

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001028	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/27/2012
NAME OF PROVIDER OR SUPPLIER GASTROINTESTINAL ENDOSCOPY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 ST MARYS DR, STE 110 W EVANSVILLE, IN 47714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005820</p> <p>Survey Date: 06/25/2012 through 6/27/2012</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 07/06/12</p>	S0000	Not Applicable. Survey information only. No corrective action necessary		

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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S0110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and staff interview, the facility failed to ensure the Governing Body reviewed the Quality Assurance Indicators for the the Indirect Patient Care Contracted Vendors for 2011.</p> <p>Findings included:</p> <p>1. At 11:00 AM on 6/26/12, staff member #1 indicated all the Indirect Patient Care Vendors Quality reviews are presented to the Governing Body on the January Board meeting. The meeting will discuss the Indirect Patient Care Vendor indicators from the previous year. However, the staff member confirmed the Board of Director minutes could not identify that the contracted Indirect Patient Care Vendors were reviewed and approved annually like the previous years as required by the facility.</p>	S0110	As indicated in the description, this discussion of care vendors did take place at the January meeting, but the minutes were lacking the summary. Indirect Patient Care Vendors summary will be added to the minutes for January 2012. This addendum will be signed off by the Board, Surgery Center Director, and Administrator. This is the Surgery Center Directors (Scott Hamrick) responsibility to ensure that this takes place and is reported in the minutes every January.	07/16/2012			

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	<p>2. The Governing Board January minutes were reviewed for the previous 5 years: 2011, 2010, 2009, 2008, and 2007. Each January Governing Board meeting had the Indirect Patient Care contracted Vendors reviewed and approved to be reviewed by the Board of Directors except for 2011. The January Board of Director minutes for 2012 did not identify the 2011 Indirect Patient Care Contracted Vendors were reviewed and approved.</p>			

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S0300	<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 staff interview, the facility failed to ensure 3 services provided by the hospital were included as part of it's comprehensive quality assessment and improvement (QA&I) program: Radiology, Pest Control, and Infection Control.</p> <p>Findings included:</p> <p>1. Quality Assessment and Improvement Program last reviewed 6/23/98 notes all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program.</p> <p>2. The quality improvement program and the minutes for the previous 12 months were reviewed with staff member #1 at 200 PM on 6/26/2012. Staff member #1 confirmed services, Radiology, Pest Control, and Infection Control have not been monitored by the Quality Assurance</p>	S0300	<p>First 30 days: Arab Pest Control and Radiology have been added to the QAPI Program under Indirect Care Vendors and will be evaluated annually. Responsible Party: Scott Hamrick Estimated Completion date: 7/20/2012</p> <p>60 days: We will continue to ask for patient feedback through comment cards and from Post-operative Follow-Up calls. This will begin with July data. A master list of Patients with Complications will be created and all patients with known issues will be logged there. In addition, each case will be evaluated for trends or acute issues within the center or with the staff that could be infection related. This will be maintained by our Charge Nurse. Responsible Party: Charge Nurse Estimated Completion date: 8/1/2012 Starting with this month's</p>	10/01/2012

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	<p>committee.</p> <p>3. The facility calls patients, but doesn't have a percentage of how many they actually contact. They send comment cards out with the patients as they are discharged from the ASC, but only get about 25% back. If a patient complains of some symptoms of infection on their return card, the ASC staff would call them to get more specifics, but the information is in the patient's individual chart. There is no ongoing log with facility follow-up.</p> <p>4. This above process was confirmed by staff member #1.</p> <p>5. At 11:30 AM on 6/27/2012, staff member #1 indicated the management team is both the infection control committee and the QA committee so nothing is officially presented in a QA meeting. The staff member indicated the comment cards provided to the patients during their discharge from the ASC were the only way the facility tracks any infections within the ASC. The data collected from the comment cards are not made part of the Quality Assurance Program.</p> <p>6. Staff member #1 confirmed the method was not the most effective way in</p>		<p>meeting, the Quality Assurance Committee and the Infection Control Committee will be unique bodies that will meet seperately. The Infection Control Committee will report progress through the Infection Control Nurse. Responsible Party: Scott Hamrick/Infection Control Nurse (Interim Andrea Schenk) Estimated Completion date: 8/30/2012 90 days +: Radiology Services will be contracted with St Marys. Initial contact with SMMC Radiology has been made. All contracts have from the SMMC side have to be approved by their President's office which can take some time, so we don't expect to have this in place for a couple of months. Responsible Party: Scott Hamrick Estimated Completion date: 9/20/2012 Infection Control Program has been added to the revised QAPI Program and Infection Control initiatives will be reported quarterly. Responsible Party: Infection Control Nurse (Interim Andrea Schenk, RN), Estimated Completion date: 10/1/2012</p>		

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	evaluating the infection rate within the ASC.			

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S0328	<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 staff interview, the facility failed to ensure the 2 contracted housekeeping services are being monitored effectively with continuous follow-up that in turn could impact on patient care.</p> <p>Findings included.</p> <p>1. Quality Assessment and Improvement program that was provided by staff member #1 was observed with the most recent approval date of 6/23/98. Quality Assessment and Improvement program stated, "Quality Assessment and Improvement Program 10 step process to the QAI program: Assigned responsibilities; Delineate scope of care; Identify important aspects of care; Establish thresholds for evaluation; Identify indicators; Collect and organize</p>	S0328	<p>A meeting was held with Ira Parrish on June 28th to address the issues found in the April Indirect Care Vendor evaluation as well as in the state survey that was discussed during the exit conference. Responsible Party: Scott Hamrick, Estimated Completion Date: 6/28/2012 (actual)</p> <p>Cleaning Services have been added to the QAPI Program under Indirect Patient Care Vendors and after the short term evaluation period will be evaluated quarterly. We have already put N & I through the evaluation period and will be changing cleaning services. Responsible Party: Scott Hamrick completed 7/20/2012 A meeting was held on 7/2/2012 with Mike Work from St Marys Building Corporation (EverClean)</p>	08/01/2012			

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	<p>data; Evaluate care; Take action to solve problems; Assess the actions and document improvement; and Communicate</p> <p>2. Staff member #1 maintains Quality Assessment and Improvement program for Indirect Patient Care Vendors. The indirect patient care vendors are evaluated semi annually by the Quality Assessment Committee and are reported to the Board of Directors at a monthly Board meeting.. The facility have two contacted housekeeping companies. Both vendors were evaluated 4/2012. The Quality Review sheet for V1 had a rating of 66% while the Quality Review for V2 was 20 %. The evaluation goal for both cleaning companies was 90%. Comments for V1 Quality Review states "Meeting with manager scheduled 7/2/12." Comments for V2 states, "Meeting with management scheduled 6/28/12." Neither Quality Review form identified in the column, Reported to Board of Directors, any action plan or any other comments that could be crucial for the Board of Directors to make their decisions on the 2 cleaning companies.</p> <p>3. At 3:00 PM on 6/28/12, staff member #1 indicated the monitoring system the facility uses for the indirect patient care vendors was not effective enough. The</p>		<p>to discuss the 4/12 review as well as state survey results discovered during the exit conference. The review in April had found that trash had not been emptied daily. Upon further discussion with the team, it was found that trash is emptied daily, but occasionally there are loose items left on the floor. Listing this as a failure of the review seems to stem more from the evaluation tool as opposed to the performance. The evaluation tool will be revised to be a percentage performance in each category as opposed to a YES/NO or PASS/FAIL. Further QAPI Program will be revised to state that any Direct or Indirect Care Vendor evaluation found to be outside of established performance range will be reviewed with their management within 30 calendar days of the review. Results of the meeting will be reported to the Quality Assurance Committee at the next meeting and then subsequently reported to the Governing Body. Responsible Party: Scott Hamrick, Estimated Completion Date: 8/1/2012</p>		

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	system takes too long to take action on a vendor that was below their Quality Review Goal. The staff member indicated 3 months to respond, report and take action on a vendor that was evaluated 20% effective is not a good and effective program to ensure safety for the patients and visitors of the ASC.			

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S0400	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, policy and procedure review, and interview, the facility to minimize infection control exposure and risks in the patient care areas.</p> <p>Findings included:</p> <p>1. Upon arrival at the facility at 11:30 AM on 06/25/12 and being escorted by staff member #A1 through the recovery area to an office, a large metal cart of clean linen was observed uncovered. Visitors in street clothes were also observed walking close by the cart.</p> <p>2. During the case tracer observation on 06/26/12, the following observations were made:</p> <p>A. At the completion of the procedure at 10:30 AM, the physician, staff member #A13, removed his/her gloves, left the room and entered data on the computer, came back into the room to retrieve a stethoscope, then left again without performing any hand hygiene.</p> <p>B. At 10:35 AM, a registered nurse (RN), applied gloves, carried a suction canister containing liquid fecal material to the soiled room and emptied the material and discarded the container, changed gloves, and proceeded to clean the procedure room for the next patient without performing any hand hygiene.</p> <p>C. At 10:45 AM, the certified registered nurse anesthetist, staff member #A24, cleaned the</p>	S0400	<p>Infection Control has been added to the QAPI and will report initiatives, risks, and issues quarterly. Responsible party: Scott Hamrick/Infection Control Nurse (Interim Andrea Schenk, RN) Completed:</p> <p>First 30 days: The Linen Holding Carts can be closed and will be required to be closed after use. Staff will be reeducated at 7/31/12 staff meeting. A sign will be placed by both carts reminding staff to keep them closed. Monitoring will be ongoing and handled by the Infection Control Nurse and non-compliance reported to the Infection Control Committee. Responsible Party: Infection Control Nurse (Interim Andrea Schenk, RN), Estimated Completion Date 7/31/2012</p> <p>Portable Linen Carts have been purchased that will eliminate the need to drag bags across the floor. Responsible Party: Tara Deardorff, Estimated Completion Date 7/16/2012 (actual)</p> <p>60 days: The Infection Control Committee has begun an Infection Control</p>	09/01/2012			

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	<p>computer area and top of the anesthesia cart without wearing gloves, then proceeded to the patient waiting area without performing any hand hygiene.</p> <p>D. At 10:50 AM, a patient care tech was observed dragging a bag of soiled linen across the floor to the soiled room, removing gloves, inserting a clean linen bag into the hamper, then taking clean linen from the cart to make the patient bed without performing any hand hygiene.</p> <p>3. The facility policy "Linen and Laundry", last reviewed 10/26/09, indicated, "...3. Clean linen is stored on covered linen carts. ...5. Gloves are to be worn to handle all soiled linens. ...Wash hands immediately after handling soiled linen."</p> <p>4. The facility policy "Hand Hygiene", last reviewed 10/26/09, indicated, "Environmental Guidelines: Gloves should always be worn when cleaning. ...Hand Hygiene: Hands should be washed before giving direct care to patients. Hands should be washed after any patient care such as taking blood pressures, temperatures, lifting patients, etc. Hands should be washed after removing gloves."</p> <p>5. At 11:30 AM on 06/27/12, staff members #A1 and A3, confirmed the breaches in infection control practices and indicated some retraining was in order.</p>		<p>project dealing with compliance of hand hygiene. Blind observation has just been completed and we will compare the results of our findings against findings from after the in-service (8/1/2012-8/8/2012) has taken place and will repeat as necessary. We will continue this process until we have reached 95% compliance. Additionally, glow-germ has been purchased to assist in the in-services. Responsible Party: Tara Deardorff, Estimated Completion Date 9/1/2012 Already completed at Tara's departure, now in reevaluation period. Reevaluation will be handled bby Infection Control Nurse/Committee. (9/4/12 Scott Hamrick)</p> <p>Infection control Policy and Procedures regarding Hand Hygiene have been reviewed and have been found adequate. In regards to staff non-compliance we will provide copy of Hand Hygiene to each staff member and every staff member will go through an in-service and competency that requires return demonstration and post test to acknowledge understanding of the policy and proper technique. These skills will be reviewed as a part of the annual competencies and will be included in new hire orientation. To encourage hand hygiene, automatic dispensing alcohol based hand sanitizers have been placed throughout the</p>		

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			center. Responsible Party: Tara Deardorff, Estimated Completion Date 9/1/2012	

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S0408	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(d)</p> <p>(d) The center shall designate a person qualified by training or experience as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on policy and procedure review, administration document review, and interview, the facility failed to ensure the person in charge of the infection control program was qualified according to policy and education and experience.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The facility policy titled "Infection Control Nurse Duties", last reviewed 09/21/2009, indicated, "The Infection Control Nurse will be the Director of Nursing or a Registered Nurse designated by the Medical Executive Committee. This professional nurse will oversee the implementation of the Gastrointestinal Endoscopy Center infection control plan as outlined through the policy, procedures and quality improvement program." 2. Review of the Safety Committee Minutes from May 9, 2011 indicated, "...[Staff member #A1] has been hired as the surgery center director. Job description will be as attached." The attached job description indicated under "Essential Duties and Responsibilities, ...Oversees all infection control aspects of the facility." The job description continued under "Basic Education, Skills and Expectations: Bachelor's Degree from an accredited college or university. Minimum of 5 years previous management experience. Excellent 	S0408	<p>Tara Deardorff, RN has been named by the Governing Body as Infection Control Nurse. Tara also serves as our Charge Nurse and participates as a member of the Quality Assurance Committee. This assignment was made official at the July Governing Body Meeting on 7/16/2012. Responsible Party: Scott Hamrick, Estimated Completion Date: 7/16/2012 (actual) Tara's last day of employment was 9/3/2012. We have named Andrea Schenk, RN as our Interim Infection Control Nurse. This interim tag will be evaluated in May of 2013 to decide whether or not the Infection Control responsibility will continue to be Andrea's or if it will revert to our Charge Nurse. (updated 9/4/2012 by Scott Hamrick) Job Description for Surgery Center Director will be changed to remove the designation of Infection Control Officer and the job description for GEC Charge Nurse will be changed to include</p>	10/31/2012			

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	<p>leadership and communication skills. Ability to discern and maintain confidentiality of sensitive or private information. Orientation to detail and organization."</p> <p>3. At 3:30 PM on 06/26/12, staff member #A1 indicated he/she was not a nurse and had no specific training in infection control. He/she indicated a manual was provided upon hire with the responsibilities of the infection control program. He/she indicated he/she had 8 years hospital experience as the Patient Access Manager.</p>		<p>assignment of Infection Control Nurse. Responsible Party: Scott Hamrick/Butch Moors, Estimated Completion Date: 8/15/2012 Tara has 12 years of experience in a hospital and clinic setting. She will also be receiving training from the American Professionals of Infection Control (APIC) this October. Tara will be working to redesign the Infection Control Program over the next couple of months. Responsible Party: Tara Deardorff, Estimated Completion Date: 10/31/2012 Andrea will be attending the training that Tara was scheduled to attend.</p>		

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S0418	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(A)</p> <p>(2) The infection control committee responsibilities must include, but are not limited to the following:</p> <p>(A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the center.</p> <p>Based on policy and procedure review, committee meeting minutes, other reports, and interview, the infection control committee failed to ensure systems were in place for monitoring infections in the center.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The facility policy "Infection Control Nurse Duties", last reviewed 09/21/2009, indicated, "...Monthly solicit reports of infections from surgeons for previous month patients using facility standardize querying reports. Investigate each reported infection utilizing facility quality improvement report." 2. The document provided for the infection control committee meeting minutes was a report prepared by staff member #A1 which just listed the various areas being clean, adequately supplied, and equipment in working order based on weekly inspection sheets. The document did not list any specific members in attendance. 3. The facility document titled "Patient Satisfaction Survey Results and Assessment of Post-Operative Infection Report" from April of 2012, indicated a summary of 5 survey questions with the last one being, "Did you have any 	S0418	<p>First 30 days: We will continue to ask for patient feedback through comment cards and from Post-operative Follow-Up calls. This will begin with July data. A master list of Patients with Complications will be created and all patients with known issues will be logged there. In addition, each case will be evaluated for trends or acute issues within the center or with the staff that could be infection related. This will be maintained by our Charge Nurse and she will review and report findings to the Infection Control Committee. Responsible Party: Charge Nurse Estimated Completion date: 8/1/2012 This duty has temporarily been given to Brandy Sievers, RN. (9/4/12 Scott Hamrick)</p> <p>60 days: Beginning with July patients, a message query will be sent to all Medical Staff members through gGastro requesting a list of patients that to the physician's</p>	10/01/2012			

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	<p>complications at home after your procedure?" Out of 172 responses, 1 person reported chills, 1 reported drainage, 1 reported abdominal pain, and 4 reported a red intravenous site.</p> <p>4. At 3:30 PM on 06/26/12, staff member #A1, the person in charge of the infection control program, indicated they rely on the patients to report any infections by returning response cards and by follow-up phone calls from staff. He/she indicated only about 25% of the cards were returned and about 50- 75% of the patients were reached by phone. He/she indicated forms were not sent to the physicians for reporting. He/she also indicated the same management team comprised both the infection control committee and the quality assessment (QA) committee and no reports of tracking or trending were officially reported to QA. Staff member #A1 indicated if the patients reported symptoms of infection, they were followed up by phone calls, but this information was only documented in that individual patient's chart.</p>		<p>knowledge had post-procedure complications. Any responses will be added to the master list of Patients with Complications described below. Responsible Party: Charge Nurse, Estimated Completion Date: 8/15/2012 Infection Control Meeting Minutes will have date time and attendants listed. This requirement will be listed in the Infection Control Committee reporting responsibilities as a part of the QAPI. Responsible Party: Tara Deardorff, Estimated Completion Date: 9/1/2012 Tara did not have a meeting prior to her departure. The Infection Control Committee will meet on 9/13/2012. Andrea Schenk will chair that meeting. (9/4/2012 Scott Hamrick) 90 days: Infection Control Program has been added to the revised QAPI Program and Infection Control initiatives will be reported quarterly. Responsible Party: Infection Control Nurse (Interim Andrea Schenk, RN), Estimated Completion Date: Added on 7/20 with first report being 10/1/2012</p>		

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S0422	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.</p> <p>Based on review of product information, policy and procedure review, employee files review, and interview, the facility failed to ensure TB testing was performed per policy for 9 of 10 staff member files reviewed (#A11, A12, A15, A16, A17, A19, A20, A21, and A22).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The manufacturer's product information for Aplisol, the solution used for TB testing, indicated the tests should be placed and read within 48 to 72 hours for accuracy. 2. The facility policy "Employee Health Tests", last revised 10/22/09, indicated, "...2. TB Skin Testing: All new employees are required to have 2 PPD skin tests. All employees will receive a 2-step PPD. The second PPD will be administered 2 weeks after the first negative PPD is given. The PPD skin test is to be read and documented with the date and time applied, date and time read; signed by a TB certified RN and results as measured in mm (millimeters). 3. Review of the employee files for staff members #A12 (hire date 10/31/11), A19 (hire date 08/08/11), and A21 (hire date 06/06/11), lacked documentation of the 2-step PPD testing. 	S0422	<p>Employee Health Tests policy will be revised and will state under TB skin testing: All new employees will receive a two-step TB skin test with the first administered in the first three weeks of employment unless they are able to present documentation from their healthcare record that a test had been administered and results recorded within the last calendar year and then one test will be accepted. TB skin tests will be administered to all employees on an annual basis concurrent with annual competencies. This will be monitored by the Surgery Center Director for new hires and then by the Charge Nurse for the annual testing. Responsible Party: Charge Nurse, Estimated Completion Date: 8/1/2012 (actual) This policy has been revised and will be submitted for approval to the Governing Body 9/10/2012.</p> <p>TB Evaluation sheet will be revised to include a blank for time and verbiage that requires the</p>	09/10/2012			

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	<p>4. Review of the employee files for staff members #A11, A15, A16, A17, A19, A20, A21, and A22 lacked documentation of times for both the placement and the reading of the PPD tests making it unable to determine the reading between 48 and 72 hours after placement.</p> <p>5. At 11:30 AM on 06/25/12, staff members #A1 and A3 confirmed the employee file findings and indicated they would sometimes accept a prior negative PPD test as the first part of a 2-step test, but confirmed their policy did not indicate that.</p>		<p>test be read between 48 and 72 hours after administration. Responsible Party: Tara Deardorff, Estimated Completion Date: 7/16/2012 (actual)</p>	

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S0432	<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 observation, policy and procedure review, and interview, the infection control committee failed to ensure the patient care areas were maintained in a clean, sanitary manner and failed to ensure chemicals were labeled appropriately.</p> <p>Findings included:</p> <p>1. During the tour of the patient care areas, beginning at 11:30 AM on 06/26/12 with staff members #A1 and A3, the following observations were made:</p> <p>A. A layer of dust on the back ledges of the procedure rooms and pre/post areas.</p> <p>B. A heavy layer of dust on the bottoms of the patient carts in the pre/post areas.</p> <p>C. Three spray bottles containing a blue solution in the housekeeping closet, 1 with no label, 1 with "DES" written on the bottle, and 1 with "spray/buff" written on the bottle.</p> <p>2. The facility policy "Endoscopic Cleaning (Procedure Room)" indicated, "1. Patient care areas will be cleaned at the end of the day. ...9. It</p>	S0432	<p>Findings from the state survey were discussed in detail with Ira Parrish, Owner of N and I cleaning who is contracted to supply cleaning services for the GEC. N&I's performance will be monitored daily and evaluated weekly for the next 30 days. All deficiencies will be reported to the Medical Director and Surgery Center Director. Subsequent monitoring will be ongoing with evaluation moved from every 6 months to quarterly. Results will be reported to the Quality Committee and to the Governing Body. Beyond counseling Mr Parrish, Scott has counseled each of the housekeepers about the areas of concern (A,B,C). In addition, we have started to look at other cleaning groups for pricing and references. Responsible Party: Scott Hamrick, Estimated Completion</p>	07/18/2012			

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	<p>is the responsibility of the staff working each day to assure the daily cleaning is completed."</p> <p>3. At 11:50 AM on 06/26/12, staff members #A1 and A3 indicated the chemicals belonged to the contacted cleaning staff and they did not know what products they were. They also indicated the contracted cleaning staff only emptied trash and mopped and vacuumed the floors and the facility staff was responsible for the daily cleaning, including the patient carts.</p>		<p>Date: 6/28/2012 (actual) C. All bottles in the closet have been labeled appropriately. The solutions were Windex and Kor-X-All at two different dilution states. Responsible Party: Scott Hamrick/Ira Parrish, Estimated Completion Date: 6/29/2012 (actual) B. The Patient Carts will be wet-wiped weekly and have been added to the services contract with N and I. Responsible Party: Scott Hamrick/Ira Parrish, Estimated Completion Date: 6/29/2012 (actual) 3. The following chemicals have been approved by GEC Management to be used in the center: Windex, Ajax, Mr Clean All Purpose Cleaner, Kor-X-All, Neutra DC Cleaner. MSDS sheets for each of these chemicals have been placed in the MSDS book kept in the Director's office. Responsible Party: Scott Hamrick, Estimated Completion Date: 7/18/2012 (actual) Cleaning Services have been added to the QAPI Program under Indirect Patient Care Vendors and after the short term evaluation period will be evaluated quarterly. We have already put N & I through the evaluation period and will be changing cleaning services. Responsible Party: Scott Hamrick completed 7/20/2012</p>		

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S0620	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(5)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(5) Plain paper facsimile orders, reports, and documents are acceptable for inclusion in the medical record if allowed by the center policies.</p> <p>Based on document review and staff interview, the facility failed to assure a written policy or procedure that specifies facsimile patient orders are received on plain paper.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The GEC Faxing of Medical Information last reviewed 3/21/2012 states, "It is the policy of the Gastrointestinal Endoscopy Center to accept information by FAX. Copies must be legible. When possible, it will be the practice of the center to fax the majority of items through the Electronic Medical Record." At 1:30 PM on 6/25/2012, staff member #1 confirmed the facility does not have a policy that all faxes will be on plain paper. 	S0620	<p>Policy GEC FAXING OF MEDICAL INFORMATION has been revised to read: "It is the policy of the Gastrointestinal Endoscopy Center to accept information by FAX. Copies must be legible and be received in plain paper form." Responsible Party: Tara Deardorff Estimated Completion Date 7/6/2012 (actual)</p>	07/06/2012	

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S0780	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on policy and procedure review, medical record review, and interview, the facility failed to have a policy regarding the use of physician standing orders and failed to acknowledge the orders for 7 of 20 patient records containing standing orders (#P2, P4, P7, P11, P12, P16, and P18).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the policy and procedure manual for the facility failed to indicate any policy regarding the use and implementation of physician standing orders for the patients of the facility. Review of the medical records for patients #P2, P4, P7, P11, P12, P16, and P18 indicated a form titled "Standing Physician Orders" which included both pre-procedure and post-procedure orders. The forms were all signed by a physician, but not timed, dated, or signed by a nurse to indicate any necessary orders were implemented. The other 13 	S0780	<p>A policy, Standing Orders, which has been added to to section 4 has been written. This new policy was presented to the Governing Body and approved on 7/16/2012. Policy changes and review of existing policies will be done at staff meeting shceduled for 7/31/2012. Responsible Party: Tara Deardorff, Estimated Completion Date: 7/31/2012We have added the proper completion of this document to the Nursing Medical Record Audit and compliance will be evaluated with all other charting elements and reported quarterly. Responsible Party: Scott Hamrick added to audit for July patients and will be reported with 3rd Quarter audit summary in October.</p>	07/16/2012

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	<p>medical records reviewed did contain this nursing documentation.</p> <p>3. At 11:30 AM on 06/27/12, staff members #A1 and A3, indicated the orders should all be noted by the nurse and confirmed the omissions. They also indicated the 7 physicians using the standing orders form all reviewed the form and agreed to its content, but confirmed the lack of an actual policy directing how it was to be used.</p>			

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S1024	<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 observation, policy review, and interview, the facility failed to ensure syringes of medication were labeled according to policy.</p> <p>Findings included:</p> <p>1. During the tour of the patient care areas at 11:45 AM on 06/26/12, accompanied by staff member #A3, the following items were observed in the anesthesia cart in procedure room 3:</p> <p>A. Four syringes of Propofol with labels indicating a date and time prepared, but no staff initials or medication expiration date.</p> <p>B. Eight syringes of Lidocaine with labels indicating a date and time prepared, but no staff initials or medication expiration date.</p> <p>2. The facility policy titled "Epix", last reviewed 12/2011, provided by staff member #A3 when documentation of medication labeling was requested, indicated under Propofol, "...2. Propofol will be drawn up from 20 milliliter (ml) bottles into 20 cubic centimeter (cm) single-use</p>	S1024	<p>Policy Named: 6.6 Cross-Contamination Guideline Item 4 will be revised to read: Syringes will be labeled with date, time drawn, provider initials and expiration date of medication vial. This was completed 7/18/2012 Responsible Party: Melissa Harper Compliance will be monitored by Melissa Harper, Lead CRNA and monitoring will be ongoing with observations to be reported to the Infection Control Nurse monthly. Melissa's compliance will be monitored in the same manner by our Infection Control Nurse. Melissa will begin reporting at the August Infection Control meeting. Policy changes and review of existing policies will be done at staff meeting scheduled for 7/31/2012. Resonsible Party: Melissa Harper</p>	07/31/2012

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	<p>syringes. 2. In the event Propofol is pre-drawn from a center pharmacy or a mixing compound pharmacy, individual syringes are used for one case and all excess Propofol is discarded after the case is completed. Syringes will be labeled with date, time drawn, time of expiration (6 hours after drawing) and Provider initials. The policy continued regarding Lidocaine, "...4. Syringes will be labeled with date, time drawn and Provider initials."</p> <p>3. At 3:00 PM on 06/27/12, staff member #A3 confirmed the medication syringes were not labeled according to policy.</p>			