

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001128	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/21/2016
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NAME OF PROVIDER OR SUPPLIER  MEDICAL CONSULTANTS SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 800 S TILLOTSON AVE MUNCIE, IN 47304
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Q 0000  Bldg. 00	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 003754</p> <p>Survey Date: 01-19/21-2016</p> <p>QA: cjl 02/17/16</p>	Q 0000		
Q 0081  Bldg. 00	<p>416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES</p> <p>(a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.</p> <p>(a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC.</p> <p>(c)(1) The ASC must set priorities for its performance improvement activities that -</p> <ul style="list-style-type: none"> <li>(i) Focus on high risk, high volume, and problem-prone areas.</li> <li>(ii) Consider incidence, prevalence, and</li> </ul>			

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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	<p>severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for 2 services furnished by a contractor, a monitor and standard for 1 directly-provided service and a standard for 1 directly-provided service in its quality assessment and performance improvement (QAPI) program for calendar year 2015.</p> <p>Findings include:</p> <p>1. Review of the facility's QAPI program for calendar year 2015 indicated it did not include the following:</p> <ul style="list-style-type: none"> <li>-a monitor and standard for the contracted services of biohazardous waste hauler and housekeeping</li> <li>-a monitor and standard for the directly-provided service of housekeeping by nursing</li> <li>-a standard for the directly provided service of nursing</li> </ul> <p>2. Interview of employee #A1, Administrator/Nursing Director, on 01-21-2016 at 2:00 pm, confirmed the above and no other documentation was provided prior to exit.</p>	O 0081	<p>Tag: Q-0081 Correction: This deficiency will be corrected by the way of a tracking system tool we already have in place in which these contracted services can be reviewed and evaluated to be performing within their contract. This tool will consist of a monitor and standard for each contracted service and directly provided services . This document will be forward to the QAcommittee section at the Governing Board meeting as required.</p> <p>Prevention: This will be prevented by continually using this tool to review and evaluate these contracted services and directly provided services by forwarding this information to the QA committee section of the Governing Board as required, and have it readily available atall times.</p> <p>Responsibility: Administrator Date: March 25, 2016</p>	03/25/2016			

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Q 0121 Bldg. 00	<p>416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.</p> <p>Based on interview and document review, the governing body failed to follow medical staff bylaws to appoint a medical director and that the medical director had current privileges.</p> <p>Findings: include:</p> <ol style="list-style-type: none"> <li>1. Interview of employee #A3, Business Office Manager, on 01-20-2016 at 2:15 pm, indicated MD#6, a rheumatologist, was the facility's medical director.</li> <li>2. Review of the medical staff bylaws, approved by the medical staff 10-23-2014 and the governing board 10-27-2014, indicated "officers shall be appointed at the annual meeting of the Governing Body." Further review of the bylaws indicated the "Medical Director/President of the medical staff shall serve as the chief administrative officer of the medical staff ... ."</li> <li>3. Staff was requested to provide</li> </ol>	O 0121	<p>Tag: Q-0121 Correction: This deficiency will be corrected by the Governing Board following the Medical Staff Bylaws to appoint a Medical Director, and the Medical Director has current privileges annually. On February 1, 2016 at the Governing Board meeting, this was corrected. Prevention: The Governing Board will follow the Medical Staff Bylaws to appoint a Medical Director, and the Medical Director has current privileges, on the annual meeting. Responsibility: Governing Board Date: February 1, 2016</p>	02/01/2016

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Q 0223 Bldg. 00	<p>documentation of governing board minutes where the medical director was appointed and no documentation was provided prior to exit.</p> <p>4. Review of a file for MD#6 indicated there was no documentation that MD#6 had current privileges.</p> <p>5. Interview of employee #A3 on 01-20-2016 at 2:15 pm confirmed all the above and no other documentation was provided prior to exit.</p> <p>416.50(b) NOTICE - PHYSICIAN OWNERSHIP The ASC must disclose, in accordance with Part 420 of this subchapter, and where applicable, provide a list of physicians who have financial interest or ownership in the ASC facility. Disclosure of information must be in writing. Based on interview, the facility failed to have a policy to notify patients that physicians have a financial interest or ownership in the facility.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:30 am, employee #A1, Administrator/Director of Nursing, was requested to provide a policy to notify patients that physicians have a financial interest or ownership in the facility.</p>	O 0223	<p>Tag: Q-0223 Correction: This deficiency will be corrected by placing a policy to notify patients that physicians have a financial interest or ownership in the facility. We already have this in place, however no policy was written. This policy will be reviewed and approved by the Medical Director/Governing Board. Prevention: A policy will be placed to notify patients that physicians have a financial interest or ownership in the facility. Responsibility: Administrator</p>	03/25/2016

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Q 0224 Bldg. 00	<p>2. In interview on 01-21-2016 at 2:30 pm, employee #A1 confirmed there was no above-requested policy and no documentation was provided prior to exit.</p> <p>416.50(c)(1)(2)(3) ADVANCED DIRECTIVES The ASC must comply with the following requirements:</p> <p>(1) Provide the patient or, as appropriate, the patient's representative with written 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>(2) 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>(3) 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 interview, the facility failed to have a policy regarding facility advanced directives, and a description and availability of applicable State advanced directive brochure.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:30 am, employee</p>	Q 0224	<p>Date: March 25, 2016</p> <p>Tag: Q-0224 Correction: This deficiency will be corrected by a new policy for Advanced Directives. A policy will be place for patients to have a description and availability of applicable State advanced directive brochure. This policy will be shared with all endoscopy staff members in a timely fashion after</p>	03/25/2016			

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Q 0225 Bldg. 00	<p>#A1, Administrator/Director of Nursing, was requested to provide a policy regarding facility advanced directives, and a description and availability of applicable State advanced directive brochure.</p> <p>2. In interview on 01-21-2016 at 2:30 pm, employee #A1 confirmed there was no above-requested policy and no documentation was provided prior to exit.</p> <p>416.50(d)(4),(5), &amp; (6) SUBMISSION AND INVESTIGATION OF GRIEVANCES 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. The following criteria must be met:</p> <p>(1) The grievance process must specify timeframes for review of the grievance and the provisions of a response.</p> <p>(2) The ASC, in responding to the grievance, must investigate all grievances made by a patient, the patient's representative, or the patient's surrogate regarding treatment or care that is (or fails to be) furnished.</p> <p>(3) The ASC must document how the grievance was addressed, as well as provide the patient, the patient's representative, or the patient's surrogate with written notice of its decision. The decision must contain the</p>		<p>the policy is reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A new policy will be placed for Advanced Directives for all patients.</p> <p>Responsibility: Administrator Date: March 25, 2016</p>	

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Q 0226 Bldg. 00	<p>name of an ASC contact person, the steps taken to investigate the grievance, the result of the grievance process and the date the grievance process was completed.</p> <p>Based on interview, the facility failed to have a policy regarding the facility's grievance process, including how to file a grievance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 01-19-2016 at 10:30 am, employee #A1, Administrator/Director of Nursing, was requested to provide a policy regarding the facility's grievance process, including how to file a grievance.</li> <li>In interview on 01-21-2016 at 2:30 pm, employee #A1 confirmed there was no above-requested policy and no documentation was provided prior to exit.</li> </ol> <p>416.50(d)(1), (2), &amp; (3) GRIEVANCES - MISTREATMENT, ABUSE .... The following criteria must be met:</p> <p>(1) All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented.</p> <p>(2) All allegations must be immediately reported to a person in authority in the ASC.</p> <p>Only substantiated allegations must be</p>	O 0225	<p>Tag: Q-0225</p> <p>Correction: This deficiency will be corrected by a new policy that states the facility's grievance process, and include how to file a grievance. This policy will be shared with all endoscopy staff members in a timely fashion after the policy is reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A new Grievance policy will be placed, and this will include on how to file a grievance.</p> <p>Responsibility: Administrator</p> <p>Date: March 25, 2016</p>	03/25/2016

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Q 0227  Bldg. 00	<p>reported to the State authority or the local authority, or both.</p> <p>Based on interview, the facility failed to have a policy regarding specific violations/grievances relating, but not limited to, various types of abuse, and appropriate reporting of them.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 01-19-2016 at 10:30 am, employee #A1, Administrator/Director of Nursing, was requested to provide a policy regarding specific violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual or physical abuse, and that all allegations are immediately reported to the facility authority, and substantiated allegations must be reported to the State and/or local authority.</li> <li>In interview on 01-21-2016 at 2:30 pm, employee #A1 confirmed there was no above-requested policy and no documentation was provided prior to exit.</li> </ol> <p>416.50(e)(1)(i) RESPECT - PROPERTY &amp; PERSON The patient has the right to the following:</p> <p>(i) Be free from any act of discrimination or reprisal.</p> <p>Based on interview, the facility failed to</p>	O 0226	<p>Tag: Q-0226</p> <p>Correction: This deficiency will be corrected by placing a policy about specific violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual or physical abuse, and that all allegations are immediately reported to the facility authority, and substantiated allegations must be reported to the State and/or local authority. This policy will be shared with all endoscopy staff members in a timely fashion after the policy is reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A policy will be placed regarding specific violation/grievance relating, but not limited to, various types of abuse, and appropriate reporting of them.</p> <p>Responsibility: Administrator Date: March 25, 2016</p>	03/25/2016			
		O 0227	<p>Tag: Q-0227</p>	03/25/2016			

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Q 0229 Bldg. 00	<p>have a policy that patients have the right to be free from any act of discrimination or reprisal.</p> <p>.Findings include:</p> <p>1. On 01-19-2016 at 10:30 am, employee #A1, Administrator/Director of Nursing, was requested to provide a policy that patients have the right to be free from any act of discrimination or reprisal.</p> <p>2. In interview on 01-21-2016 at 2:30 pm, employee #A1 confirmed there was no above-requested policy and no documentation was provided prior to exit.</p> <p>416.50(e)(1)(iii) EXERCISE OF RIGHTS - INFORMED CONSENT [[ (1) The patient has the right to the following: ]</p> <p>(iii) Be fully informed about a treatment or procedure and the expected outcome before it is performed.</p> <p>Based on interview, the facility failed to have a policy that patients have the right to be fully informed about a treatment or procedure and the expected outcome before it is performed.</p> <p>Findings include:</p>	O 0229	<p>Correction: This deficiency will be corrected by a new policy that patients have the right to be free from any act of discrimination or reprisal. This policy will be shared with all endoscopy staff members in a timely fashion after the policy is reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A new policy will be placed for patients have the right to be free from any act of discrimination or reprisal.</p> <p>Responsibility: Administrator Date: March 25, 2016</p> <p>Tag: Q-0229</p> <p>Correction: This deficiency will be corrected by a new policy that patients have the right to be fully informed about a treatment or procedure and the expected outcome before it is performed. We were already completing this task, but no policy was written. This</p>	03/25/2016

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Q 0230  Bldg. 00	<p>1. On 01-19-2016 at 10:30 am, employee #A1, Administrator/Director of Nursing was requested to provided documentation of a policy that patients have the right to be fully informed about a treatment or procedure and the expected outcome before it is performed.</p> <p>2. In interview on 01-21-2016 at 2:30 pm, employee #A1 confirmed there was no above-requested policy and no documentation was provided prior to exit.</p> <p>416.50(e)(2 )&amp; (3) EXERCISE OF RIGHTS BY OTHERS (2) If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.</p> <p>(3) If a State court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>Based on interview, the facility failed to have a policy that if a patient is incompetent, as adjudged by a court or not, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf, or any legal representative or surrogate designated by</p>	O 0230	<p>policy will bereviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A newpolicy will be placed for patients have the right to be fully informed about atreatment/procedure and the expected outcome before it is performed.</p> <p>Responsibility: Administrator Date: March 25, 2016</p> <p>Tag: Q-0230 Correction: Thisdeficiency will be corrected by placing a policy that if a patient isincompetent, as adjudged by a court or not, the rights of the patient areexercised by the person appointed under State law to act on the patient's behalf, or any legal</p>	03/25/2016	

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Q 0233 Bldg. 00	<p>the patient in accordance with State law.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:30 am, employee #A1, Administrator/Director of Nursing was requested to provided documentation of a policy that if a patient is incompetent, as adjudged by a court or not, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf, or any legal representative or surrogate designated by the patient in accordance with State law.</p> <p>2. In interview on 01-21-2016 at 2:30 pm, employee #A1 confirmed there was no above-requested policy and no documentation was provided prior to exit.</p> <p>416.50(f)(3) SAFETY - ABUSE/HARASSMENT [The patient has the right to - ] (3) Be free from all forms of abuse or harassment</p> <p>Based on interview, the facility failed to have a policy that the patient has the right to be free from all forms of abuse, neglect, or harassment.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:30 am, employee</p>	O 0233	<p>representative or surrogate designated by the patient inaccordance with State Law. This policywill be reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A policy will be placed that if a patient is incompetent, as adjudged by a court or not, the rights of the patient areexercised by the person appointed under State law to act on the patient's behalf, or any legal representative or surrogate designated by the patient inaccordance with State Law.</p> <p>Responsibility: Administrator Date: March 25, 2016</p> <p>Tag: Q-0233</p> <p>Correction: Thisdeficiency will be corrected by placing a policy that the patient has the rightto be free from all forms of abuse, neglect, or harassment. This policy will be reviewed and approved bythe Medical Director/Governing Board.</p> <p>Prevention: A policywill be place that the patient has the right to be</p>	03/25/2016

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Q 0234 Bldg. 00	<p>#A1, Administrator/Director of Nursing was requested to provided documentation of a policy that the patient has the right to be free from all forms of abuse, neglect, or harassment .</p> <p>2. In interview on 01-21-2016 at 2:30 pm, employee #A1 confirmed there was no above-requested policy and no documentation was provided prior to exit.</p> <p>416.50(g) CONFIDENTIALITY OF CLINICAL RECORDS The ASC must comply with the Department's rules for the privacy and security of individually identifiable health information, as specified at 45 CFR parts 160 and 164. Based on interview, the facility failed to have a policy that the patient has the right for the privacy and security of individually identifiable health information, as specified at 45 CFR parts 160 and 164, generally known as the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security rules.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:30 am, employee #A1, Administrator/Director of Nursing was requested to provided documentation</p>	O 0234	<p>free from all forms of abuse, neglect, or harassment. Responsibility: Administrator Date: March 25, 2016</p> <p>Tag: Q-0234 Correction: This deficiency will be corrected by placing a policy for the Health Insurance Portability and Accountability Act (HIPAA). Although we give the patients HIPAA information, we did not have a policy in place. This policy will be reviewed and approved by the Medical Director/Governing Board. Prevention: A policy will be placed for the Health Insurance Portability and Accountability Act. Responsibility: Administrator Date: March 25, 2016</p>	03/25/2016

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Q 0241 Bldg. 00	<p>of a policy that the patient has the right for the privacy and security of individually identifiable health information, as specified at 45 CFR parts 160 and 164, generally known as the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security rules.</p> <p>2. In interview on 01-21-2016 at 2:30 pm, employee #A1 confirmed there was no above-requested policy and no documentation was provided prior to exit.</p> <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 document review, observation and interview, the facility failed to maintain a clean and orderly environment. Findings Include:</p> <ol style="list-style-type: none"> <li>Policy IC-38, Warmer Temperature and Cleaning Policy and Procedure, approved and effective January 2015, section III(6) states that all warmers will be cleaned as needed.</li> </ol>	Q 0241	<p>Tag: Q-0241 Correction: The deficiency Item #1, 2 and 3 will be corrected by discussing with staff members that the Medication Room must be cleaned, including the blanket warmer. This will be monitored by creating an audit tool to ensure completion. Item #4 and 5 will be corrected by creating an audit tool to monitor housekeeping and cleanliness of department. Item #6 and 7 will be completed by maintenance to do a walk through and identify all wall imperfections and repair all</p>	03/25/2016

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	<p>2. While on tour with staff N2, Infection Control Practitioner, it was observed that there was a heavy accumulation of dust and debris on top of the blanket warmer and paper towel dispenser in room 1147, medication room.</p> <p>3. Interview with staff N2, infection control practitioner, at 3:20 PM confirmed that those items should have been cleaned by the nursing staff and were not.</p> <p>4. It was observed in pre op prep area, on 1-20-2016 at 11:00 AM, dust was observed on the window sill of pre op room #2 and on the backside of the computer on wheels, and computer stand. Gouges and missing paint on the walls of pre op rooms #1, #2, #3, were also observed.</p> <p>5. Interview on 1-20-2016 at 11:37 AM with staff #55, pre op RN (registered nurse), confirmed that the computer and window sills were dusty. It was also confirmed that the walls could not be disinfected appropriately due to the rough wall surface.</p>		<p>damaged walls. Item #8 and 9 will discuss with staff members the importance of cleaning each piece of equipment in procedure rooms and discuss equipment should be included with the daily cleaning. Item #11 and 12 will be corrected by removing recycle bins from procedure rooms and replace with work stations so nurses will have work space.</p> <p>Prevention: These corrections will be prevented by creating auditing tools to ensure the cleanliness of the department. The QA committee and Infection Control Officer will monitor the auditing tools that will be implemented and correct and findings.</p> <p>Responsibility: Administrator, Maintenance, QA committee, Infection Control</p> <p>Date: March 25, 2016</p>				

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	<p>6. It was observed in the recovery area on 1-20-2016 at 12:25 PM, gouges and missing paint were observed in recovery room #12 (gouge area was approximately 16 " long, 1 " wide and ¼ " deep), and #14 (gouge area was approximately 18 inches long, 1 1/2 inches wide and ¼ inch deep).</p> <p>7. Interview with staff #59, recovery RN, confirmed that the walls in rooms #12 and #14 could not be properly disinfected and that there is no set way of notifying maintenance of the problem.</p> <p>8. Policy # IC 1.03, Daily Terminal Cleaning of Endoscopy Procedure Rooms Policy &amp; Procedure, approved and effective January 2015, section III(A) states High dusting: All surfaces and fixtures above shoulder height shall be dusted in a manner that will prevent dust from being dispersed.</p> <p>9. While observing staff N5, housekeeper, do a terminal clean of procedure room #3 on 1-19-2016 at 3:00 PM , dust was found</p>			

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S 0000  Bldg. 00	<p>on a horizontal surface on the back of the Olympus monitor.</p> <p>10. Interview with staff N5, housekeeping, on 1-19-2016 at 3:15 PM confirmed that nursing should clean the monitoring equipment and it was dusty.</p> <p>11. At 11:54 AM on 1/20/16, while observing in procedure room #2, it was observed that RN (registered nurse) #57 placed the patient record clip board on top of the lid of the soiled trash hamper to make notations on, and moved this hamper on wheels between the computer terminal and the patient's gurney through out the procedure.</p> <p>12. At 2:30 PM on 1/21/16, interview with staff member # N2, the infection control practitioner, it was confirmed that the top lid of the trash container would not be an aseptic place to put the clip board that would ultimately be used for other patients and would be moving from pre op to procedure room to post op throughout the day.</p> <p>This visit was for a State licensure</p>	S 0000		

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S 0110 Bldg. 00	<p>survey.</p> <p>Facility Number: 003754</p> <p>Survey Date: 01-19/21-2016</p> <p>QA: cjl 02/17/16</p> <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 interview, the facility's governing board failed to review reports of the quality assessment performance improvement (QAPI) program of a monitor and standard for 2 services furnished by a contractor, a monitor and standard for 1 directly-provided service, a standard for 1 directly-provided service and a monitor and standard for 2 other activities in its quality assessment and performance improvement (QAPI) program for calendar year 2015.</p>	S 0110	<p>Tag: S-0110</p> <p>Correction: This deficiency will be corrected by reporting to the governing board the quality assessment performance improvement (QAPI) activities that are being monitored by the QA committee. This will include contracted services and directly provided services used by the facility, and other activity being monitored by the QA committee</p> <p>Prevention: This will be prevented by continuous monitoring by the QA committee that uses a tool</p>	03/25/2016

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S 0156 Bldg. 00	<p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the governing board meeting minutes for calendar year 2015 indicated the governing board failed to review QAPI activities for 2 services furnished by a contractor, 2 directly-provided services and 2 other activities.</li> <li>Interview of employee #A1, Director, on 9-9-2015 at 10:30 am, confirmed all the above and no other documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review, observation and interview, the Governing Body failed</p>	S 0156	<p>toevaluate contracted services and directly provided services used by thefacility. All Monitoring by the QACommittee will provide documentation to review at the governing boardmeetings. Responsibility: Administrator Date: March 25, 2016</p> <p>Tag: S-0156 Correction: Thisdeficiency will be</p>	03/14/2016	

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S 0310  Bldg. 00	<p>to ensure that an annual evaluation was conducted for 1 of 3 RNs, Registered Nurses, in 2015, nurse N4.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. Review of the Medical Consultants, P.C. Employee Handbook, revised August 1, 2010, section 2.12 Performance Appraisal, indicated an evaluation form will be completed by your manager, discussed with you in confidence and signed by you to acknowledge having read the evaluation. It will become a part of your permanent record in the Human Resources Department.</li> <li>2. Review of personnel file indicated that no evaluation was completed for N4, RN, for the year 2015.</li> <li>3. Interview with staff N1, Administrator/Director of Nursing, on 1-21-2016 at 12:50 PM confirmed the finding.</li> </ol> <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</p>		<p>corrected by following the Medical Consultants, P.C. Employee Handbook that all employees will receive an annual evaluation. Each Performance Appraisal will be discussed in confidence and signed by the Administrator and the employee. The Performance Appraisal will be kept as a permanent record in the employee's personal file.</p> <p>Prevention: This will be prevented by following the Employee Handbook that all employees will receive an annual evaluation. This will be monitored on yearly basis by the Administrator. Each Performance Appraisal will be kept as a permanent record in the employee's personal file.</p> <p>Responsibility: Administrator Date: March 14, 2016</p>				

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	<p>have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include a monitor and standard for 2 services furnished by a contractor, a monitor and standard for 1 directly-provided service, and a standard for 1 directly-provided service in its quality assessment and performance improvement (QAPI) program for calendar year 2015.</p> <p>Findings include:</p> <p>1. Review of the facility's QAPI program for calendar year 2015 indicated it did not include the following:</p> <ul style="list-style-type: none"> <li>-a monitor and standard for the contracted services of biohazardous waste hauler and housekeeping</li> <li>-a monitor and standard for the directly-provided service of housekeeping by nursing</li> <li>-a standard for the directly provided service of nursing</li> </ul> <p>2. Interview of employee #A1, Administrator/Nursing Director, on 01-21-2016 at 2:00 pm, confirmed the</p>	S 0310	<p>Tag: S-0310 Correction: This deficiency will be corrected by the way of a tracking system tool we already have in place in which these contracted services can be reviewed and evaluated to be performing within their contract. This tool will consist of a monitor and standard for each contracted service and directly provided services . This document will be forward to the QAcommittee section at the Governing Board meeting as required. Prevention: This will be prevented by continually using this tool to review and evaluate these contracted services and directly provided services by forwarding this information to the QA committee section of the Governing Board as required, and have it readily available at all times.Responsibility: AdministratorDate: March 25, 2016</p>	03/25/2016

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S 0320 Bldg. 00	<p>above and no other documentation was provided prior to exit.</p> <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 facility failed to include a monitor and standard for the activities of discharge and medication errors in its quality assessment and performance improvement (QAPI) program for calendar year 2015.</p> <p>Findings include:</p> <p>1. Review of the facility's QAPI program for calendar year 2015 indicated it did not include a monitor and standard for the activities of discharge and medication errors.</p>	S 0320	<p>Tag: S-0320</p> <p>Correction: This deficiency will be corrected by the way of a tracking system tool we already have in place for the activities of discharge and medication errors. This tool will consist of a monitor and standard for the activity of discharge and medication errors. This is to be monitored by the Quality Assessment and Performance Improvement (QAPI) committee. This document will be forward to the QA committee section at the Governing Board meeting as required.</p> <p>Prevention: This will be prevented by continually using this tool to</p>	03/25/2016

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S 0332 Bldg. 00	<p>2. Interview of employee #A1, Administrator/Director of Nursing, on 01-21-2016 at 2:00 pm, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the center: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure</p>		<p>review and evaluate the activity of discharge and medication errors by forwarding this information to the QA committee section of the Governing Board as required, and have it readily available at all times. Responsibility: Administrator, Quality Assessment and Performance Improvement Committee Date: March 25, 2016</p>				

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	<p>performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations:</p> <p>(AA) that occur in the course of surgery; or</p> <p>(BB) whose exigency precludes obtaining informed consent;</p> <p>or both</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded:</p> <p>(AA) Objects intentionally implanted as part of a planned intervention.</p> <p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p>			

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	<p>(CC) Infusion pumps. (DD) Ventilators. (iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events: (i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center.</p> <p>(D) The following care management events: (i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability. (ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible</p>			

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	<p>blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events: (i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion. (ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient: (AA) contains the wrong gas; or (BB) is contaminated by toxic substances. (iii) Patient death or serious disability associated with a burn incurred from any</p>			

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NAME OF PROVIDER OR SUPPLIER  MEDICAL CONSULTANTS SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 800 S TILLOTSON AVE MUNCIE, IN 47304
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	<p>source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the center.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for the activity of reportable events in its quality assessment and performance improvement (QAPI) program for calendar year 2015.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's QAPI program for calendar year 2015 indicated it did not include a monitor and standard for the activity of reportable events.</li> <li>Interview of employee #A1, Administrator/Director of Nursing, on 01-21-2016 at 2:00 pm, confirmed the above and no</li> </ol>	S 0332	<p>Tag: S-0332</p> <p>Correction: This deficiency will be corrected by the way of a tracking system tool we already have in place for the activity of reportable events. This tool will consist of a monitor and standard for the activity of reportable events. This is to be monitored by the Quality Assessment and Performance Improvement (QAPI) committee. This document will be forward to the QA committee section at the Governing Board meeting as required.</p> <p>Prevention: This will be prevented by continually using this tool to review and evaluate the activity of reportable events by forwarding this information to the QA committee section of the Governing Board as required, and have it readily</p>	03/25/2016

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S 0428 Bldg. 00	<p>other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on observation and interview, the infection control committee failed to ensure that aseptic techniques and universal precautions were established and maintained in the procedure room.</p> <p>Findings Include: 1. At 11:54 AM on 1/20/16, while observing in procedure room #2, it was observed that RN (registered nurse) #57 placed the patient record clip board on top of the lid of the soiled trash hamper to make notations on, and moved this hamper on wheels between the computer terminal and the patient's gurney throughout the procedure.</p>	S 0428	<p>available at all times. Responsibility: Administrator, Quality Assessment and Performance Improvement Committee Date: March 25, 2016</p> <p>Tag: S-0428 Correction: This deficiency will be corrected by the infection control committee to discuss and review the importance of aseptic techniques and universal precautions while working in the procedure rooms. A workstation will be placed in the procedure rooms. Prevention: The infection control committee will discuss and review aseptic techniques and universal precautions. In finding #1 this citation will be prevented by removing soiled trash hamper and place a workstation for Nurses in the procedure rooms. Responsibility: Administrator Date: March 25, 2016</p>	03/25/2016

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S 0466 Bldg. 00	<p>2. At 2:30 PM on 1/21/16, interview with staff member # N2, the infection control practitioner, it was confirmed that the top lid of the trash container would not be an aseptic place to put the clip board that would ultimately be used for other patients and would be moving from pre op to procedure room to post op throughout the day.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(g)(3)</p> <p>Sterilization services must be directed by a qualified person or persons and must provide for the following:</p> <p>(3) Records of results must be maintained and evaluated periodically in accordance with 410 IAC 15-2.4-2 to include, but not limited to, the following:</p> <p>(A) Records of recording thermometers or a daily record of the sterilizing cycle (date, time, temperature, pressure, and contents) for each sterilizer load.</p> <p>(B) Results of biological indicators used in testing the sterilizing processes.</p> <p>Based on document review and</p>	S 0466	Tag: S-0466 Correction: This	03/03/2016

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S 0480 Bldg. 00	<p>interview, the infection control committee failed to ensure that sterilization/reprocessing processes were evaluated periodically by the infection/quality committee.</p> <p>Findings Include:</p> <p>1. Review of the combined infection/quality committee (and medical staff committee) meeting minutes of 2/19/15, 4/2/15, 8/25/15, 10/1/15 and 1/7/16 lacked any indication that reprocessing/biologicals were discussed and reviewed/evaluated during that time frame by the committee.</p> <p>2. At 12:50 PM on 1/21/16, interview with staff member N2, the infection practitioner, confirmed that reprocessing data and biological information are not reported to the combined infection/quality and medical staff meetings.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(2)(i)(1)(A)</p> <p>(i) The center, whether it operates its own laundry or uses outside laundry service, shall ensure that the laundry process complies with a recognized laundry standard as follows:</p> <p>(1) Clean linen must be separated from</p>		<p>deficiency will be corrected by the infection control committee. The infection control committee will report the sterilization/reprocessing process to the Infection control committee and QA committee, and medical staff meetings. Prevention: The infection control officer will report the sterilization/reprocessing process data to the Infection control committee and QA committee and monthly medical staff meetings. This process will be discussed and reviewed and evaluated during the medical staff meeting. This data will be monitored by the infection control officer. Responsibility: Infection Control Officer Date: March 3, 2016</p>		

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S 0526	<p>soiled linen at all times as follows:</p> <p>(A) Contaminated linens must be clearly identified and bagged. Based on document review and interview, the infection control committee failed to ensure the proper cleaning, laundering and disinfection processes were maintained for the contracted linen company that launders the contracted housekeeping staff's mop heads and cleaning cloths.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of the contracted laundry service records was completed as part of the infection control survey process.</li> <li>At 2:50 PM on 1/19/16, interview with staff member #N5, the contracted housekeeper, confirmed that the soiled mop heads and cleaning cloths go to laundry #1, not the facility contracted laundry company, laundry #2.</li> <li>At 9:00 AM on 1/20/16, interview with the administrator/director of nursing, staff member N1, confirmed that laundry service #2 was being monitored by the infection control committee and the quality committee, but laundry service #1 was not</li> </ol> <p>410 IAC 15-2.5-2</p>	S 0480	<p>Tag: S-0480</p> <p>Correction: This deficiency will be corrected by the Infection Control Committee and the Quality Control Committee by monitoring all outside laundry services. This monitoring system will include housekeeping mop heads, cleaning cloths, and all linen.</p> <p>Prevention: This will be prevented by creating a monitoring tool that will monitor all outside laundry services</p> <p>Responsibility: Administrator</p> <p>Date: March 25, 2016</p>	03/25/2016			

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Bldg. 00	<p>LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed. Based on document review, and interview, the DON, Director of Nursing, failed to ensure that 1 of 3 RNs, Registered Nurses, completed the annual point of care testing competencies, nurse N4.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. Review of personnel files indicated that no annual point of care testing competencies were completed for N4, RN, for the year of 2015.</li> <li>2. Interview with N1, Administrator/Director of Nursing, on 1-21-2016 at 12:50 PM confirmed the finding. N1 also confirmed that the competencies should have been completed annually.</li> </ol>	S 0526	<p>Tag: S-0526 Correction: This deficiency will be corrected by all Registered Nurses, or other personal that use point of care testing, will complete the annual point of care testing competencies. Prevention: This will be prevented by all Registered Nurses, or other personal that use point of care testing, will take an annual point of care testing competencies. Each competency will remain in the employee personal file. Responsibility: Administrator Date: March 14, 2016</p>	03/14/2016			
S 0640 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN.						

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	<p>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 interview, the facility failed to have a policy for a procedure to verify entries of questionable legibility and readability of medical records.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide a policy for a procedure to verify entries of questionable legibility and readability of medical records.</p> <p>2. In interview on 01-21-2016 1:45 pm, employee #A1 confirmed there was no above-requested documentation and no documentation was provided prior to exit.</p>	S 0640	<p>Tag: S-0640 Correction: This deficiency will be corrected by placing a policy for a procedure to verify entries of questionable legibility and readability of medical records. This policy will be reviewed and approved by the Medical Director/Governing Board. Prevention: A new policy will be placed to verify entries of questionable legibility and readability of medical records.</p> <p>Responsibility: Administrator Date: March 25, 2016</p>	03/25/2016			
S 0644 Bldg. 00	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(2)</p> <p>All entries in the medical record must be as follows:</p>						

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	<p>(2) Made only by authorized individuals as specified in center and medical staff policies.</p> <p>Based on interview, the facility did not document which individuals/categories of staff/professionals were allowed to make entries in the medical records.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide a policy of which individuals/categories of staff/professionals were allowed to make entries in the medical records.</p> <p>2. Interview of employee #A1 on 01-21-2016 at 1:45 pm, confirmed there was no documentation of which individuals/categories of staff/professionals were allowed to make entries in the medical records. No documentation was provided prior to exit.</p>	S 0644	<p>Tag: S-0644</p> <p>Correction: This deficiency will be corrected by reviewing and updating the policy and procedure in which individuals/categories of staff/professionals are allowed to make entries in the medical records. This policy will be reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: This updated policy and procedure will identify which individuals/categories of staff/professionals are allowed to make entries in the medical records.</p> <p>Responsibility: Administrator, Compliance Officer</p> <p>Date: March 25, 2016</p>	03/25/2016			
S 0676 Bldg. 00	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or legally reproduced medical records</p>						

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S 0744	<p>must be maintained by the center for a period of seven (7) years in accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure.</p> <p>Based on interview, the facility failed to produce an approved waiver to store medical records offsite that were less than 7 years old.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Interview of employee #A1, Administrator/Director of Nursing, on 01-21-2016 at 1:10 pm, indicated the facility stored both original and electronic copies of patient records less than 7 years old at off-site locations.</li> <li>2. At the above date and time, the employee was requested to provide documentation the facility received a waiver from the State to store those records offsite.</li> <li>3. Interview of employee #A1 on the above-stated date and time, indicated not being able to produce the document and no further documentation was received prior to exit.</li> </ol>	S 0676	<p>Tag: S-0676</p> <p>Correction: This deficiency will be corrected by filing for a state waiver so this facility can store original and/or electronic copies of patient records less than 7 years old to an off-site location.</p> <p>Prevention: By filing for a state waiver, and receiving a state waiver this will allow this facility to store original and/or electronic copies of patient records less than 7 years old to an off-site location.</p> <p>Responsibility: Administrator Date: March 18, 2016</p>	03/18/2016	
	410 IAC 15-2.5-4				

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Bldg. 00	<p>MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(D)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(D) A procedure for designating an individual practitioner with current privileges as chief, president, or chairperson of the staff.</p> <p>Based on interview and document review, the governing body failed to follow medical staff bylaws to appoint a medical director and that the medical director had current privileges in 1 instance.</p> <p>Findings: include:</p> <p>1. Interview of employee #A3, Business Office Manager, on 01-20-2016 at 2:15 pm, indicated MD#6, a rheumatologist, was the facility's medical director.</p> <p>2. Review of the medical staff bylaws, approved by the medical staff 10-23-2014 and the governing board 10-27-2014, indicated "officers shall be appointed at the annual meeting of the Governing Body." Further review of the bylaws indicated the "Medical Director/President of the medical staff shall serve as the chief administrative officer of the</p>	S 0744	<p>Tag: S-0744</p> <p>Correction: This deficiency will be corrected by the Governing Board following the Medical Staff Bylaws to appoint a Medical Director, and the Medical Director has current privileges annually. On February 1, 2016 at the Governing Board meeting, this was corrected.</p> <p>Prevention: The Governing Board will follow the Medical Staff Bylaws to appoint a Medical Director, and the Medical Director has current privileges, on the annual meeting.</p> <p>Responsibility: Governing Board</p> <p>Date: February 1, 2016</p>	02/01/2016			

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S 0780 Bldg. 00	<p>medical staff ... ."</p> <p>3. Staff was requested to provide documentation of governing board minutes where the medical director was appointed and no documentation was provided prior to exit.</p> <p>4. Review of a file for MD#6 indicated there was no documentation that MD#6 had current privileges.</p> <p>5. Interview of employee #A3 at the above-stated date and time, confirmed there was no documentation of privileges for MD#6 and none were provided prior to exit.</p> <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</p>			

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S 0784  Bldg. 00	<p>(30) days. Based on interview, the medical staff failed to have a requirement that all orders are to be authenticated by a responsible practitioner within a time frame specified by the medical staff not to exceed 30 days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 0119-2016 at 10:00 am, employee #A1, Administrator./Director of Nursing, was requested to provide documentation of a medical staff requirement that all orders are to be authenticated by a responsible practitioner within a time frame specified by the medical staff not to exceed 30 days.</li> <li>Interview of employee #A1 on 01-21-2016 at 3:15 pm, indicated there was no above-requested documentation and none was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(P)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p>	S 0780	<p>Tag: S-0780 Correction: Thisdeficiency will be corrected by placing a policy that all orders are to beauthenticated by a responsible practitioner within a time frame specified bythe medical staff not to exceed 30 days. The medical staff will specify the time frame, with time frame not toexceed 30 days. This policy will bereviewed and approved by the Medical Director/Governing Board Prevention: A policy will be place that all orders are to beauthenticated by a responsible practitioner within 30 days. Responsibility: MedicalStaff, Administrator Date: March 25, 2016</p>	03/25/2016			

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NAME OF PROVIDER OR SUPPLIER  MEDICAL CONSULTANTS SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 800 S TILLOTSON AVE MUNCIE, IN 47304			
(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			
S 0788 Bldg. 00	<p>(P) A requirement that the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge.</p> <p>Based on interview, the facility failed to have a medical staff approved policy that the final diagnosis is to be completed in the medical record within 30 days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide a medical staff approved policy that the final diagnosis is to be completed in the medical record within 30 days.</li> <li>In interview on 01-21-2016 at 3:15 pm, employee #A1 confirmed there was no above-requested documentation and no documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(R)</p> <p>These bylaws and rules must be as follows:</p>	S 0784	<p>Tag: S-0784</p> <p>Correction: This deficiency will be corrected by placing a policy that the final diagnosis is to be completed in the medical records within 30 days. The physicians all ready do this task, however there was no policy written. This policy will be reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A new policy will be placed that the medical staff will have the final diagnosis completed in the medical records within 30 days.</p> <p>Responsibility: Administrator Date: March 25, 2016</p>	03/25/2016			

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S 0824  Bldg. 00	<p>(3) Include, at a minimum, the following:</p> <p>(R) A requirement that a physician shall be available to the center during the period any patient is present in the center.</p> <p>Based on interview, the facility failed to have a medical staff approved policy that a physician is available whenever there is a patient in the facility.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide a medical staff approved policy that a physician is available whenever there is a patient in the facility.</p> <p>2. In interview on 01-21-2016 at 3:15 pm, employee #A1 confirmed there was no above-requested documentation and no documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(D)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p>			S 0788	<p>Tag: S-0788</p> <p>Correction: This deficiency will be corrected by placing a policy that a physician is available whenever there is a patient in the facility. We already have this policy in place, however, a policy was not written. This policy will be reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A policy will be placed that a physician is available whenever there is a patient in the facility.</p> <p>Responsibility: Administrator Date: March 25, 2016</p>		03/25/2016

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S 0842 Bldg. 00	<p>(D) Safety rules to be followed. Based on interview, the facility failed to have a medical staff approved policy of safety rules to be followed in the operating rooms and the use of anesthetics.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide a medical staff approved policy of safety rules to be followed in the operating rooms and the use of anesthetics.</li> <li>In interview on 01-21-2016 at 3:15 pm, employee #A1 confirmed there was no above-requested documentation and no documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(3)</p> <p>(c) The anesthesia service is responsible for all anesthesia administered in the center as follows:</p> <p>(3) A requirement that all anesthetic agents, flammable and/or potentially flammable liquids or agents, will be stored or used in the center in accordance with current standards of</p>	S 0824	<p>Tag: S-0824</p> <p>Correction: This deficiency will be corrected by placing a policy for safety rules to be followed in the procedure rooms and the use of anesthetics. This policy will be discussed with the endoscopy staff in a timely manner after the policy is reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A new policy will be placed for safety rules to be followed in the procedure rooms and the use of anesthetics.</p> <p>Responsibility: Administrator Date: March 25, 2016</p>	03/25/2016

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S 0852  Bldg. 00	<p>practice and as required by NFPA. Based on interview, the facility failed to have a medical staff approved policy that all anesthetic agents, flammable and/or potentially flammable liquids or agents, will be stored and used in the center in accordance with current standards of practice and as required by NFPA (National Fire Protection Association).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide a medical staff approved policy that all anesthetic agents, flammable and/or potentially flammable liquids or agents, will be stored and used in the center in accordance with current standards of practice and as required by NFPA.</li> <li>In interview on 01-21-2016 at 3:15 pm, employee #A1 confirmed there was no above-requested documentation and no documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(1)</p> <p>Requirements for surgical services include:</p>			S 0842	<p>Tag: S-0842 Correction: This deficiency will be corrected by placing a policy that all anesthetic agents, flammable and /or potentially flammable liquids or agents will be stored and used in the center in accordance with current standards of practice and as required by National Fire Protection Association (NFPA). This policy will be discussed with all staff members after the policy is reviewed and approved by the Medical Director/Governing Board. Prevention: A policy will be placed that all anesthetic agents, flammable and /or potentially flammable liquids or agents will be stored and used in the center in accordance with current standards of practice that's required by NFPA Responsibility: Administrator Date: March 25, 2016</p>		03/25/2016

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S 0884 Bldg. 00	<p>(1) Surgical services are under the direction of a physician, dentist, or podiatrist qualified by experience and training.</p> <p>Based on interview, the facility failed to have a medical staff approved policy that the surgical services are under the direction of a physician, dentist or podiatrist qualified by experience and training.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide a medical staff approved policy that the surgical services are under the direction of a physician, dentist or podiatrist qualified by experience and training.</p> <p>2. In interview on 01-21-2016 at 3:15 pm, employee #A1 confirmed there was no above-requested documentation and no documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(E)</p>	S 0852	<p>Tag: S-0852</p> <p>Correction: This deficiency will be corrected by placing a policy that the endoscopy center are under the direction of a physician, dentist or podiatrist qualified by experience and training. This policy will be discussed with all staff members after it is reviewed and approved by the Medical Director/Governing Board.</p> <p>Prevention: A policy will be placed that the endoscopy center is under the direction of a physician, dentist or podiatrist qualified by experience and training.</p> <p>Responsibility: Administrator Date: March 25, 2016</p>	03/25/2016	

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NAME OF PROVIDER OR SUPPLIER  MEDICAL CONSULTANTS SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 800 S TILLOTSON AVE MUNCIE, IN 47304			
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S 0888 Bldg. 00	<p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(E) A requirement that the patient register is complete and up to date. Based on interview, the facility failed to have a medical staff approved policy that the patient register is complete and up to date.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide a medical staff approved policy that the patient register is complete and up to date.</p> <p>2. In interview on 01-21-2016 at 3:15 pm, employee #A1 confirmed there was no above-requested documentation and no documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p>	S 0884	<p>Tag: S-0884</p> <p>Correction: This deficiency will be corrected by a new policy stating that the patient register is complete and up to date. This policy will be shared with all endoscopy staff members in a timely fashion after the policy is reviewed and approved by the governing board.</p> <p>Prevention: A new policy will be place stating that the patient register is complete and up to date</p> <p>Responsibility: Administrator/Governing Board</p> <p>Date: March 25, 2016</p>	03/25/2016			

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	<p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on interview, the facility failed to have a medical staff approved policy that the operative report describes techniques, findings, and tissue removed or altered and is to be written or dictated immediately following surgery and authenticated by the surgeon.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide a medical staff approved policy that the operative report describes techniques, findings, and tissue removed or altered and is to be written or dictated immediately following surgery and authenticated by the surgeon.</p>	S 0888	<p>Tag: S-0888</p> <p>Correction: Thisdeficiency will be corrected by placing a policy that the operative reportdescribes techniques, findings, and tissue removed or altered and is to bewritten or dictated immediately following surgery and authenticated by thesurgeon. We all ready have this policyin place, however no policy was written. This policy will be reviewed and approved by the MedicalDirector/Governing Board.</p> <p>Prevention: A policywill be place that the operative report describes techniques, findings, andtissue removed or altered and is to be written or dictated immediatelyfollowing surgery and authenticated by the surgeon.</p> <p>Responsibility: Administrator Date: March 25,20165</p>	03/25/2016

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S 1146 Bldg. 00	<p>2. In interview on 01-21-2016 at 3:15 pm, employee #A1 confirmed there was no above-requested documentation and no documentation was provided prior to exit.</p> <p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation, and interview, the facility failed to ensure that no condition was created that might result in a hazard to employees in relation to the staff refrigerator located in the women's dressing room.</p> <p>Findings Include: 1. Review of the policy: Refrigerator Temperature and Cleaning Policy and Procedure, policy number IC I.14, last approved January 2015, indicated: A daily record of temperatures for all refrigerators will be maintained. All</p>	S 1146	<p>Tag: S-1146</p> <p>Correction: This deficiency will be corrected by keeping a daily log record of the cleanliness and temperature of the employee refrigerator. This daily recorded will be appointed to staff members. Any deficiency noted on recorded will be addressed by the Infection Control Officer.</p> <p>Prevention: A daily log recorded of the employee refrigerator will check for temperature and cleanliness.</p> <p>Responsibility: Infection Control Officer, Administrator</p> <p>Date: March 1, 2016</p>	03/01/2016

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S 1164 Bldg. 00	<p>refrigerators will be cleaned as needed.</p> <p>2. At 2:15 PM on 1/19/16, while in the women's dressing room in the company of staff member #54, a registered nurse, it was observed that there were &gt;3 10 to 12 inch long hairs on the bottom shelf of the small refrigerator.</p> <p>3. At 2:20 PM on 1/19/16, interview with staff member #54 confirmed that:</p> <p>A. The staff refrigerator is not addressed in the refrigerator policy.</p> <p>B. The staff refrigerator is not on a cleaning schedule.</p> <p>C. Temperatures were not being monitored for the staff refrigerator.</p> <p>D. There were long hairs on the lower shelf of the refrigerator indicating a need for cleaning.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</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>						

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	<p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule. Based on document review and interview, the facility failed to have a policy to conduct preventive maintenance (PM) on 1 piece of equipment on a schedule in accordance with acceptable standards of practice or with the manufacturer's recommended maintenance schedule.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provided documentation of a policy to conduct PM on a schedule in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule for a wheelchair.</li> <li>Interview of employee #A1 on 01-21-2016 at 2:30 pm, confirmed there was no policy as requested, above, and no other documentation was provided prior to exit.</li> </ol>	S 1164	<p>Tag: S-1164</p> <p>Correction: This deficiency will be corrected by placing a preventive maintenance (PM) policy onequipment. This policy will include an acceptablestandard of practice with the manufacturer's recommended maintenanceschedule. This policy will be reviewedand approved by the Medical Director/Governing Board.</p> <p>Prevention: A policywill be placed for Preventive Maintenance. This will include an acceptable standard of practice with themanufacturer's recommended maintenance schedule.</p> <p>Responsibility: Administrator/Maintenance</p> <p>Date: March 25, 2016</p>	03/25/2016			

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S 1166 Bldg. 00	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii)</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>(ii) There must be evidence of preventive maintenance on all patient care equipment. Based on document review and interview, the facility failed to provide evidence of preventive maintenance (PM) on 1 of 7 pieces of patient care equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's PM reports indicated there was no documentation of PM for a wheelchair.</li> <li>Interview of employee #A1, Administrator/Director of Nursing, on 01-21-2016 at</li> </ol>	S 1166	<p>Tag: S-1166 Correction: This deficiency will be corrected by following policy that all equipment will be on a preventive maintenance schedule. All equipment will be checked annually. Prevention: We will prevent this lapse in the future by following the annual preventive maintenance schedule. We will have a preventive maintenance check on the wheelchair that had no documentation. Responsibility: Administrator/Maintenance Date: March 25, 2016</p>	03/25/2016

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S 1168 Bldg. 00	<p>2:30 pm, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</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>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the facility failed to conduct triennial analysis of the procedures to conduct preventive maintenance (PM) for 2 of 7 pieces of patient care equipment.</p> <p>Findings include:</p> <p>1. On 01-12-2016 at 10:00 am, employee</p>	S 1168	<p>Tag: S-1168</p> <p>Correction: This deficiency will be corrected by following the triennially analysis of the preventive maintenance for all equipment.</p> <p>Prevention: We will prevent this lapse in the future by following the triennially requirement in a timely fashion for all equipment. For the deficiency on the suction/vacuum machine and wheelchair, we will set</p>	03/25/2016

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NAME OF PROVIDER OR SUPPLIER  MEDICAL CONSULTANTS SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 800 S TILLOTSON AVE MUNCIE, IN 47304		
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S 1172 Bldg. 00	<p>#A1, Administrator/Director of Nursing, was requested to provide documentation of a triennial analysis of the procedures to conduct PM for 7 pieces of patient care equipment:</p> <p>2. Review of facility documentation provided indicated there was no documentation of a triennial analysis of the procedures to conduct PM for a suction/vacuum machine and a wheelchair.</p> <p>3. Interview of employee #A1 on 01-20-2016 at 2:30 pm confirmed there was no documentation of a triennial analysis of the procedures to conduct PM for the above-stated pieces of equipment and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)</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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and</p>		<p>up aschedule to have a preventive maintenance check. Responsibility: Administrator/Maintenance Date: March 25, 2016</p>		

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	<p>furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: Based on document review, observation and interview, the infection practitioner failed to maintain a clean and orderly environment. Findings Include:</p> <ol style="list-style-type: none"> <li>1. Policy IC-38, Warmer Temperature and Cleaning Policy and Procedure, approved and effective January 2015, section III(6) states that all warmers will be cleaned as needed.</li> <li>2. While on tour with staff N2, Infection Control Practitioner, it was observed that there was a heavy accumulation of dust and debris on top of the blanket warmer and paper towel dispenser in room 1147, medication room.</li> <li>3. Interview with staff N2, infection control practitioner, at 3:20 PM confirmed that those items should have been cleaned by the nursing staff and were not.</li> <li>4. It was observed in pre op prep area, on 1-20-2016 at 11:00 AM, dust was observed on the window sill of pre op room #2 and on the</li> </ol>	S 1172	<p>Tag: S-1172 Correction: The deficiency item #1, 2 and 3 will be corrected by discussing with staff member that the Medication Room must be cleaned, including the blanket warmer. This will be monitored by creating an audit tool to ensure completion. Item #4 and 5 will be corrected by creating an audit tool to monitor housekeeping and cleanliness of department. Item #6 and 7 will be completed by maintenance to do a walk through and identify all wall imperfections and repair all damaged walls. Item #8 and 9 will discuss with staff members the importance of cleaning each piece of equipment in procedure rooms and discuss equipment should be included with the daily cleaning. Item #11 and 12 will be corrected by removing recycle bins from procedure rooms and replace with work stations so nurses will have work space. Prevention: These corrections will be prevented by creating auditing tools to ensure the cleanliness of the department. The QA committee and Infection Control Officer will monitor the auditing tools that will be implemented and correct and findings. Responsibility: Administrator, Maintenance, QA committee,</p>	03/25/2016

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	<p>backside of the computer on wheels, and computer stand. Gouges and missing paint on the walls of pre op rooms #1, #2, #3, were also observed.</p> <p>5. Interview on 1-20-2016 at 11:37 AM with staff #55, pre op RN (registered nurse), confirmed that the computer and window sills were dusty. It was also confirmed that the walls could not be disinfected appropriately due to the rough wall surface.</p> <p>6. It was observed in the recovery area on 1-20-2016 at 12:25 PM, gouges and missing paint were observed in recovery room #12 (gouge area was approximately 16 " long, 1 " wide and ¼ " deep), and #14 (gouge area was approximately 18 inches long, 1 1/2 inches wide and ¼ inch deep).</p> <p>7. Interview with staff #59, recovery RN, confirmed that the walls in rooms #12 and #14 could not be properly disinfected and that there is no set way of notifying maintenance of the problem.</p> <p>8. Policy # IC 1.03, Daily Terminal</p>		<p>Infection Control Date: March 25, 2016</p>	

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	<p>Cleaning of Endoscopy Procedure Rooms Policy &amp; Procedure, approved and effective January 2015, section III(A) states High dusting: All surfaces and fixtures above shoulder height shall be dusted in a manner that will prevent dust from being dispersed.</p> <p>9. While observing staff N5, housekeeper, do a terminal clean of procedure room #3 on 1-19-2016 at 3:00 PM , dust was found on a horizontal surface on the back of the Olympus monitor.</p> <p>10. Interview with staff N5, housekeeping, on 1-19-2016 at 3:15 PM confirmed that nursing should clean the monitoring equipment and it was dusty.</p> <p>11. At 11:54 AM on 1/20/16, while observing in procedure room #2, it was observed that RN (registered nurse) #57 placed the patient record clip board on top of the lid of the soiled trash hamper to make notations on, and moved this hamper on wheels between the computer terminal and the patient's gurney through out the procedure.</p> <p>12. At 2:30 PM on 1/21/16, interview with staff member # N2, the</p>			

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S 1188 Bldg. 00	<p>infection control practitioner, it was confirmed that the top lid of the trash container would not be an aseptic place to put the clip board that would ultimately be used for other patients and would be moving from pre op to procedure room to post op throughout the day.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on document review and interview, the facility failed to include in its written fire control plan a provision for cooperation with firefighters.</p> <p>Findings include:</p>	S 1188	<p>Tag: S-1188</p> <p>Correction: As per the rule requirements and our Policy and Procedure, we will write a firecontrol plan with cooperation with firefighting authorities. We will complete and have</p>	03/25/2016
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S 1198 Bldg. 00	<p>1. Review of the facility's fire control plan, approved 01-26-2015, did not indicate a provision for cooperation with firefighting authorities.</p> <p>2. Interview of employee #A1, Administrator/Director of Nursing,, on 01-20-2016 at 3:15 pm, confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on interview, the facility failed to perform a disaster drill on a regular basis in 1 instance.</p> <p>Findings include:</p> <p>1. On 01-19-2016 at 10:00 am, employee #A1, Administrator/Director of Nursing, was requested to provide documentation of the most recent disaster drill</p>	S 1198	<p>adequatedocumentation of quarterly fire alarm drills performed in the facility.</p> <p>Prevention: We willcomplete quarterly fire drills on a quarterly basis as required, and keep theresults and documentation of all participants, and have cooperation withfirefighting authorities.</p> <p>Responsibility: Administrator Date: March 25, 2016</p> <p>Tag: S-1198 Correction: We willfollow our Emergency Preparedness policy as it relates to Disaster preparednessand have adequate documentation of the disaster drill performed. There was a disaster drill preformed on April10, 2015 but documentation was not readily available. Prevention: We willperform a disaster/emergency drill and keep adequate records and complete</p>	03/25/2016

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	<p>performed by the facility.</p> <p>2. Review of documentation indicated the facility performed a table-top activity in 2015 but not a disaster drill. No further documentation was provided prior to exit.</p>		<p>an annual review of our Emergency Preparedness Policy as required.</p> <p>Responsibility: Administrator</p> <p>Date: March 25, 2016</p>		