

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001153	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/08/2016
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NAME OF PROVIDER OR SUPPLIER  LAKESHORE SURGICARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 VILLAGE POINTE CHESTERTON, IN 46304
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S 0000  Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 011186</p> <p>Survey Date: 3/7/2016 to 3/8/2016</p> <p>QA: cjl 04/18/16</p>	S 0000		
S 0164  Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES</p> <p>410 IAC 15-2.4-1 (c)(5) (H)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program.</p> <p>Based on document review and interview, the chief executive officer failed to develop and implement policies</p>	S 0164	S164 How to Correct- Updated policy ADM-IPC-012 to state-Employment	05/30/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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	<p>related to post offer physical examination for 10 of 10 (N1-N10) personnel files reviewed.</p> <p>Findings:</p> <p>1. Policy #ADM-IPC-012, Infection Prevention/Colleague Health Services, revised/reapproved 9/1/15 indicated on pg. 2, point A.1., Employment Physical Examination...When indicated the colleague will be required to complete a functional capacity evaluation to determine a colleague's ability to perform the essential function of the job as indicated. The testing could include re-examination of the history and physical, functional capacity testing, neuro-psychological testing, pulmonary function testing, or other tests as indicated.</p> <p>2. Review of personnel files confirmed personnel:</p> <p>A. N1 (Clinical Unit Manager) was hired 3/9/15 and lacked documentation of a post offer physical examination.</p> <p>B. N2 (Registered Nurse [RN]) was hired on 4/10 and lacked documentation of a post offer physical examination.</p> <p>C. N3 (RN) was hired on 4/10 and lacked documentation of a post offer physical examination.</p> <p>D. N4 (RN) was hired on 10/11 and</p>		<p>preplacement health history and assessment examination will be completed on all new hire candidates Supporting new hire packet includes checklist The Medical Director of Center will perform physicals on all current colleagues in the Center over the next 30 days to be completed by 5/30/16 and add to all employee files, to ensure all colleagues have a physical on file</p> <p>How to Prevent- Colleague Health and Human Resource colleagues collaborated on new hire packets and practice HR gets the green light that the colleague is able to start once the packet is completed There are emails between both, than at that time the new colleagues is approved to go through essentials training, this this the first day of work for new colleagues Colleague health will not release new hire to work until the new hire packet is complete</p> <p>Who is Responsible- Colleague Health will not release colleague until hiring packet is complete</p>	

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S 0404	<p>lacked documentation of a post offer physical examination.</p> <p>E. N5 (RN) was hired on 12/14 and lacked documentation of a post offer physical examination.</p> <p>F. N6 (Certified Surgical Tech [CST]) was hired on 4/15 and lacked documentation of a post offer physical examination.</p> <p>E. N7 (CST) was hired on 4/10 and and lacked documentation of a post offer physical examination.</p> <p>F. N8 (CST) was hired on 10/11 and and lacked documentation of a post offer physical examination.</p> <p>G. N9 (Radiology Tech) was hired on 4/10 and and lacked documentation of a post offer physical examination.</p> <p>H. N10 (CST) was hired on 4/10 and and lacked documentation of a post offer physical examination.</p> <p>3. Staff N11 (Administrator) was interviewed on 3/7/16 at approximately -1130 hours, and confirmed the above-mentioned personnel lacked documentation of a post offer physical examination. Also, policy did not clearly define that a post offer physical examination was required.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM</p>			

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Bldg. 00	<p>410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the facility failed to maintain a written, active, and effective center-wide infection control program related to a Tuberculosis (TB) infection control program and annual PPD (purified protein derivate) testing for 8 of 10 (N2-N5 and N7-N10) personnel files reviewed.</p> <p>Findings:</p> <p>1. Policy #IC.11.005, Infection Control Program, revised/reapproved 11/15 indicated on pg.:</p> <p>A. 1, under Policy section, an ongoing center-wide active Infection Control program is established and based on nationally recognized infection control guidelines.</p> <p>B. 2, under Procedure section, point C.d., PPD testing up to date - conversions and/or necessary for follow up.</p>	S 0404	<p>S0404- How to Correct- policies updated to reflect annual education on signs and symptoms of tuberculosis, in addition to reporting is consistent with practice Policy Infection Control Program- IC-11-005,page 3, and Policy ADM-IPC-012,page 3, and LP-ADM-IPC-019, also updated and consistent with all policies referencing annual training and education; Note that charts reviewed with hire date of 4/1/2010 did not have 2-step, this was due to all colleagues at time of new ownership were assumed(not new) from prior company and had current PPD testing, and were not required to go through the process Center maintained annual PPD testing through 2013, and then went to annual review and education of sign and symptoms for tuberculosis; all new hires have and will go through 2-step process; The center completed a CDC tuberculosis risk assessment worksheet and will</p>	04/29/2016

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	<p>2. Policy #ADM-IPC-012, Infection Prevention/Colleague Health Services, revised/reapproved 9/1/15 indicated on pg. 3, point 4.a., Tuberculosis Skin test...A 2 (two) step TB test will be required for all new colleagues, unless contraindicated.</p> <p>3. Review of personnel files confirmed personnel:</p> <p>A. N2 (Registered Nurse [RN]) was hired on 4/10 and lacked documentation of a 2 step TB test.</p> <p>B. N3 (RN) was hired on 4/10 and lacked documentation of a 2 step TB test.</p> <p>C. N4 (RN) was hired on 10/11 and lacked documentation of a 2 step TB test.</p> <p>D. N5 (RN) was hired on 12/14 and lacked documentation of a 2 step TB test.</p> <p>E. N7 (Certified Surgical Tech [CST]) was hired on 4/10 and lacked documentation of a 2 step TB test.</p> <p>F. N8 (CST) was hired on 10/11 and lacked documentation of a 2 step TB test.</p> <p>G. N9 (Radiology Tech) was hired on 4/10 and lacked documentation of a 2 step TB test.</p> <p>H. N10 (CST) was hired on 4/10 and lacked documentation of a 2 step TB test.</p> <p>4. Staff N1 (Clinical Unit Manager) was interviewed on 3/7/16 at approximately - -1115 hours, and confirmed the above-mentioned personnel lacked</p>		<p>repeat this every year as part of our annual Infection Control Program policy that was updated to reflect, and references to policy LP-ADM-IPC-019 on risk classification and prevention; this was approved by the Medical Executive Committee 4/20/16</p> <p>Who is Responsible- Clinical Educator responsible for annual education and compliance; Administrator responsible for annual board agenda and TB risk assessment completed, and colleague health is responsible for new hire 2 step-PPD process</p>	

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S 0408 Bldg. 00	<p>documentation of a 2 step TB test as required per facility policy and procedure. Facility had designated themselves as a low risk classification for TB testing, but did not complete a TB risk assessment to determine facility is a low risk for transmission of TB. The facility is providing personnel an annual questionnaire in lieu of PPD testing, but the two policies referenced above do not address this questionnaire or the process for determining low risk classification.</p> <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 document review and interview, the facility failed to designate a person qualified by training or experience as responsible for the ongoing infection control activities for 1 of 10 (N1) personnel files reviewed.</p> <p>Findings:</p> <p>1. Policy #IC.11.005, Infection Control Program, revised/reapproved 11/15</p>	S 0408	<p>S 0408 How to Correct- designated Lesa Corkwell, RN as interim infection control nurse , until a new Manager of Clinic can be hired and trained Lesa was recommended and approved at the Medical Executive Committee on 4/20/16; Infection Control Policy IC-11-005 was updated to reflect the current job title and job description, which collaborates this position as Infection Control Nurse which went through MEC</p>	04/26/2016

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	<p>indicated on pg. 2, under Procedure section, points A. and C., Infection Control Program is coordinated by a designated, Board of Directors approved, Registered Nurse with knowledge regarding responsibilities of the Infection Control Program, housekeeping services, and functions of the 'Infection Control Nurse'...Infection Control Nurse, fulfilled by the Center's Clinical Manager.</p> <p>2. Review of personnel files confirmed personnel N1 was hired 3/9/15 and had a job description of Clinical Director, which states this person allots reasonable time for monitoring the infection and safety programs as the Infection and Safety Officer and reports to the Quality Improvement committee.</p> <p>3. Review of the Medical Executive Committee/Medical Quality Improvement Committee meeting minutes dated 4/15/15 confirmed on pg. 8, point 6, the current Clinical Director stepped down from this position and N1 was welcomed as the new director.</p> <p>4. Staff N1 (Clinical Director) was interviewed on 3/7/16 at approximately - -1115 hours, and confirmed their job title is Clinical Director, not Center's Clinical Manager. The above-mentioned policy states the job title of the person</p>		<p>on 4/20/16 How to Prevent- Add this job designation to an annual board template at the annual board meeting, template completed on 4/26/16 Who is responsible- Administrator is responsible for Board Agenda</p>				

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S 1006 Bldg. 00	<p>responsible for the Infection Control Program is the Center's Clinical Manager. There was a lack of clear designation of a specific person as being responsible for the facility Infection Control Program as required by facility policy and procedure.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(2)</p> <p>Pharmaceutical services must have the following:</p> <p>(2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed.</p> <p>Based on document review and interview, pharmaceutical services failed to ensure accurate records of stock supplies of all scheduled substances stocked and dispensed for 1 of 4 (Pre Op/Post Anesthesia Recovery Unit/Post Op) areas toured.</p> <p>Findings:</p> <p>1. Review of the Pre Op/Post Anesthesia Recovery Unit/Post Op Perpetual Narcotic Inventory List confirmed: A. column titled, Amt given, had 2 mg documented four times on 3/8/16 at 0710, 0842, 0930 and 1115 hours and lacked documentation of what medication was</p>	S 1006	<p>S1006 How to Correct- updated the perpetual narcotic inventory log with a "medication name", that previously was not there on both forms for the operating room and PreOp/Post anesthesia recovery forms; current strengths provided were updated on all medications listed on the form; the Policy Narcotics Inventory, Administration and Waste was reviewed and reflects the process; which was approved at MEC on 4/20/16, staff was educated on new forms and a sign-in inservice record was utilized to track completion; forms were placed into use on 5/2/16 How to Prevent-The center has a pharmacy audit completed quarterly by our contracted</p>	05/02/2016

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S 1146 Bldg. 00	<p>given.</p> <p>B. column titled, Amt wasted, lacked documentation of what medication was wasted.</p> <p>C. column titled, Tylenol Elixir w/Codeine, lacked documentation of what mg/ml was stocked.</p> <p>2. Staff N11 (Administrator) was interviewed on 3/7/16 at approximately - -1130 hours, and confirmed the above-mentioned narcotic inventory list lacked accurate documentation of medications given, wasted and/or stocked.</p> <p>3. A copy of the policy and procedure related to documentation of narcotic inventory was not 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</p>		<p>pharmacist on pharmaceutical practices and this has been added to his report to audit and ensure compliance, audit period would start on 5/2/16</p> <p>Who is responsible- Manager of Clinic receives quarterly pharmacy report for compliance, and implements new forms, and submits policies to MEC</p>	

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	<p>maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review and interview, the facility failed to record operating room daily temperatures for three of three operating rooms.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Review of 2015 edition of Perioperative Standards and Recommended Practices (AORN) indicated "Operating room(s) temperatures should be monitored and recorded daily using a log format."</li> <li>Review of March 2016 Surgery Monthly Unit Checklist indicated the log did not have documented evidence of operating rooms' daily temperature readings.</li> <li>In interview at 10:45 AM on 3/8/2016, staff member #1 (Administrator) confirmed all the above and no other documentation was provided prior to exit.</li> </ol>	S 1146	<p>S1146</p> <p>How to Correct-Updated surgical daily checklist to include daily temperature and humidity recording, updated policy "Safe Care Through Identification of Potential Hazards in the Surgical Environment" NU-05-112, to reflect process of recording daily temps and humidity on a log; this was approved through MEC 4/20/16, staff was educated on new forms and utilized an in-service sign in sheet to track education of members; new forms began on 4/1/2016</p> <p>How to Prevent- new logs will be audited quarterly as part of our grand safety rounds and recorded on grand round checklist ; these reports are reviewed at quarterly MEC, with next reporting period audit starting 4/1/2016-6/1/2016, and ongoing reporting</p> <p>Who is responsible- Manage of Clinic, prepares reports and compliance as part of MEC agenda monthly and quarterly tracking</p>	04/01/2016