." (to be marked in either the box "yes" or the box "no")</p> <p>3. interview with staff member #50, the nursing and facility administrator, at</p>		<p>by the Director to include "Completeness of ALL anesthesia records." The updated policies will be submitted to the Chief of Anesthesia for review and acceptance for the year 2013. This review will be documented in the Patient Care Manual. The Director will meet with the operating room RNs to discuss completeness of the record as it pertains to the "Person Exempting" the sending of specimen to the laboratory.</p>				

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	<p>11:35 AM and 2:30 PM on 5/14/13 indicated:</p> <p>a. no facility policy could be found that states medical records will be complete, except as listed in 1. above related to Anesthesia completion</p> <p>b. the medical records are lacking complete documentation as listed in 2. above</p>			

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Q000181	<p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on patient medical record review and interview, the facility failed to ensure that nursing staff administered medications per physician orders, as per standards of practice, for 4 of 22 patients, pts. #1, 3, 6 and 13; and with policy and procedure review, observation and interview, failed to implement its policy related to dating multi-dose vials after opening, in one surgical suite.</p> <p>Findings: 1. Review of patient medical records on 5/14/13, indicated: a. pt. #1: A. had a post op order for "Fentanyl Titrate 25 mcg-50 mcg IV (intravenous) every 10 minutes prn (as needed) for pain > 4 for Adult patients" B. was given 50 mcg of Fentanyl at 1255 hours on 2/5/13 and another dose of 50 mcg Fentanyl at 1300 hours on 2/5/13 b. pt. #3: A. had a post op verbal order for "Versed 2 mg IVP (intravenous push) Now x i dose" B. was given 1 mg of Versed at 1300 hours on 1/15/13 c. pt. #6: A. had a post op order for "Albuterol</p>	O000181	<p>The Director will meet with the Preop and PACU staff to review the survey citations and deficiencies as they relate to safe medication administration. Current Policies and Procedures will be reviewed as they relate to the citations. Current processes will be reviewed for needed improvements. Every PACU record will be monitored for safe medication practice. Medication charting improvements and deficiencies will be trended with results reported and posted quarterly. The Director will take corrective action with negative trends on an individualized basis. After meeting with the nursing staff, the Director identified problems with the physician order sheets themselves. These order sheets were revised improving the medication administration process for the nurses. Additionally, per the nurses request, another order sheet was created with medications that were not on the current order sheet. This order sheet was designed with a TIME column and with medications for which verbal orders were commonly written. This decreases the chances for errors when taking the verbal order. All the PACU and PreOp</p>	06/20/2013			

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	<p>1/2 cc in 3cc normal saline per nebulizer treatment" written on 3/25/13</p> <p>B. was given two Albuterol nebulizer treatments (one at 0740 hours and one at 1005 hours on 3/25/13)</p> <p>d. pt. #13:</p> <p>A. had a post op order for "Fentanyl Titrate 25 mcg-50 mcg IV every 10 minutes prn for pain > 4 for Adult patients"</p> <p>B. was given 50 mcg of Fentanyl at 1540 hours on 4/25/13 and another 50 mcg at 1542 hours on 4/25/13</p> <p>2. Interview with staff member #50, the nursing and facility administrator, at 1135 hours and 1430 hours on 5/14/13 indicated:</p> <p>a. patients #1, #3, and #13 were not given medications by nursing staff as per physicians orders</p> <p>b. the order for an Albuterol nebulizer treatment was written as a one time order and was given twice by nursing without receiving a new order</p> <p>3. at 12:40 PM on 5/13/13, review of the policy and procedure binder indicated a policy titled: "Expiration of Medications & Solutions" with an "originated date" of 12/2012, which indicated:</p> <p>a. under "Procedure", it reads: "All medications and solutions should be checked for the manufacturer's expiration</p>		nurses medication administration charting is being audited for accuracy and compliance. To date, the compliance is 100%. Spot checking of the charting during patient care hours will be done by the Director in a spontaneous and random manner.		

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	<p>date prior to use, not to exceed 28 days for opened Multi-dose vials...Multi-dose medication and solutions may be used after opening provided the expiration date is noted on the container...Multi-dose Vials...Manufacturer's Outdate or 28 days after opening, whichever comes first..."</p> <p>4. while on tour of the facility, and while observing a patient in the OR (operating room) surgical suite #2, at 10:05 AM on 5/15/13, it was observed that one multi-dose vial of Lidocaine with Epinephrine was opened, sitting on a table top, and lacked notation of the day opened, or the 28 day expiration date</p> <p>5. interview with staff member #51, a PACU (post anesthesia care unit) nurse and infection control practitioner, at 2:00 PM on 5/15/13, indicated:</p> <p>a. nursing staff should be noting on multi-dose vials the date of the 28 days for expiration, as required by facility policy</p>				

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Q000184	<p>416.48(a)(3) VERBAL ORDERS Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician. Based on review of the Medical Staff Rules and Regulations, policy and procedure review, patient medical record review, and staff interview, the medical staff failed to ensure the implementation of the facility policy related to verbal orders in 4 of 22 patient records reviewed (pts. #1, 5, 12, and 19).</p> <p>Findings: 1. at 11:40 AM on 5/15/13, review of the Medical Staff Rules and Regulations indicated: a. under "General Considerations", it reads: "A. All practitioners privileged at the Center shall abide by the Professional Staff Bylaws, Rules and Regulations, and the Center Bylaws and Policies..."</p> <p>2. at 12:45 PM on 5/15/13, review of the policy and procedure "Verbal Orders", with a "Revised" date of 12/2012, indicated: a. under "II. Procedure", it reads: "...D. the receiver will record the order in the medical record with the date, time, signature and...Repeated and Verified."</p> <p>3. review of patient medical records on 5/14/13, indicated:</p>	O000184	<p>The Medical Staff Rules and Regulations will be amended to include the statement that Verbal Orders must be dated and TIMED by the nurse that receives the order. This change will be made to the document by A1 the Director and sent to the Medical Staff meeting on the above date for review and approval. The Director will be communicate this change with the PreOp and PACU nursing staff for overall compliance throughout the TSC. This revision was reviewed by the TSC Governing Board and adopted 6/26/13. The Director met with the PreOp and PACU nursing staff on 6/19 and 6/20/13 and communicated changes. Verbal orders are being monitored for completeness during chart reviews of every patient chart. The Director will collect the results and share them with the nursing staff and report the results to the QAPI committee.</p>	06/26/2013			

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	<p>a. pt. #1 had a verbal order for Versed written on 2/5/13 that lacked a time of the order</p> <p>b. pt. #5 had a verbal order for Fentanyl written on 4/1/13 that lacked a time of the order</p> <p>c. pt. #12 had a Labetolol verbal order written on 4/25/13 that lacked a time of the order</p> <p>d. pt. #19 had a Versed verbal order written on 4/24/13 that lacked a time of the order</p> <p>4. interview with staff member #50, the nursing and facility administrator, at 11:35 AM and 2:30 PM on 5/14/13 indicated:</p> <p>a. nursing staff are failing to note the time of verbal orders, as listed in 3. above, as per facility policy</p> <p>b. currently, Medical Staff Rules and Regulations fail to state that the time of a verbal order must be documented as well as the date of the order</p>			

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Q000224	<p>416.50(a)(2) ADVANCE DIRECTIVES The ASC must comply with the following requirements:</p> <p>(i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms.</p> <p>(ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care.</p> <p>(iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>Based on document review and interview, the center policy on Advance Directives failed to assure that a copy of the State Advanced Directives brochure was provided to patients if requested.</p> <p>Findings:</p> <p>1. The policy/procedure Patient Rights (approved 12-11) and Advanced Directives (approved 12-11) failed to indicate that the center would provide a copy of the State Advanced Directives brochure to the patient or the patient's representative upon request.</p> <p>2. During an interview on 5-15-13 at 1530 hours, staff A1 confirmed that the</p>	0000224	<p>The ISDH Advanced Directives brochure was found on line at isdh.in.gov. A message was left for Rachel in Legal Dept. on 6/7/13 @ 1320 asking if there is a published brochure available for distribution to patients that request the information. Until more information is obtained, we will have this 7 page document available for our patients should they request information. The Advance Directives Policy will be reviewed and revised to include updated suspension of directive language in the policy. The A1, Director will research this topic and update the policy accordingly. The policy will be taken to the Governing Board for review and adoption.</p>	06/07/2013			

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	policy/procedures failed to indicate that a copy of the State Advanced Directives would be provided to the patient upon request.			

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Q000225	<p>416.50(a)(3)(i), (v), (vi), (vii) SUBMISSION AND INVESTIGATION OF GRIEVANCES</p> <p>(i) The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC.</p> <p>(v) The grievance process must specify timeframes for review of the grievance and the provisions of a response.</p> <p>(vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished.</p> <p>(vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.</p> <p>Based on document review and interview, the grievance policy/procedure failed to assure that the name of a contact person, the steps taken to investigate the grievance, the results of the grievance process and the date the process was completed were included in the written notice of determination to the patient.</p> <p>Findings:</p> <p>1. The policy/procedure Patient Grievance Policy (approved 12-11) and Patient Complaints/Concerns (approved 12-11) failed to indicate the following:</p>	Q000225	The Patient Grievance Policy will be revised to include the use of a form to record the complaint or grievance and track the grievance procedure through to written response and final disposition and report to the Governing Board. A template was found, saved and used for a complaint 6/6/13. This form will be reviewed with the revised policy and procedure by the Governing Board. The A1, Director will be responsible for aligning the updated policy with the current Patient Rights declaration currently distributed to every TSC patient.	07/23/2013			

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	<p>A. name of a contact person</p> <p>B. steps taken to investigate the grievance</p> <p>C. the determination of the grievance process</p> <p>D. the date of grievance process completion</p> <p>2. During an interview on 5-15-13 at 1530 hours, staff A1 confirmed that the policy regarding the grievance notice lacked the indicated provisions for a response.</p>			

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Q000226	<p>416.50(a)(3)(ii), (iii), (iv) GRIEVANCES - MISTREATMENT, ABUSE, NEGLIGENCE</p> <p>(ii) All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented.</p> <p>(iii) All allegations must be immediately reported to a person in authority in the ASC.</p> <p>(iv) Only substantiated allegations must be reported to the State authority or the local authority, or both.</p> <p>Based on document review and interview, the center failed to ensure that all allegations of abuse, neglect, or mistreatment which are alleged to have occurred at the center will be fully documented, immediately reported to the responsible person at the center and reported to the State and/or a local authority if authenticated.</p> <p>Findings:</p> <p>1. On 5-13-13 at 1030 hours, staff A1 was requested to provide a grievance policy/procedure regarding an observation or allegation of patient abuse, neglect or mistreatment and none was provided prior to exit.</p> <p>2. The policy/procedure Patient Grievance Policy (approved 12-11) failed to indicate a process for responding to allegations involving mistreatment, neglect, verbal, mental, sexual, or</p>	Q000226	Separate from the Grievance Policy will be developed a Mistreatment, Abuse, and Neglect Policy indicating the procedure for all allegations of this type to be fully documented and reported immediately to the A1, Director, with substantial allegations reported to State and or Local authority. The Director will research and write this policy for review and adoption by the TSC Governing Board.	07/23/2013			

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Q000233	<p>physical abuse alleged to have occurred at the center.</p> <p>3. During an interview on 5-15-13 at 1515 hours, staff A1 confirmed that the grievance policy/procedure failed to indicate a center response to allegations of patient abuse, neglect, or mistreatment.</p> <p>416.50(c)(3) SAFETY - ABUSE/HARASSEMENT [The patient has the right to -] Be free from all forms of abuse or harassment</p> <p>Based on document review and interview, the center failed to ensure that patients are free from all forms of abuse or harassment.</p> <p>Findings:</p> <p>1. The policy/procedure Patient Rights (approved 12-11) and the Notice of Patient Rights (approved 12-11) failed to indicate the patient right to be free from abuse or harassment.</p> <p>2. During an interview on 5-15-13 at 1530 hours, staff A1 confirmed that the Notice and Patient Rights policy failed to indicate the patient right to be free from abuse or harassment.</p>	Q000233	The Patient Rights Policy and Procedure and the Notice of Patient Rights will be amended to include the statement "The patient has the right to be free from abuse or harassment. The A1, Director will be responsible for revising these documents after which they will be taken to the TSC Governing Board for approval and adoption.	07/23/2013	

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Q000241	<p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on policy and procedure review, document review, and interview, the center failed to ensue a sanitary environment by the lack of approval of the cleaning products used by facility staff and contracted housekeeping staff members.</p> <p>Findings: 1. at 12:40 PM on 5/13/13, review of the policy and procedure manual indicated a policy titled: "Housekeeping Infection Control" (with a "copyright 1994" and "1997 Edition" at the bottom of the page), which read: a. under "II. Procedure:...C. Cleaning with an approved germicidal/virucidal/tuberculocidal product shall be a regular part of the daily housekeeping routine..."</p> <p>2. review of the infection control committee 4/2013 meeting minutes indicated there was no documentation of discussion related to approved cleaning products for either facility staff (related to between case cleaning and instrument cleaning/sterilization), or for contracted</p>	Q000241	The Infection Control Committee will record, review for effectiveness and approve all cleaning products used in the TSC. This list of products will be reported to the TSC Governing Board for review, approval, and adoption for use by the TSC staff for instrument cleaning/sterilization, between case cleaning and for use of the cleaning products used by the contracted cleaning services. A1, the Director is ultimately responsible for this process to approve these cleaning agents. These agents will then be included in the Infection Control Policies and Procedures.	07/23/2013			

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	<p>housekeeping services (related to terminal cleaning).</p> <p>3. interview with staff member #51, the infection control nurse, at 2:00 PM on 5/15/13, indicated:</p> <p>a. the infection control committee is newly formed and has only met one time (in April 2013)</p> <p>b. the infection control committee has not adopted/approved of the cleaning solution used by the contracted housekeeping agency</p> <p>c. the infection control committee has not formally approved cleaning products for use in the facility related to instrument cleaning/sterilization and between case cleaning by nursing staff</p>				

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Q000242	<p>416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.</p> <p>Based on policy and procedure review, observation, and staff interview, the infection control committee failed to implement its policy regarding surgical attire as related to masks about the neck, jewelry in the surgical suite, outside clothing not covered by surgical scrubs in the surgery suite, and extraneous items in the surgical suite and failed to ensure the availability of instruments when several like cases are scheduled on the same day.</p> <p>Findings: 1. at 12:40 PM on 5/13/13, review of the policy and procedure manual indicated a policy titled: "Surgical Attire", with an "originated" date of "1.2013", which read: a. under "Procedure:" "All persons entering the restricted and semi-restricted area of the OR (operating room) will abide by the following: Surgical Scrub apparel...Jewelry must be contained within surgical apparel or removed:...Necklace contained within scrub top...Surgical mask...Covers mouth</p>	0000242	<p>The policy titled Surgical Attire will be reviewed and revised to bring the TSC staff behaviors in line with appropriate surgical practice. The revisions will be reviewed, revised and adopted by the TSC Governing Board. The enforcement will begin with a staff meeting where these rules will be presented. The A1 Director and the Infection Control officer or their designee will be responsible for monitoring this behavior quarterly, recording compliance, the results of which will be reported to the TSC Governing Board at the quarterly meeting where further action and monitoring may be advised. The Director will conduct spontaneous and random monitoring with spot inspections for compliance. Anesthesiologists personal bags or packs will not be allowed in the OR suite. These items will be dropped off in the physicians locker room for safe keeping during the hours of patient care. Anesthesiologist undershirt attire will be address and corrected. The Director will address these</p>	07/31/2013			

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	<p>and nose and secured to prevent venting Removed and discarded after single use (not to be worn around neck with strings hanging loosely)...Fanny packs, back packs or briefcases are prohibited in the restricted (Operating Room) arena, secondary to inability to wash these articles."</p> <p>2. at 1:07 PM on 5/14/13, while on tour of the surgery area of the facility, it was observed that the anesthesiologist in OR suite #2:</p> <p>a. had a long sleeved shirt with collar that was extending beyond the sleeves of the surgical scrub top and above the v-neck opening of the shirt/top</p> <p>b. had a surgical mask that gapped on the sides (allowed venting)</p> <p>3. at 9:10 AM on 5/15/13, in the pre op area of the facility, it was observed that the surgeon entered pre op bay #4 to speak to the next operative patient (and to transport them to the OR) while the surgical mask used for the last patient was down about the neck with the strings dangling</p> <p>4. at 9:20 AM on 5/15/13, while observing a patient in OR suite #2, it was noted that a black briefcase was sitting on the floor near the anesthesiologist (briefcase remained there for the second</p>		<p>deficiencies with the Chief of Anesthesia at a meeting to be conducted no later than 6/28/13. The Director will conduct spontaneous and random monitoring with spot inspections for compliance. Lack of compliance will be reported to the Chief of Anesthesia who will address the deficiencies with the Anesthesia Staff. A new autoclave for the substerile area has been ordered due to the frequency of repairs on the old model. The delivery is set for 07/13. This upgrade will be the springboard for changes needed to reduce flash sterilization of instrumentation for to follow cases. Staff education on the current regulations and the new autoclave will happen simultaneously including plans for the purchase of more instrumentation. The purchase as already been approved by the Executive Committee for the additional instruments. Additional instruments will be ordered in stages beginning with Myringotomy Instruments. A list of these instruments and sterilization cases has been assembled and priced for ordering. The Director will place the order and arrange for the inservicing of OR staff members.</p>				

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	<p>OR case observed at 10:10 AM)</p> <p>5. at 9:50 AM on 5/15/13, while touring the surgery area, it was observed that the anesthesiologist from OR suite #1 went to the recovery room with one patient, went on to pre op bay #2 to see another patient, and then went back to OR #1 with the same surgical mask down about the neck (with dangling strings) and proceeded (at 10:05 AM) to put the same mask back on for the next patient having surgery in OR suite #1</p> <p>6. at 10:10 AM on 5/15/13, during surgery in OR suite #2, it was observed that a circulating staff member entered to assist in the case with a long necklace on that was not enclosed beneath the scrub top</p> <p>7. interview with staff member #51, the infection control nurse, at 2:00 PM on 5/15/13, indicated:</p> <p style="padding-left: 20px;">a. currently there is no surveillance/observation of facility staff to ensure standards of practice, regarding proper surgical attire, as stated in the facility policy, are adhered to</p> <p style="padding-left: 20px;">b. it was unknown that facility policy exempted the presence of briefcases in the operating suites</p> <p>8. interview with staff member #50, the</p>				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>facility administrator, at 1:45 PM on 5/14/13, indicated:</p> <ul style="list-style-type: none"> a. the facility "can't schedule two nasal surgery cases at the same time due to a lack of instrument for two simultaneous cases and not time to sterilize the instruments" b. flash sterilization (immediate use sterilization) is being done more than it should be at the facility <p>9. at 10:45 AM on 5/15/13, interview with staff member #54, a CST (certified surgical technician), indicated:</p> <ul style="list-style-type: none"> a. there are not enough instruments for the number of cases being performed b. the most needed instruments are for myringotomy and tonsil cases c. flash sterilization (immediate use sterilization) is being done more than it should be at the facility 				

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S000000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 009566</p> <p>Survey Date: 5-13-13 to 5-15-13</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 05/23/13</p>	S000000			

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S000162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on policy and procedure review, personnel file review, and staff interview, the facility failed to ensure current CPR (cardiopulmonary resuscitation) certification for 1 of 5 RNs (registered nurses) as required per facility policy (staff member N8).</p> <p>Findings:</p> <p>1. at 12:40 PM on 5/13/13, review of the facility policy and procedure manual indicated a policy titled: "Cardio Pulmonary Competency" (dated at the bottom of the page 3/05), which read:</p> <p>a. under "Policy": "All team members providing patient care shall be certified and maintain certification"</p> <p>b. under "Procedure": "A. The surgery center professional staff will be at minimum CPR certified B. All nursing, scrub technicians....will be CPR</p>	S000162	The CPR Certification expiring 08/2014 for N8 was provide to A1 on 5/16/13. A1 forwarded this to Linda Plummer, however, the electronic message did not send correctly. All other RN records were reviewed for completeness and found to be current. The soonest expiration date is 07/2013. This nurse is signed up for recertification in 07/2013. All other RNs records were reviewed and found to be current until 01/2014. The Director will be responsible for knowing who needs recertification.	05/16/2013			

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	<p>certified..."</p> <p>2. at 3:35 PM on 5/14/13 and 12:05 PM on 5/15/13, review of the personnel file for RN N8 (hired 7/29/08) indicated their CPR certification had expired 2/13</p> <p>3. interview with staff member #50, the facility administrator, indicated current CPR certification documentation for staff member N8 cannot be found at this time</p>			

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S000176	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on policy and procedure review, document review; personnel file review, and staff interview, the facility failed to implement its policy related to monitoring contracted housekeeping services.</p> <p>Findings:</p> <p>1. review of the policy and procedure binder at 12:40 PM on 5/13/13 indicated a policy titled "Housekeeping Services" (with a "copyright" date of 1994, and an "edition" date of 1997) which read:</p> <p>a. "I. Policy: A...Contract services shall be monitored to assure their performance is consistent with accepted standards...II. Responsibility: A...The Director is responsible for monitoring contracted housekeeping services that are provided to assure accepted levels of cleanliness..."</p> <p>2. at 3:55 PM on 5/13/13, review of the infection control meeting minutes of</p>	S000176	Operating Room contracted cleaning is currently with Enviro Clean. This contracted service will be evaluated for the quality of work performed and the competence of the service staff by the Director or designee. This evaluation will be performed by the above date and reported on quarterly to the TSC Governing Board. In addition, the Policy and Procedure: Cleaning O.R. Between Cases will be reviewed and revised as deemed necessary by the TSC Governing Board.	06/28/2013			

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	<p>April, 2013 indicated there was a lack of discussion related to the monitoring of contracted housekeeping services</p> <p>3. at 1:45 PM on 5/15/13, review of the contracted housekeeper's file (N9) indicated:</p> <p>a. the last competency document in the file was dated 9/14/11</p> <p>4. at 4:30 PM on 5/13/13, interview with staff member #51, the infection control nurse, indicated:</p> <p>a. this staff member has not observed the contracted cleaning person to determine if they are cleaning the surgery area as per facility requirements</p> <p>5. at 2:45 PM on 5/15/13, interview with staff member #50, the facility administrator/director, indicated:</p> <p>a. at this time there is no documented "monitoring" of contracted housekeeping staff to determine that appropriate cleaning is being accomplished in the surgery areas</p>						

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S000226	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review, the center failed to maintain a list of all contracted services, including the scope and nature of services provided for 4 (fire extinguisher service, fire alarm system certification, fire alarm monitoring service and fire sprinkler service) of 31 services.</p> <p>Findings:</p> <p>1. The document Surgery Center Service Contracts failed to indicate 4 fire service providers (fire extinguisher service V1, fire alarm system certification V2, fire alarm monitoring service V3 and fire sprinkler service V4) identified through a document review.</p> <p>2. On 5-14-13 at 1615 hours, staff A1 confirmed that the service contract list lacked the indicated fire service</p>	S000226	4 Fire service providers currently on contract through Lutheran Hospital for TSC were added to the Service Contract QA Spreadsheet with their contact phone numbers. The Director will be responsible for scheduling the surveillance by these contractors on the per the established and required routine.	06/06/2013			

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S000300	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the center failed to develop and maintain an organized and effective quality assessment and improvement program to ensure ongoing monitoring of all services and important aspects of care.</p> <p>Findings:</p> <p>1. The Quality Assurance [QA] Program (approved 12-11) indicated the following: " The QA committee receives and reviews all committee reports and minutes including tissue review ...medical record review ...safety, fire and disaster activities ...and will report at least quarterly to the governing body. " The QA program description failed to indicate that contracted services and the required functions of medication errors, and response to patient emergencies would be reviewed.</p>	S000300	<p>The TSC Quality "Assurance" Program was published in 1994, reissued in 1997, Edited in 2009 and last approved by the Governing Board 12/19/2011. This document will be rewritten as "The Quality Assessment Performance Improvement Plan" following AAAHC regulations mirrored with the CMS requirements. The Director will be responsible for authoring this plan. This plan will include but is not limited to 2 performance improvement projects: Post Operative Tonsil Bleed Response Time, and Admitting Diagnosis for Problematic Unforeseen Outpatient Hospital Admissions from PACU. These projects will be reported on quarterly as an agenda item at the TSC Governing Board Meeting. Added to the TSC Governing Board Meeting Agenda are the following previously missing required reporting elements: contracted services</p>	06/26/2013			

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	<p>2. On 5-13-13 at 1030 hours, staff A1 was requested to provide documentation of QA committee minutes and none was provided prior to exit.</p> <p>3. The governing board meeting minutes dated 3-27-12, 11-07-12 and 2-20-13 failed to indicate that QA committee activity was being conducted or reported at least quarterly to the governing board. The minutes failed to indicate a review of tissue reports or results of medical record reviews performed on 11-21-12 or 2-10-13 and failed to indicate any safety, fire and disaster activities were conducted or reviewed.</p> <p>4. During an interview on 5-13-13 at 1545 hours, staff A1 confirmed that the center lacked an organized and effective QA program and confirmed that the QA Program description had not been maintained.</p>		evaluation/review,and response to patient emergencies .	

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S000310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the center failed to establish standards for evaluating its contracted services through its quality assurance (QA) program for 6 of 31 contracted services.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance Program (approved 12-11) failed to indicate that contracted services were evaluated through the QA program.</p> <p>2. The QA reporting tool Surgery Center Service Contracts (approved 2-13) failed to indicate any standards for evaluating 2 interpreter services and lacked 4 fire service providers (fire extinguisher service V1, fire alarm system certification V2, fire alarm monitoring service V3 and fire sprinkler service V4) identified through a document review. The QA tool failed to indicate that any of the listed services had been evaluated in 2013.</p>	S000310	<p>The ENT Service Contract QA Spreadsheet.2013 will be updated with current contract information. These contracts will be evaluated by A1 the Director. Methods of evaluation will be researched through AAAHC, CMS, and ISDH resources for appropriate measurable indicators. This contract evaluation process will begin 3rd Quarter July 1, 2013. An evaluation method was researched and created by the Director with TSC contract serviced providers. The evaluation tool was submitted to TSC Governing Board, approved on 6/26/13 and adopted for use. The Director will be responsible for evaluating the contracted services. This evaluation will be reported to TSC Governing Board at Quarterly meetings by the Director.</p>	07/01/2013			

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	3. During an interview on 5-14-13 at 1530 hours, staff A1 confirmed that the QA Program description failed to indicate that contracted services were evaluated through the QA program and confirmed that the Service Contracts QA reporting tool lacked documentation indicating the ongoing evaluation of each contracted service in 2013.			

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S000320	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the center failed to ensure that the functions of medication errors and response to patient emergencies were evaluated by the Quality Assurance (QA) program.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance Program (approved 12-11) failed to indicate that all functions including medication errors and response to patient emergencies were evaluated and reviewed.</p> <p>2. During an interview on 5-14-13 at 1530 hours, staff A1 confirmed that the QA program description had not been revised to assure that medication errors</p>	S000320	<p>The TSC Quality "Assurance" Program was published in 1994, reissued in 1997, Edited in 2009 and last approved by the Governing Board 12/19/2011. This document will be rewritten as "The Quality Assessment Performance Improvement Plan" following AAAHC regulations mirrored with the CMS requirements. The Director will be responsible for authoring this plan. Medication errors and patient emergencies both reported on incident report forms will be added to the standing agenda items for the TSC Governing Board meeting. Included for the 2nd quarter meeting will be results from the ISDH/CMS survey deficiencies regarding Verbal Orders Q 184 and medication errors Q 181 regarding recovery room medication dosing. The</p>	06/26/2013			

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	and patient emergencies were evaluated through the QA program.		Director will review with the Chief of Anesthesia, post operative Medication orders as currently authored to discuss any changes needed to assist recovery room nurses with the timeliness of necessary patient care. These changes will be reflected in a revised version of the current orders.		

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S000328	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the center failed to document an appropriate action in response to opportunities for improvement identified through the Quality Assurance (QA) program.</p> <p>Findings:</p> <p>1. On 5-13-13 at 1030 hours, staff A1 was requested to provide documentation of QA committee recommendations and actions implemented in response to services and functions reviewed through the program and none was provided prior to exit.</p> <p>2. Review of governing board meeting minutes dated 11-07-12 and 2-20-13 failed to indicate that the governing board/ QA committee identified an area</p>	S000328	The QAPI meeting minutes format will be revised by the Director to include actions taken and evaluation of the actions with recommendations needed for improvement of patient care. The Director will make the changes and this format will be presented to TSC Governing Board for review, revision, approval and adoption. TSC Governing Board approved the format at their meeting on 6/26/13.	06/26/2013			

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	<p>for improvement in response to the services and functions subject to review at each meeting. The 2-20-13 minutes indicated 6 incident reports, one medication error, 20 patient transfers and one patient emergency occurred in 2012 and the minutes lacked documentation of a QA committee recommendation or corrective action in response to the identified concerns.</p> <p>3. During an interview on 5-14-13 at 1540 hours, staff A1 confirmed that the governing board/QA meeting minutes failed to document an action in response to identified concerns.</p>				

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S000432	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on policy and procedure review, document review, and interview, the infection control committee failed to approve the cleaning products for facility staff use and contracted housekeeping use.</p> <p>Findings:</p> <p>1. at 12:40 PM on 5/13/13, review of the policy and procedure manual indicated a policy titled: "Housekeeping Infection Control" (with a "copyright 1994" and "1997 Edition" at the bottom of the page), which read:</p> <p>a. under "II. Procedure:...C. Cleaning with an approved germicidal/virucidal/tuberculocidal product shall be a regular part of the daily housekeeping routine..."</p> <p>2. review of the infection control</p>	S000432	The Infection Control Committee will record, review for effectiveness and approve all cleaning products used in the TSC. This list of products will be reported to the TSC Governing Board for review, approval, and adoption for use by the TSC staff for instrument cleaning/sterilization, between case cleaning and for use of the cleaning products used by the contracted cleaning services. A1, the Director is ultimately responsible for this process to approve these cleaning agents. These agents will then be included in the Infection Control Policies and Procedures.	07/23/2013			

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	<p>committee 4/2013 meeting minutes indicated there was no documentation of discussion related to approved cleaning products for either facility staff (related to between case cleaning and instrument cleaning/sterilization), or for contracted housekeeping services (related to terminal cleaning).</p> <p>3. interview with staff member #51, the infection control nurse, at 2:00 PM on 5/15/13, indicated:</p> <p>a. the infection control committee is newly formed and has only met one time (in April 2013)</p> <p>b. the infection control committee has not adopted/approved of the cleaning solution used by the contracted housekeeping agency</p> <p>c. the infection control committee has not formally approved cleaning products for use in the facility related to instrument cleaning/sterilization and between case cleaning by nursing staff</p>			

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S000444	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on policy and procedure review, observation, and staff interview, the infection control committee failed to implement its policy regarding surgical attire as related to masks about the neck, jewelry in the surgical suite, outside clothing not covered by surgical scrubs in the surgery suite, and extraneous items in the surgical suite.</p> <p>Findings: 1. at 12:40 PM on 5/13/13, review of the policy and procedure manual indicated a policy titled: "Surgical Attire", with an "originated" date of "1.2013", which read: a. under "Procedure:" "All persons entering the restricted and semi-restricted area of the OR (operating room) will abide by the following: Surgical Scrub apparel...Jewelry must be contained</p>	S000444	<p>The policy titled Surgical Attire will be reviewed and revised to bring the TSC staff behaviors in line with appropriate surgical practice. The revisions will be reviewed, revised and adopted by the TSC Governing Board. The enforcement will begin with a staff meeting where these rules will be presented. The A1, Director and the Infection Control officer or their designee will be responsible for monitoring this behavior quarterly, recording compliance, the results of which will be reported to the TSC Governing Board at the quarterly meeting where further action and monitoring may be advised. Anesthesiologists personal bags or packs will not be allowed in the OR suite. These items will be dropped off in the physicians locker room for safe keeping during the hours of patient care.</p>	07/31/2013	

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	<p>within surgical apparel or removed:...Necklace contained within scrub top...Surgical mask...Covers mouth and nose and secured to prevent venting Removed and discarded after single use (not to be worn around neck with strings hanging loosely)...Fanny packs, back packs or briefcases are prohibited in the restricted (Operating Room) arena, secondary to inability to wash these articles."</p> <p>2. at 1:07 PM on 5/14/13, while on tour of the surgery area of the facility, it was observed that the anesthesiologist in OR suite #2:</p> <p>a. had a long sleeved shirt with collar that was extending beyond the sleeves of the surgical scrub top and above the v-neck opening of the shirt/top</p> <p>b. had a surgical mask that gapped on the sides (allowed venting)</p> <p>3. at 9:10 AM on 5/15/13, in the pre op area of the facility, it was observed that the surgeon entered pre op bay #4 to speak to the next operative patient (and to transport them to the OR) while the surgical mask used for the last patient was down about the neck with the strings dangling</p> <p>4. at 9:20 AM on 5/15/13, while observing a patient in OR suite #2, it was</p>		<p>Anesthesiologist undershirt attire will be address and corrected.</p> <p>The Director will address these deficiencies with the Chief of Anesthesia at a meeting to be conducted no later than 6/28/13. The Director will conduct spontaneous and random monitoring with spot inspections for compliance. Lack of compliance will be reported to the Chief of Anesthesia who will address the deficiencies with the Anesthesia Staff. A new autoclave for the substerile area has been ordered due to the frequency of repairs on the old model. The delivery is set for 07/13. This upgrade will be the springboard for changes needed to reduce flash sterilization of instrumentation for to follow cases. Staff education on the current regulations and the new autoclave will happen simultaneously including plans for the purchase of more instrumentation. The purchase as already been approved by the Executive Committee for the additional instruments. Additional instruments will be ordered in stages beginning with Myringotomy Instruments. A list of these instruments and sterilization cases has been assembled and priced for ordering. The Director will place the order and arrange for the inservicing of OR staff members.</p>				

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	<p>noted that a black briefcase was sitting on the floor near the anesthesiologist (briefcase remained there for the second OR case observed at 10:10 AM)</p> <p>5. at 9:50 AM on 5/15/13, while touring the surgery area, it was observed that the anesthesiologist from OR suite #1 went to the recovery room with one patient, went on to pre op bay #2 to see another patient, and then went back to OR #1 with the same surgical mask down about the neck (with dangling strings) and proceeded (at 10:05 AM) to put the same mask back on for the next patient having surgery in OR suite #1</p> <p>6. at 10:10 AM on 5/15/13, during surgery in OR suite #2, it was observed that a circulating staff member entered to assist in the case with a long necklace on that was not enclosed beneath the scrub top</p> <p>7. interview with staff member #51, the infection control nurse, at 2:00 PM on 5/15/13, indicated:</p> <p>a. currently there is no surveillance/observation of facility staff to ensure standards of practice, regarding proper surgical attire, as stated in the facility policy, are adhered to</p> <p>b. it was unknown that facility policy exempted the presence of briefcases in the</p>			

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	operating suites			

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S000514	<p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2(e)</p> <p>(e) The medical staff and a pathologist shall determine, as specified by medical staff rules and laboratory policy, what tissue specimen examination will be utilized on each specimen as follows:</p> <p>(1) Microscopic examination only.</p> <p>(2) Macroscopic examination only.</p> <p>(3) Both microscopic and macroscopic examinations.</p> <p>Based on document review and interview, the center failed to indicate the tissue specimens to be exempted from laboratory/pathology examination.</p> <p>Findings:</p> <p>1. On 5-13-13 at 1030 hours, staff A1 was requested to provide a policy/procedure indicating the type and categories of tissue exempted from laboratory and pathology examination and none was provided prior to exit.</p> <p>2. The policy/procedure Tissue Specimens (approved 12-11) failed to indicate the " certain exempted tissue " not required to be submitted for laboratory examination.</p>	S000514	<p>On May 20, 2013, the pathology service organization was changed per request of the Executive Committee. The Director will update and revise the current documents associated with this service to include a tissue exemption list as it relates to the specialty practice. In addition the operative record will be reviewed for clarity on tissue exemption. If the current record specimen section is ambiguous, the record will be revised. The Director will present any revision to TSC Governing Body for approval and adoption. The Director will inservice the surgery nursing staff regarding completeness of the record as it pertains to surgical specimen documentation.</p>	07/23/2013			

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	3. During an interview on 5-15-13 at 1445 hours, staff A1 confirmed that the center lacked a list of exempted tissues.			

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S000640	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the completeness of documentation in the medical records for 9 of 22 patient records (Pts. #2, 7, 12, 14, 15, 16, 18, 19, and 20).</p> <p>Findings: 1. at 12:40 PM on 5/13/13, review of the policy and procedure manual indicated: a. a policy titled "Anesthesia Record", with an "originated" date of 12/2012, which reads: A. under "Procedure": "...Assessment of adequate recovery from anesthetic prior to discharge. Any pertinent information to assure continuity of care for the patient..." b. a policy titled "Anesthesia Provider Responsibilities", with an "originated" date of 12/2012, which reads: A. under "Policy": "...The anesthesia provider will be responsible for the following:...Assignment of ASA (American Society of Anesthesiologists) status..."</p>	S000640	The Anesthesia policies will be reviewed and revised by the Director to include the provider responsibility for a completeness of all anesthesia records, including ASA classification and criteria for medical discharge met by the patient. This revision and all Anesthesia policies will be submitted for review by the Chief of Anesthesia Services. The Chief of Anesthesia will be responsible for enforcing the changes as needed with the Anesthesia Staff Physicians. In addition the operative record will be reviewed for clarity on tissue exemption. If the current record specimen section is ambiguous, the record will be revised. The Director will make revisions and present them to TSC Governing Body for approval and adoption. The surgery nursing staff will be inserviced by the Director regarding completeness of the record as it pertains to surgical specimen documentation.	06/28/2013			

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	<p>2. review of patient medical records on 5/14/13 indicated:</p> <p>a. pts. #2, #7, #18, and #19 lacked completion on the "Operative Record" form of the "Person Exempting" the sending of tissue specimen to the laboratory</p> <p>b. pt. #12 lacked on the "Anesthesia Record" form, an assignment of ASA level for the patient prior to a general anesthesia procedure</p> <p>c. pts. #12, #14, #15, #16, and #20 lacked, on the "Anesthesia Record" form, documentation at the bottom of the page for "Patient has met criteria for medical discharge from anesthesia services." (to be marked in either the box "yes" or the box "no")</p> <p>3. interview with staff member #50, the nursing and facility administrator, at 11:35 AM and 2:30 PM on 5/14/13 indicated:</p> <p>a. no facility policy could be found that states medical records will be complete, except as listed in 1. above related to Anesthesia completion</p> <p>b. the medical records are lacking complete documentation as listed in 2. above</p>						

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S000736	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based upon document review and interview, the medical staff failed to follow its Bylaws and ensure that the medical staff met quarterly.</p> <p>Findings:</p> <p>1. On 5-13-13 at 1030 hours, staff A1 was requested to provide documentation of medical staff meetings and none was provided prior to exit.</p> <p>2. The Surgery Center Professional Staff Bylaws (approved 12-11) indicated the following: " Professional Staff Meetings ...Staff meetings shall be at least quarterly. "</p> <p>3. During an interview on 5-14-13 at 1610 hours, staff A1 confirmed that the medical staff lacked documentation of</p>	S000736	<p>TSC Governing Board, lead by the TSC Medical Director, representing the Medical Staff at TSC will begin regular meetings prior to the Medical Staff Meetings and the Board Meeting. This meeting will occur at least quarterly. The 2nd quarter meeting will be held 6/26/13. Attending will be TSC Director, CEO, TSC Governing Board, Infection Control Officer as needed for reporting. TSC Director or the CEO record minutes. Said minutes will be distributed electronically by the Director or the CEO from the prior meeting and the agenda for the next meeting no later than 5 business days prior to said meeting. As for the TSC Governing Board meeting, the Medical Staff Meeting and the Board Meeting, the CEO will record minutes for these meetings.</p>	06/26/2013

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	quarterly medical staff meetings.			

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S000742	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(C)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(C) A provision for maintaining records of all meetings of the medical staff and its committees. Based upon document review and interview, the medical staff failed to document quarterly medical staff meetings.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 5-13-13 at 1030 hours, staff A1 was requested to provide documentation of medical staff meetings and none was provided prior to exit. The governing board meeting minutes dated 11-07-12 and 2-20-13 failed to indicate a medical staff heading/topic among the listed areas and lacked documentation to indicate that medical staff meeting activity was conducted on the day of the board meetings. During an interview on 5-14-13 at 1610 hours, staff A1 confirmed that no documentation of medical staff meetings 	S000742	<p>TSC Governing Board, lead by the TSC Medical Director, representing the Medical Staff at TSC will begin regular meetings prior to the Medical Staff Meetings and the Board Meeting. This meeting will occur at least quarterly. The 2nd quarter meeting will be held 6/26/13. Attending will be TSC Director, CEO, TSC Governing Board, Infection Control Officer as needed for reporting. TSC Director or the CEO record minutes. Said minutes will be distributed electronically by the Director or the CEO from the prior meeting and the agenda for the next meeting no later than 5 business days prior to said meeting. As for the TSC Governing Board meeting, the Medical Staff Meeting and the Board Meeting, the CEO will record minutes for these meetings.</p>	06/26/2013			

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	was available.				

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S000782	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(O)</p> <p>These bylaws and rule must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(O) A provision for personnel authorized to take a verbal order. Based on review of the Medical Staff Rules and Regulations, policy and procedure review, patient medical record review, and staff interview, the medical staff failed to ensure the implementation of the facility policy related to verbal orders in 4 of 22 patient records reviewed (pts. #1, 5, 12, and 19).</p> <p>Findings:</p> <p>1. at 11:40 AM on 5/15/13, review of the Medical Staff Rules and Regulations indicated:</p> <p>a. under "General Considerations", it reads: "A. All practitioners privileged at the Center shall abide by the Professional Staff Bylaws, Rules and Regulations, and the Center Bylaws and Policies..."</p> <p>2. at 12:45 PM on 5/15/13, review of the policy and procedure "Verbal Orders", with a "Revised" date of 12/2012, indicated:</p> <p>a. under "II. Procedure", it reads: "...D.</p>	S000782	<p>The Medical Staff Rules and Regulations will be amended to include the statement that Verbal Orders must be dated and TIMED by the nurse that receives the order. This change will be made to the document by A1 the Director and sent to the Medical Staff meeting on the above date for review and approval. The Director will be communicate this change with the PreOp and PACU nursing staff for overall compliance throughout the TSC. This revision was reviewed by the TSC Governing Board and adopted 6/26/13. The Director met with the PreOp and PACU nursing staff on 6/19 and 6/20/13 and communicated changes. Verbal orders are being monitored for completeness during chart reviews of every patient chart. The Director will collect the results and share them with the nursing staff and report the results to the QAPI committee.</p>	06/26/2013			

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	<p>the receiver will record the order in the medical record with the date, time, signature and...Repeated and Verified."</p> <p>3. review of patient medical records on 5/14/13, indicated:</p> <p>a. pt. #1 had a verbal order for Versed written on 2/5/13 that lacked a time of the order</p> <p>b. pt. #5 had a verbal order for Fentanyl written on 4/1/13 that lacked a time of the order</p> <p>c. pt. #12 had a Labetolol verbal order written on 4/25/13 that lacked a time of the order</p> <p>d. pt. #19 had a Versed verbal order written on 4/24/13 that lacked a time of the order</p> <p>4. Interview with staff member #50, the nursing and facility administrator, at 11:35 AM and 2:30 PM on 5/14/13 indicated:</p> <p>a. nursing staff are failing to note the time of verbal orders, as listed in 3. above, as per facility policy</p> <p>b. currently, Medical Staff Rules and Regulations fail to state that the time of a verbal order must be documented as well as the date of the order</p>			

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S000920	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following: Based on policy and procedure review, patient medical record review, and staff interview, the nursing director failed to ensure the implementation of the policy related to post op telephone calls for 3 of 6 transfer patients (pts. #3, 4, and 5) and one other patient (#19).</p> <p>Findings: 1. at 12:40 PM on 5/13/13, review of the policy and procedure manual indicated a policy titled: "Post Operative Telephone Calls" (with "copyright" 1994 and "1997 Edition" at the bottom of the page), which indicated: a. under "I. Policy", it reads: "To assure patients are satisfied with the quality of care and are recovering without complications, post operative telephone calls will be made within three (3) business days."</p> <p>2. patient medical record review on 5/14/13 indicated: a. pt. #3 had a septoplasty, turbinates, and rhinoplasty on 1/15/13, was subsequently transferred due to</p>	S000920	<p>The policy titled Post Operative Telephone Calls will be revised by the Director to specifically include those outpatients that happen to be transferred and admitted to the hospital needing additional observation. The phone call will be made within 48 hours after the patient is discharged to home.</p> <p>The nurses agreed that a followup call would be appreciated by the patient and/or their caregivers. The Director will revise the policy and submit it to TSC Governing Board for review, approval, and adoption. This new policy will be reviewed with the PACU staff to ensure that ALL patients receive a postoperative telephone call as indicated in the policy with the only exceptions being from the exempted list. At their meeting on 6/26/13, TSC Governing Board reviewed the policy revision and adopted it.</p>	06/19/2013	

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	<p>decreasing oxygen saturation levels, and lacked documentation of a post op telephone call by nursing staff</p> <p>b. pt. #4 had a tonsillectomy and adenoidectomy (T & A) on 4/3/13, was transferred for hypoxia, and lacked documentation of a post op telephone call by nursing staff</p> <p>c. pt. #5 had a T & A on 4/1/13, was transferred for pain management, and lacked documentation of a post op telephone call by nursing staff</p> <p>d. pt. #19 had a tonsillectomy and BTT (Bilateral Tympanostomy Tubes) on 4/24/13, was discharged to home, and lacked documentation of a post op telephone call by nursing staff</p> <p>3. interview with staff member #50, the facility administrator, indicated:</p> <p>a. the policy exempts certain surgical procedures from a post op telephone call</p> <p>b. even though the procedures for patients #3, 4, and 5 were not exempt from a post op call, the staff was under the impression that patients who had been transferred (not discharged home) were exempt from calls</p> <p>c. the policy does not exempt transferred patients from a post op telephone call</p>						

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	d. T & A's and tonsillectomy patients are to get a post op call, it is unknown why patient #19 lacked this documentation			

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S001012	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(B)</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>(B) Drug administration according to established center policies and acceptable standards of practice.</p> <p>Based on patient medical record review and interview, the facility failed to ensure that nursing staff administered medications per physicians orders, as per standards of practice, for 4 of 22 patients (pts. #1, 3, 6 and 13).</p> <p>Findings:</p> <p>1. Review of patient medical records on 5/14/13, indicated:</p> <p>a. pt. #1:</p> <p>A. had a post op order for "Fentanyl Titrate 25 mcg-50 mcg IV (intravenous) every 10 minutes prn (as needed) for pain > 4 for Adult patients"</p> <p>B. was given 50 mcg of Fentanyl at 1255 hours on 2/5/13 and another dose of 50 mcg Fentanyl at 1300 hours on 2/5/13</p> <p>b. pt. #3:</p> <p>A. had a post op verbal order for "Versed 2 mg IVP (intravenous push)</p>	S001012	<p>The Director will meet with the Preop and PACU staff to review the survey citations and deficiencies as they relate to safe medication administration.</p> <p>Current Policies and Procedures will be reviewed as they relate to the citations. Current processes will be reviewed for needed improvements. Every PACU record will be monitored for safe medication practice. Medication charting improvements and deficiencies will be trended with results reported and posted quarterly. The Director will take corrective action with negative trends on an individualized basis. After meeting with the nursing staff, the Director identified problems with the physician order sheets themselves. These order sheets were revised improving the medication administration process for the nurses.</p>	06/19/2013			

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	<p>Now x i dose"</p> <p>B. was given 1 mg of Versed at 1300 hours on 1/15/13</p> <p>c. pt. #6:</p> <p>A. had a post op order for "Albuterol 1/2 cc in 3cc normal saline per nebulizer treatment" written on 3/25/13</p> <p>B. was given two Albuterol nebulizer treatments (one at 0740 hours and one at 1005 hours on 3/25/13)</p> <p>d. pt. #13:</p> <p>A. had a post op order for "Fentanyl Titrate 25 mcg-50 mcg IV every 10 minutes prn for pain > 4 for Adult patients"</p> <p>B. was given 50 mcg of Fentanyl at 1540 hours on 4/25/13 and another 50 mcg at 1542 hours on 4/25/13</p> <p>2. Interview with staff member #50, the nursing and facility administrator, at 1135 hours and 1430 hours on 5/14/13 indicated:</p> <p>a. patients #1, #3, and #13 were not given medications by nursing staff as per physicians orders</p> <p>b. the order for an Albuterol nebulizer treatment was written as a one time order and was given twice by nursing without receiving a new order</p>		<p>Additionally, per the nurses request, another order sheet was created with medications that were not on the current order sheet. This order sheet was designed with a TIME column and with medications for which verbal orders were commonly written. This decreases the chances for errors when taking the verbal order. All the PACU and PreOp nurses medication administration charting is being audited for accuracy and compliance. To date, the compliance is 100%. Spot checking of the charting during patient care hours will be done by the Director in a spontaneous and random manner.</p>				

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S001024	<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 clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>Based on policy and procedure review, observation, and staff interview, the facility failed to implement its policy, related to dating multi-dose vials after opening, in one surgical suite.</p> <p>Findings:</p> <p>1. at 12:40 PM on 5/13/13, review of the policy and procedure binder indicated a policy titled: "Expiration of Medications & Solutions" with an "originated date" of 12/2012, which indicated:</p> <p>a. under "Procedure", it reads: "All medications and solutions should be checked for the manufacturer's expiration date prior to use, not to exceed 28 days for opened Multi-dose vials...Multi-dose medication and solutions may be used after opening provided the expiration date</p>	S001024	<p>The policy titled Expiration of Medications & Solutions will be revised by the Director to read, "Multi-dose vials are marked with a 28 day expiration date after opening, not the opening date." This change does not affect the intent of the policy but rather to clarify and reinforce the policy and procedure. The Director will reinforce this policy with the nursing staff through poster reminders in front of the medications in the storage areas. Spot rounds and medication inspections will be made by the Director to monitor compliance.</p>	06/19/2013	

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	<p>is noted on the container...Multi-dose Vials...Manufacturer's Outdate or 28 days after opening, whichever comes first..."</p> <p>2. while on tour of the facility, and while observing a patient in the OR (operating room) surgical suite #2, at 10:05 AM on 5/15/13, it was observed that one multi-dose vial of Lidocaine with Epinephrine was opened, sitting on a table top, and lacked notation of the day opened, or the 28 day expiration date</p> <p>3. interview with staff member #51, a PACU (post anesthesia care unit) nurse and infection control practitioner, at 2:00 PM on 5/15/13, indicated:</p> <p>a. nursing staff should be noting on multi-dose vials the date of the 28 days for expiration, as required by facility policy</p>			

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S001170	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review, observation and interview, the center failed to follow its policy/procedure and ensure that defibrillator inspection and testing was performed as recommended by the manufacturer.</p> <p>Findings:</p> <p>1. The Phillips M4735A HeartStart XL Defibrillator/Monitor (2006) Instructions for Use indicated the following: " Perform a Shift/System Check every shift ...along with visual inspection of the device and all cables, controls,</p>	S001170	The policy/procedure titled Check of Emergency Equipment will be revised by the Director to include: "perform a visual inspection of the devise, additional checks indicated on the monitor report printout, additional checks per manufacturer's recommendations". The Director will meet with the staff members assigned to testing this equipment and instruct them using the equipment check documentation that is included on the Shift/System Check strip documentation. This strip documentation will be collected as a continuous roll print out with	06/10/2013			

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	<p>accessories and supplies. Also regularly check expiration dates of all supplies, such as multifunction defib electrode pads ... "</p> <p>2. The policy/procedure Check of Emergency Equipment (approved 12-11) indicated the following: " The defibrillator check shall be performed in accordance with the manufacturer ' s directions at the beginning of the day. " The policy/procedure failed to indicate the following: A. perform a visual inspection of the device (page 11-6) B. additional checks indicated on the monitor report printout (example page 11-5) C. additional checks per manufacturer ' s recommendations (page 11-6).</p> <p>3. During a tour on 5-14-13 at 1030 hours, the Phillips M4735A defibrillator was observed on the top of the Crash Cart with the document Crash Cart Defibrillator Check Sheet. The check sheet documentation failed to include the Shift/System Check strip documentation or indicate the recommended checks listed in Section 11 Maintaining the HeartStart XL Equipment and a list of recommended checks to be performed was not observed elsewhere on the Crash Cart.</p>		<p>the Crash Cart Defibrillator. This revision does not change the intent of the policy/procedure, but only meant to clarify and complete the procedure. The Director will monitor compliance with spot checks of the process for compliance.</p>	

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	4. During an interview on 5-14-13 at 1205 hours, staff A1 confirmed that the daily defibrillator checks were not being performed according to the manufacturer's recommendations.			

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S001180	<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 5-13-13 at 1030 hours, staff A1 was requested to provide documentation of a safety management program including committee membership and minutes and none was provided prior to exit.</p> <p>2. The policy/procedure Quality Assurance Program (approved 12-11) failed to establish a safety committee component with representatives from administration and patient care and failed to indicate a frequency for safety</p>	S001180	<p>A safety management committee will be appointed including a membership with representatives from administration and patient care services. The Director will define the program in writing and assign a safety officer. The program will be incorporated as a reportable component in the QAPI Program which is reviewed by TSC Governing Board quarterly. This report is recorded in the TSC Governing Board meeting minutes.</p>	06/26/2013			

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	<p>committee meetings.</p> <p>3. The governing board meeting minutes dated 11-07-12 and 2-20-13 failed to indicate a Safety heading/topic among the listed areas and failed to indicate attendance by the safety officer A2.</p> <p>4. During an interview on 5-14-13 at 1445 hours, staff A1 confirmed that the center lacked a safety management program that reviewed safety functions and confirmed that the governing board/QA minutes lacked documentation of a safety committee component including a representative from patient care services.</p>				

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S001182	<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 on document review and interview, the center lacked documentation of a functioning safety management program that collected and evaluated information about safety practices and hazards.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 5-13-13 at 1030 hours, staff A1 was requested to provide documentation of a safety management program including program objectives and areas to be addressed and none was provided prior to exit. The policy/procedure Quality Assurance Program (approved 12-11) failed to establish a safety committee component and failed to indicate the safety functions to be performed and reviewed by the QA committee. The governing board meeting minutes 	S001182	The safety management program will be written by the Director and will include the following but not limited to: safety functions to be performed, safety officer responsibilities, quarterly safety hazards survey data collection documents. The information collected will be evaluated and reported in the QAPI Program to TSC Governing Board.	06/26/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001065	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/15/2013
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	<p>dated 11-07-12 and 2-20-13 failed to indicate a Safety heading among the topic areas and failed to indicate that quarterly fire drills or center safety checks performed by the safety officer A2 were reported or reviewed The minutes lacked documentation of committee recommendations in response to identified safety concerns or events.</p> <p>4. During an interview on 5-14-13 at 1445 hours, staff A1 confirmed that the center lacked documentation of a center-wide program that evaluated and reviewed safety functions.</p>				

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S001188	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on document review and interview, the center failed to maintain its fire control plan.</p> <p>Findings:</p> <p>1. The policy/procedure Fire - Code F (approved 12-11) indicated the following: " alert others by intercom ...alert the staff of the fire by using the intercom ... "</p> <p>2. During an interview on 5-14-13 at 1615 hours, staff A1 confirmed that the center did not have an intercom for announcing a fire alert in the center and confirmed that the policy/procedure had not been maintained.</p>	S001188	The Fire Plan will be updated and revised by the Director to include all necessary elements from activation through RACE including cooperation with firefighting authorities. Research will be conducted to determine the ability of the current phone system to convey department wide fire activation announcements. The revised plan will update the fire drill format, documentation including staff member involvement, and evaluation of the drill. New tools for these purposes will be developed. Fire drills will be conducted within TSC quarterly and, when advantageous, in conjunction with Lutheran Hospital Fire Drills. The revisions will be presented to TSC	06/28/2013	

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	<p>3. Documentation indicated on 2-14-13 that a fire drill was conducted by the Lutheran Health Security department with participation by the surgery center staff.</p> <p>4. During an interview on 5-14-13 at 1615 hours, staff A1 confirmed that the fire plan lacked a provision for conducting fire drills in cooperation with Lutheran Health Security and had not been maintained.</p>		<p>Governing Board for approval and adoption. The 2nd quarter fire drill will take place on 6/28/13. Lutheran Hospital Safety Officer was contacted by the Director asking for templates to monitor and evaluate Fire Drills. These templates were gladly shared and will be used by the Director for future Fire Drills either singly in the TSC or jointly with Lutheran Hospital.</p>		