

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001102	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/01/2011
NAME OF PROVIDER OR SUPPLIER VISION SURGICAL CENTER AT SPRINGHILL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 302 W 14TH ST STE 100 B JEFFERSONVILLE, IN47130		
(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	
O0000	<p>This visit was for a Federal recertification survey.</p> <p>Facility #: 002769</p> <p>Survey Dates: 10-31/11-01-11</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: 11/17/11</p>	O0000			

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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O0042	<p>(1) The ASC must have an effective procedure for the immediate transfer, to a hospital, of patients requiring emergency medical care beyond the capabilities of the ASC.</p> <p>(2) This hospital must be a local, Medicare participating hospital or a local, nonparticipating hospital that meets the requirements for payment for emergency services under §482.2 of this chapter.</p> <p>(3) The ASC must -</p> <p>(i) Have a written transfer agreement with a hospital that meets the requirements of paragraph (b)(2) of this section; or</p> <p>(ii) Ensure that all physicians performing surgery in the ASC have admitting privileges at a hospital that meets the requirements of paragraph (b)(2) of this section.</p> <p>Based on document review and interview, the medical staff failed to ensure 2 of 6 (MD#2, 3) credentialed physicians had hospital privileges in the same county as the ASC or an adjoining county in the state of Indiana for those patients requiring transfer for emergency medical care beyond the capabilities of the ASC.</p> <p>Findings include:</p> <p>1. Review of physician credential files on 10-31-11 lacked evidence that 2 of 6 (MD#2, 3) credentialed physicians had hospital privileges in the same county as the ASC or an adjoining county in the state of Indiana for those patients requiring transfer for emergency medical care beyond the capabilities of the ASC.</p>	O0042	<p>The physician without a current DEA and without hospital privileges has never practiced in our facility and will be officially removed as one of our credentialed physicians. The other physician applied for hospital privileges in our county on 11/29/2011. All physicians at the Vision Surgical Center will maintain hospital privileges. Copies of current DEA certification will be kept in the credentialing files of all practicing physicians. The DON will be responsible for credentialing files. The Date of Correction is 11/29/11 when the physician filed for admitting privileges. The Vision Surgical Center expects privileges will be granted over the next 30 days.</p>	11/29/2011

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Q0061	<p>2. Interview with B#1 on 11-1-11 at 0840 hours confirmed 2 of 6 credentialed physicians (MD#2, 3) do not have hospital privileges in the same county as the ASC or an adjoining county in the state of Indiana for those patients requiring transfer for emergency medical care beyond the capabilities of the ASC.</p> <p>A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.</p> <p>Based on observation and interview, a physician failed to examine the patient immediately before surgery to evaluate the risk of the procedure to be performed for 1 patient observed (patient #N30).</p> <p>Findings include:</p> <p>1. Observation of patient #N30 throughout his/her stay at facility indicated the following: (A) He/she arrived at 11:30 a.m. for cataract removal by M.D. #5. (B) The physician or other qualified practitioner did not examine the patient prior to the procedure.</p> <p>2. Patient #N30 indicated in interview at 11:35 a.m. on 11/1/11 that M.D. #5 had not performed an H&P or a physical</p>	Q0061	<p>A physician will examine the patient immediately before surgery. Medical staff will be in-serviced by 12/7/11. The DON will monitor daily times 2 weeks, then weekly times 4 then quarterly. The Date of Correction is 11/30/11. Our pre-anesthesia policy was revised and updated 11/30/11. All staff will be in-serviced and the policy changes implemented over the next 30 days.</p>	11/30/2011

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O0082	<p>assessment of him/her prior to his/her visit.</p> <p>(b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.</p> <p>(b)(2) The ASC must use the data collected to -</p> <p style="padding-left: 20px;">(i) Monitor the effectiveness and safety of its services, and quality of its care.</p> <p style="padding-left: 20px;">(ii) Identify opportunities that could lead to improvements and changes in its patient care.</p> <p>(c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.</p> <p>(c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.</p> <p>Based on document review and interview, the facility failed to include all services, including those provided by contract, in the facility Quality Assurance and Performance Improvement (QAPI) program to ensure they are provided safely, effectively, and appropriately.</p> <p>Findings include:</p> <p>1. Review of facility QAPI data on</p>	O0082	The above services will be added to the QAPI program and will be reviewed quarterly. Contracted service for radiology will be set up with Clark County Memorial Hospital. All contracted services will be reviewed. The QI officer will be in-serviced 12-7-11. The DON is responsible to ensure the services are reviewed. Date of Correction is 12/01/11 when the laboratory, transcription and discharge services were added to the QAPI program.. Contracted	12/01/2011	

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O0181	<p>10-31-11 and 11-1-11 lacked evidence that the direct services of laboratory, transcription, and discharges, and the contracted service of radiology were included in the facility QAPI program.</p> <p>2. Interview with B#1 and B#2 on 11-1-11 at 1330 hours confirmed the direct services of laboratory, transcription, and discharges, and the contracted service of radiology are not included in the facility QAPI program.</p> <p>Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on document review, observation, and staff interview, the facility failed to witness narcotic wastage per policy, failed to discard single dose vials after use, failed to discard multi-dose vials within specified time frames, failed to remove expired medications from patient stock, and failed to have orders signed by a physician.</p> <p>Findings include:</p> <p>1. Facility policy titled "Medication Administration" last reviewed/revised 9/15/11 states under policy on page 1: "Medication will only be administered on the order of a physician....." Page 2 states: "1. All medication orders must</p>	O0181	<p>services for radiology were also applied for and requested 12/01/11. Vision Surgical Center expects the processing and approval for the contracted radiology service to occur over the next 30 days.</p> <p>The pharmacy nurse or designee will review all supplies in the crash cart monthly with the pharmacy consultant. All medications will be removed a month prior to their expiration date so all supplies will remain current. All single dose vials will be discarded immediately after use and all multi-dose vials will be discarded on or by the 28th day. All nurses will follow the narcotics wastage policy and procedure. The physician will authenticate records by written signature or personally applying their rubber stamp to the record. The Medical Record policy will be revised and updated to reflect this change. Medical staff, medical record staff, and nursing staff will be in-serviced by 12/7/11. The DON or designee will monitor</p>	11/30/2011			

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	<p>include the name of the drug, dose, route, frequency, and the licensed physician's signature."</p> <p>2. Facility policy titled "Medication Storage" last reviewed/revised 1/26/11 states on page 1: "6. Medications shall not be kept in stock after the expiration date on the label. and 8. Multidose vials of injectable medications are to be dated and initialed when opened. The vials shall be destroyed when expired per manufacturer guidelines or 28 days, whichever is first." Page 2 states: "9. All single dose vials or vials without preservations must be discarded at time of use and not reserved for further use."</p> <p>3. Facility policy titled "Narcotics Management" last reviewed/revised 1/26/11 states on page 2: "7. Wastage will be witnessed and co-signed by a second RN, MD, or CRNA."</p> <p>4. Observation of narcotic waste at 12:15 p.m. on 11/1/11 indicated the following: (A) RN #N5 prepared a syringe of Versed and had to waste the remainder of contents of two (2) vials of Versed. He/she put the vials in the sharps container. After putting the vials in the sharps container, he/she summoned RN #N7 and requested he/she to initial as a witness.</p>		<p>daily for 2 weeks then weekly for one month then quarterly. The Date of Correction is 11/30/11. The policy for chart authentication was revised and updated 11/30/11. Outdated medications and supplies were removed 11/3/11. Single dose vials have been discarded after each use since 11/3/11. Outdated multi-dose vials were removed 11/3/11. Staff will be in-serviced and all changes implemented over the next 30 days.</p>				

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	<p>(B) RN #N7 initialed the wastage, however he/she did not witness the wastage of the narcotic.</p> <p>5. Observation of refrigerated medication storage in the clean storage room at 1:40 p.m. on 11/1/11 indicated the following: (A) One (11) vial of sodium chloride had not been discarded after use per policy. The vial labeled as single dose was dated as opened on 10/24/11. (B) One (1) vial of Lidocaine had not been discarded after 28 days per policy. The vial was labeled as multi-dose and opened on 10/3/11. (C) One (1) vial of Marcaine had not been discarded after 28 days per policy. The vial was labeled as multi-dose and opened on 10/3/11.</p> <p>6. Observation of the crash carts contents at 1:15 p.m. on 11/1/11 revealed the following expired items: (A) One (1) bag of sodium chloride .9% with an expiration date of 3/11 (B) One (1) 10 ml. vial of Dopamine with an expiration date of 10/1/11.</p> <p>7. Review of patients #N9-N11, N18-N20, and N26 indicated the following: (A) The order sheet had a stamped physician signature for M.D. #5.</p>						

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O0221	<p>8. Staff member #B4 indicated in interview at 1:40 p.m. on 11/1/11 that he/she stamps M.D. #5's records "about 99% of the time".</p> <p>The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands.</p> <p>Based on document review and staff interview, the facility failed to ensure patients received notice of patient rights in advance of surgery for 8 of 29 patients (patients #N3-N6, N13, N21, and N28-N29).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Patients #N3 and N4 had procedure on 7/28/11. Their medical records lacked documentation that the patients had received notice of patient rights prior to the procedure. 2. Patients #N5 and N6 had procedures on 7/13/11. Their medical records lacked documentation that the patients had received notice of patient rights prior to the procedure. 3. Patient #N13 had procedure on 6/30/11. His/her medical record lacked documentation that the patient had 	O0221	<p>All patients will be provided notice of patients rights in advance of surgery for all procedures. Staff will be in-serviced by 12/7/11. The DON or designee will monitor weekly times 4 then quarterly. The Date of Correction is 12/01/11. The form for Advance Notice notification was revised and updated 12/1/11. Staff will be in-serviced and changes to the procedure implemented over the next 30 days.</p>	12/01/2011

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O0222	<p>received notice of patient rights prior to the procedure.</p> <p>4. Patient #N21 had procedure on 5/31/11. His/her medical record lacked documentation that the patient had received notice of patient rights prior to the procedure.</p> <p>5. Patients #N28 and N29 had procedures on 8/10/11. Their medical records lacked documentation that the patients had received notice of patient rights prior to the procedure.</p> <p>6. Staff member #B4 verified the above at 3:00 p.m. on 11/1/11.</p> <p>In addition, the ASC must - Post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. Based on observation, document review, and interview, the facility failed to include the name, address, and telephone number of a representative of the State agency to</p>	O0222	The State agency and Ombudsman contact information have been added to the posting. Staff will be in-serviced on Patient Rights by 12/7/11. The Date of	12/01/2011

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	<p>whom patients can report complaints, as well as the web site for the Office of the Medicare Beneficiary Ombudsman in the patient rights.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. While touring the facility on 11-1-11 at 1300 hours, it was observed that the copy of patient's rights posted in the facility waiting area lacked the name, address, and telephone number of a representative of the State agency to whom patients can report complaints, as well as the web site for the Office of the Medicare Beneficiary Ombudsman in the patient rights. 2. Interview with B#2 on 11-1-11 at 1400 hours confirmed the document posted in the facility waiting area lacked evidence that the name, address, and telephone number of a representative of the State agency to whom patients can report complaints, as well as the web site for the Office of the Medicare Beneficiary Ombudsman is listed on the document outlining patient rights posted in the facility waiting area. 		Correction is 12/1/11. The Notice of Posting was revised, updated and re-posted on 11/30/11. Staff will be in-serviced by 12/7/11.		

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O0223	<p>The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure.</p> <p>Based on document review and staff interview, the facility failed to ensure patients received notice of physician financial interests or ownership in advance of surgery for 8 of 29 patients (patients #N3-N6, N13, N21, and N28-N29).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Patients #N3 and N4 had procedure on 7/28/11. Their medical records lacked documentation that the patients had received notice of physician ownership or financial interest prior to the procedure. 2. Patients #N5 and N6 had procedures on 7/13/11. Their medical records lacked documentation that the patients had received notice of physician ownership or financial interest prior to the procedure. 3. Patient #N13 had procedure on 6/30/11. His/her medical record lacked documentation that the patient had received notice of physician ownership or financial interest prior to the procedure. 	O0223	All patients will be provided notice of physician ownership or financial interest prior to each procedure in the Vision surgical Center. Staff will be in-serviced by 12/7/11. The DON or designee will monitor weekly times four then quarterly. The Date of Correction is 12/1/11. The form with notice of physician financial interest or ownership was revised 12/1/11. Staff will be in-serviced and the new form implemented over the next 30 days.	12/01/2011			

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O0224	<p>4. Patient #N21 had procedure on 5/31/11. His/her medical record lacked documentation that the patient had received notice of physician ownership or financial interest prior to the procedure.</p> <p>5. Patients #N28 and N29 had procedures on 8/10/11. Their medical records lacked documentation that the patients had received notice of physician ownership or financial interest prior to the procedure.</p> <p>6. Staff member #B4 verified at 3:00 p.m. on 11/1/11 that the patients had not received notice of rights which contains information on physician ownership.</p> <p>The ASC must comply with the following requirements: (i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms. (ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>Based on document review and staff</p>	O0224	All patients will be offered	12/01/2011	

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	<p>interview, the facility failed to ensure patients received advance directive information prior to surgery and failed to document in the medical record whether the patient had an advance directive for 11 of 29 patients (patients #N3, N5, N6, N7, N8, N12, N13, N21, N27, N28 and N29).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Patient #N3 had a procedure on 7/28/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive. 2. Patients #N5 and N6 had procedures on 7/13/11. Their medical records lacked documentation that they received information on advance directives and failed to document in the medical record whether the patient had an advance directive. 3. Patients #N7, N8, N12 and N13 had procedures on 6/30/11. Their medical records lacked documentation that they received information on advance directives and failed to document in the medical record whether the patient had an advance directive. 		<p>advance directive information. The medical record will document whether a patient had an advanced directive. Staff will be in-serviced by 12/7/11. The DON or designee will monitor every week times 4 weeks then quarterly. The Date of Correction is 12/1/11. The form notifying patients of advanced directive information was revised 12/1/11. Staff will be in-serviced and the new form implemented over the next 30 day</p>		

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	<p>4. Patient #N21 had a procedure on 5/31/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive.</p> <p>5. Patients #N27, N28, and N29 had procedures on 8/10/11. Their medical records lacked documentation that they received information on advance directives and failed to document in the medical record whether the patient had an advance directive.</p> <p>6. Facility policy titled "Advance Directives" last reviewed/revised 1/11 states under procedure: "1. An inquiry will be made by the surgical receptionist during the admissions process of the patient, or if the patient is incapacitated to the patient's significant other, as to whether or not the patient has completed an advance directive."</p> <p>7. Staff member #B4 verified the above at 3:00 p.m. on 11/1/11.</p>				

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O0225	<p>(i) The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC.</p> <p>(v) The grievance process must specify timeframes for review of the grievance and the provisions of a response.</p> <p>(vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished.</p> <p>(vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.</p> <p>Based on document review and interview, the facility failed to include all required elements in the facility grievance policy and procedure.</p> <p>Findings include:</p> <p>1. Review of the facility policy titled PATIENT RIGHTS AND RESPONSIBILITIES, GRIEVANCE PROCESS on 10-31-11 and 11-1-11 lacked evidence that procedure included a provision for a response to the complainant, how the grievance will be addressed, or a provision to include a written response to the complainant</p>	O0225	The grievance policy and procedure will be revised and updated to include a provision for a response to the complainant, how the grievance will be addressed and a provision to include a written response to the complainant regarding the decision. Staff will be in-serviced by 12/7/11 on the revised policy. The DON is responsible for the revision of the policy and procedure. The Date of Correction is 12/01/11. The policy on the grievance process was revised and updated 12/01/11. Staff will in-serviced by 12/7/11.	12/01/2011

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O0230	<p>regarding the decision that was made based on the investigation.</p> <p>2. Interview with B#2 on 11-1-11 at 1420 hours confirmed the facility policy titled PATIENT RIGHTS AND RESPONSIBILITIES, GRIEVANCE PROCESS lacked provisions for a response to the complainant, how the grievance will be addressed, or a provision to include a written response to the complainant regarding the decision that was made following the investigation.</p> <p>(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 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 document review and interview, the facility failed to develop a policy/procedure to protect the rights of patients adjudged incompetent by a court of law of proper jurisdiction.</p> <p>Findings include:</p> <p>1. Review of facility documents on 10-31-11 and 11-1-11 lacked evidence that the facility had developed and approved a policy/procedure to address</p>	O0230	The Vision Surgical Center will develop the policy and procedure to protect the right of patients adjudged incompetent by a court of law and have the policy approved by the Governing Board. Staff will be in-serviced on the new policy by 12/7/11. The DON will be responsible for the development of the policy. The Date of Correction is 12/1/11. A new policy on patients adjudged incompetent was written on 12/01/11. A date of 2/21/12 has been set for the next quarterly meeting of the GB and MEC	12/01/2011	

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Q0241	<p>and protect the rights of patients adjudged incompetent by a court of law of proper jurisdiction.</p> <p>2. Interview with B#2 on 11-1-11 at 1400 hours confirmed the facility has not developed/approved a policy/procedure to address and protect the rights of patients adjudged incompetent by a court of law of proper jurisdiction.</p> <p>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 observation, staff interview and document review, the facility failed to provide a sanitary environment for 2 of 2 operating rooms.</p> <p>Findings include;</p> <p>1. During observation of the terminal cleaning of the operating rooms beginning at 2:30 p.m. on 10/31/11, the following was observed: (A) Staff members #N6 and N8 failed to mix separate containers of solution for mopping and cleaning surfaces. The staff members utilized cleaning solution in a mop bucket for both wiping surfaces and for mopping.</p> <p>2. Staff member #N6 indicated in interview during the observation that</p>	Q0241	<p>committees. Staff will be in-serviced on the policy.</p> <p>Separate containers will be used for cleaning solutions to wipe surfaces and mopping. Manufacturer's recommendations for the use of chemicals will be followed. All staff will be in-serviced by 12/7/11. The Director of Nursing will monitor daily for 2 weeks, then weekly for 4 weeks, then quarterly. The Date of Correction is 11/25/11. Separate cleaning containers were provided to staff. The policy will be updated over the next 30 days (11/30/11) and staff in-serviced (by 12-7-11.</p>	11/25/2011

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O0261	<p>he/she mixes "about 1/2 bottle" of Meritz germicidal solution to "about 2 bottles of water" for the solution in the mop bucket.</p> <p>3. Label instructions for the Meritz germicidal solution states "do not dilute".</p> <p>Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. Based on observation, document review, and interview, the facility failed to ensure that a history and physical (H&P) was conducted by a physician or qualified practitioner for 30 of 30 patients (patients #N1-N30).</p> <p>Findings include:</p> <p>1. Observation of patient #N30 visit to the facility indicated the following: (A) He/she arrived at 11:30 a.m. for cataract removal by M.D. #5. (B) The physician did not examine the patient prior to the procedure. (C) RN #N5 took the patients vitals and completed the H&P document.</p> <p>2. Review of patients #N1, N2, N4, N9-N11, N14-N20, N22-N26 medical</p>	O0261	A physician will complete a History and Physical (H&P) pre-operatively. The current Vision Surgical Center H&P and the H&P policy and procedure will be revised and updated. Medical staff and nursing staff will be in-serviced by 12/7/11. The DON or designee will monitor daily times 2 weeks, then weekly times 4 then quarterly. The Date of Correction is 12/1/11 when the H&P form was revised and updated. All staff will be in-serviced and the new form implemented over the next 30 days.	12/01/2011	

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	<p>records indicated that a nurse completed the physical exam portion of the H&P document.</p> <p>3. Review of patients #N3, N5-N8, N12, N13, N21, and N27-N29 indicated the patient completed a health history form. The record lacked documentation of a history and physical exam.</p> <p>4. Medical staff by laws/rules and regulations last approved 3/17/09 states "A history and physical examination shall be performed on all patients."</p> <p>5. Patient #N30 indicated in interview at 11:35 a.m. on 11/1/11 that M.D. #5 had not performed an H&P or a physical assessment of him/her prior to his/her visit.</p> <p>6. Staff member #B4 verified at 3:00 p.m. on 11/1/11 the above medical record documentation. He/she indicated that a nurse is completing the physical exam portion of H&P form if there is an H&P or the patient is completing a health history form.</p>				

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O0262	<p>Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals.</p> <p>Based on observation and interview, the facility failed to provide a presurgical assessment for 1 patient observed (patient #N30).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation of patient #N30 throughout his/her stay at facility indicated the following: <ul style="list-style-type: none"> (A) He/she arrived at 11:30 a.m. for cataract removal by M.D. #5. (B) The physician or other qualified practitioner did not examine the patient prior to the procedure. 2. Patient #N30 indicated in interview at 11:35 a.m. on 11/1/11 that M.D. #5 had not performed an H&P or a physical assessment of him/her prior to his/her visit. 	O0262	<p>A pre-anesthesia examination will be conducted on all patients receiving anesthesia. The anesthesia policy and procedure has been revised and updated. Medical staff and nursing staff will be in-serviced by 12/7/11. The DON or designee will monitor daily times 2 weeks then weekly times 4 then quarterly. The Date of Correction is 11/30/11 when the policy was revised and updated. All staff will be in-serviced and the policy changes implemented over the next 30 days.</p>	11/30/2011	

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S0116	<p>410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</p> <p>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on document review and interview, the governing body failed to act on the reappointment of 1 of 6 physicians (MD#5) as required by the medical staff bylaws and facility policy.</p> <p>Findings include:</p> <p>1. Review of physician credential files on 10-31-11 and 11-1-11 indicated the Medical Executive Committee recommended MD#5 for reappointment on 12-17-09 following a prior approval 3-17-2008.</p>	S0116	<p>The Governing Board held an addendum meeting on November 29, 2011 and approved the 2010 reappointment of Dr. Black. All re-appointments since have been approved. The Director of Nursing (DON) is responsible for re-appointments and motion for approval at Governing Board meetings. The Administrator will monitor re-appointments and approval for the next four meetings and ongoing as needed. The Date of Correction is 11-29-11 when the Governing Board Addendum meeting was held and Dr. Black's</p>	11/29/2011

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	<p>2. Review of the Medical Staff Bylaws, approved 3-17-09, on 10-31-11 and 11-1-11 indicated the following under APPOINTMENTS AND PRIVILEGES: All appointments and reappointments to the Staff shall be made by the Board after recommendation of the Medical Executive Committee and be effective for a maximum two-year period. Initial appointments to the Staff will be for a period not to exceed 12 months. Reappointments will not exceed two years.</p> <p>3. Review of facility policy titled LICENSE/CREDENTIALING on 10-31-11 and 11-1-11 indicated applicants shall apply for reappointment every 2 years; the governing board will then vote and confirm the appointment.</p> <p>4. Review of Governing Board meeting minutes lacked evidence that the governing board acted on the reappointment of MD#5 from 12-17-09 to present, thus the privileges expired 3-17-10.</p> <p>5. Interview with B#1 on 11-1-11 at 0840 hours confirmed the privileges of MD#5 expired 3-17-10, MD#5 was recommended for reappointment by the medical executive committee on 12-17-09, and the governing body did not act on the reappointment of MD#5 from 12-17-09 to present.</p>		<p>reappointment was approved. The next GB meeting is scheduled for 2/21/12</p>				

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S0310	<p>410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include all services, including those provided by contract, in the facility Quality Assurance and Performance Improvement (QAPI) program to ensure they are provided safely and appropriately.</p> <p>Findings include:</p> <p>1. Review of facility QAPI data on 10-31-11 and 11-1-11 lacked evidence that the direct services of laboratory, transcription, and discharges, and the contracted service of radiology were included in the facility QAPI program.</p> <p>2. Interview with B#1 and B#2 on 11-1-11 at 1330 hours confirmed the direct services of laboratory, transcription, and discharges, and the contracted service of radiology are not included in the facility QAPI program.</p>	S0310	<p>The above services will be added to the QAPI program and will be reviewed quarterly. Contracted service for radiology will be set up with Clark County Memorial Hospital. All contracted services will be reviewed. The QI officer will be in-serviced 12-7-11. The DON is responsible to ensure the services are reviewed. Date of Correction is 12/01/11 when the laboratory, transcription and discharge services were added to the QAPI program.. Contracted services for radiology were also applied for and requested 12/01/11. Vision Surgical Center expects the processing and approval for the contracted radiology service to occur over the next 30 days</p>	12/01/2011	

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S0400	<p>410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, the facility failed to remove outdated supplies from patient stock for 1 crash cart observed.</p> <p>Findings include:</p> <p>1. Observation of the crash carts contents at 1:15 p.m. on 11/1/11 revealed the following expired items:</p> <p>(A) One (1) package of CO2 detectors with an expiration date of 7/14/11</p> <p>(B) One (1) 20 cc syringe with an expiration date of 10/08.</p> <p>(C) Two (2) packages of connecting tubing with an expiration date of 7/11</p> <p>(D) Four (4) packages of surgical gloves with an expiration date of 12/31/10</p>	S0400	The pharmacy nurse or designee will review all supplies in the crash cart monthly with the pharmacy consultant. All outdated supplies will be removed and reordered. Outdated supplies will be removed a month prior to their expiration so all supplies will remain current. Staff will be in-serviced 12-7-11. The DON will monitor every month for 6 months and as needed. The Date of Correction is 12/1/11. All outdated supplies were removed by 11/2/11. Staff will be in-serviced and changes implemented over the next 30 days.	12/01/2011	
S0422	<p>410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.</p>				

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S0428	<p>Based on document review, the infection control committee failed to review employee exposure incidents for 2 incidents.</p> <p>Findings include:</p> <p>1. Review of incident reports for the previous year indicated the following: (A) Staff member #N9 stabbed his/her finger with a contaminated instrument on 1/12/11. (B) Staff member #N6 stuck self with a contaminated needle on 5/16/11.</p> <p>2. Review of the infection control meeting minutes for the previous year indicated the following: (A) The above exposure incidents were not addressed by the infection control committee.</p> <p>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, staff interview, and</p>	S0422	The 2011 and all future employee incidents will be reviewed by the Infection Control committee and documented in the meeting minutes. The Infection Control designee will be in-serviced by 12/7/11. The DON will monitor quarterly. The Date of Correction is 12/0/11. An addendum Infection Control meeting was held on 12/1/11 and the 2011 incidents were reviewed. Staff will be in-serviced and changes implemented over the next 30 days. The next quarterly Infection Control meeting is scheduled for 12/22/11.	12/01/2011			
		S0428	Separate containers will be used	11/25/2011			

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	<p>document review, the facility failed to provide a sanitary environment for 2 of 2 operating rooms.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During observation of the terminal cleaning of the operating rooms beginning at 2:30 p.m. on 10/31/11, the following was observed: (A) Staff members #N6 and N8 failed to mix separate containers of solution for mopping and cleaning surfaces. The staff members utilized cleaning solution in a mop bucket for both wiping surfaces and for mopping. 2. Staff member #N6 indicated in interview during the observation that he/she mixes "about 1/2 bottle" of Meritz germicidal solution to "about 2 bottles of water" for the solution in the mop bucket. 3. Label instructions for the Meritz germicidal solution state "do not dilute". 		<p>for cleaning solutions to wipe surfaces and mopping. Manufacturer's recommendations for the use of chemicals will be followed. All staff will be in-serviced by 12/7/11. The Director of Nursing will monitor daily for 2 weeks, then weekly for 4 weeks, then quarterly. The Date of Correction is 11/25/11. Separate cleaning containers were provided to staff. The policy will be updated over the next 30 days (11/30/11) and staff in-serviced (by 12-7-11).</p>		

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S0616	<p>410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on document review and staff interview, the facility failed to ensure records were authenticated according to policy for 7 of 7 patients under the care of M.D. #5 (patients #N9-N11, N18-N20, and N26).</p> <p>Findings include:</p> <p>1. Facility policy titled "Medical Record: Physician Documentation" last reviewed/revised 1/11 states "8. Physicians may use rubber stamps to authenticate signatures."</p> <p>2. Review of patients #N9-N11, N18-N20, and N26 indicated the following: (A) All areas requiring physician signature was stamped with signature of M.D. #5.</p>	S0616	The physician will authenticate records by written signature or personally applying their rubber stamp to the record. The Medical Record policy will be revised and updated to reflect this change. Medical staff and medical record staff will be in-serviced by 12/7/11. The DON or designee will monitor daily for 2 weeks then monthly x 3 then quarterly. The Date of Correction is 11/30/11 when the policy and procedure for chart authentication was revised and updated. All physicians will be in-serviced and compliant with the policy change over the next 30 days.	11/30/2011	

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S0622	<p>3. Staff member #B4 indicated in interview at 1:40 p.m. on 11/1/11 that he/she stamps M.D. #5's records "about 99% of the time".</p> <p>410 IAC 15-2.5-3(c)(6)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(6) The center shall have a system of coding and indexing medical records which allows for timely retrieval of records by diagnosis and procedure, physician, and condition on discharge, in order to support continuous quality assessment and improvement activities. Based on document review and interview, the facility failed to have a system of coding and indexing which allowed for timely retrieval of records by diagnosis and condition on discharge.</p> <p>Findings include:</p> <p>1. Review of the facility patient index log on 10-31-11 lacked evidence that the patients' diagnosis and condition on discharge were included in the log to allow for timely retrieval of records.</p> <p>2. Review of facility policy titled</p>	S0622	The diagnosis and condition on discharge will be added to the Patient Index Log. Staff will in-serviced by 12/7/11. The DON or designee will monitor daily for 2 weeks, then weekly for 4 weeks, then quarterly. Date of Correction is 12/01/11 when a new Patient Index Report with all the required elements was created on 12/1/11. Staff will be in-serviced and the new report used over the next 30 days.	12/01/2011

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S0676	<p>PATIENT REGISTER ELECTRONIC on 11-1-11 indicated the following: To provide a permanent record of procedures performed and pertinent information regard each procedure; to include the information of date/time, patient name, operation performed, surgeon, type of anesthesia, phone number, sex/age.</p> <p>3. Interview with B#2 on 10-31-11 at 1400 hours confirmed the facility system of coding and indexing lacks the patients' diagnosis and condition on discharge to allow for timely retrieval by diagnosis or condition on discharge.</p> <p>410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or legally reproduced medical records 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 document review and interview, the facility failed to obtain a waiver for off-site patient medical record storage as required by IC 15-2.2-2(c).</p> <p>Findings include:</p> <p>1. Review of facility documents on 11-1-11 lacked evidence that the facility</p>	S0676	The Vision Surgical Center will convert their current off site stored medical records to an electronic format. Due to the high volume of records involved, this conversion will take place over the next 90 days. The DON or designee will monitor the progress of the conversion to ensure timely completion. The Date of Correction is	11/29/2011	

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	had applied for/been granted a waiver to store patient medical records off-site as required by IC 15-2.2-2(c). 2. Interview with B# 2 on 11-1-11 at 1155 hours confirmed patient medical records are stored in an area that is not leased or operated by the ASC and the ASC has not applied for or been granted a waiver for off-site storage of patient medical records as required by IC 15-2.1-2(c).		11/29/11when a contract was obtained, with Eye Associates, for the stored documents to be converted into electronic format.Due to the high volume of records the conversion will take place over the next 90 days.		

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S0710	<p>410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p> <p>(iv) Documentation of experience in the practice of medicine.</p>			

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	<p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on document review and interview, the medical staff failed to insure 2 of 6 (MD#2, 3) credentialed physicians had hospital privileges in the same county as the ASC or an adjoining county in the state of Indiana in accordance with IC 16-18-2-14(3)(C) and 1 of 6 physicians (MD# 3) lacked documentation of a Drug Enforcement Agency registration.</p> <p>Findings include:</p> <p>1. Review of physician credential files on 10-31-11 lacked evidence that 2 of 6 (MD#2, 3) credentialed physicians had hospital privileges in the same county as</p>	S0710	<p>The physician without a current DEA and without hospital privileges has never practiced in our facility and will be officially removed as one of our credentialed physicians. The other physician applied for hospital privileges in our county on 11/29/2011. All physicians at the Vision Surgical Center will maintain hospital privileges. Copies of current DEA certification will be kept in the credentialing files of all practicing physicians. The DON will be responsible for credentialing files. The Date of Correction is 11/29/11 when the physician filed for admitting privileges. The Vision Surgical Center expects</p>	11/29/2011

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	<p>the ASC or an adjoining county in the state of Indiana in accordance with IC 16-18-2-14(3)(C) and 1 of 6 credentialed physicians (MD# 3) lacked documentation of a Drug Enforcement Agency registration.</p> <p>2. Interview with B#1 on 11-1-11 at 0840 hours confirmed 2 of 6 credentialed physicians (MD#2, 3) do not have hospital privileges in the same county as the ASC or an adjoining county in the state of Indiana and 1 of 6 credentialed physicians (MD# 3) lacks a DEA registration in the physician's credential file.</p>		privileges will be granted over the next 30 days.		

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S0772	<p>410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on observation, document review, and interview, the facility failed to ensure that a history and physical (H&P) was conducted by a physician or qualified practitioner for 30 of 30 patients (patients #N1-N30).</p> <p>Findings include:</p>	S0772	A physician will complete a History and Physical (H&P) pre-operatively. The current Vision Surgical Center H&P and the H&P policy and procedure will be revised and updated. Medical staff and nursing staff will be in-serviced by 12/7/11. The DON or designee will monitor daily times 2 weeks, then weekly times 4 then quarterly. The Date of Correction is 12/1/11 when the	12/01/2011	

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	<p>1. Observation of patient #N30 throughout his/her visit to the facility indicated the following: (A) He/she arrived at 11:30 a.m. for cataract removal by M.D. #5. (B) The physician did not examine the patient prior to the procedure. (C) RN #N5 took the patients vitals and completed the H&P document.</p> <p>2. Review of patients #N1, N2, N4, N9-N11, N14-N20, N22-N26 medical records indicated that a nurse completed the physical exam portion of the H&P document.</p> <p>3. Review of patients #N3, N5-N8, N12, N13, N21, and N27-N29 indicated the patient completed a health history form. The record lacked documentation of a history and physical exam.</p> <p>4. Medical staff by laws/rules and regulations last approved 3/17/09 state "A history and physical examination shall be performed on all patients."</p> <p>5. Patient #N30 indicated in interview at 11:35 a.m. on 11/1/11 that M.D. #5 had not performed an H&P or a physical assessment of him/her prior to his/her visit.</p> <p>6. Staff member #B4 verified the above</p>		H&P form was revised and updated. All staff will be in-serviced and the new form implemented over the next 30 days.		

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S0780	<p>medical record documentation at 3:00 p.m. on 11/1/11. He/she indicated that a nurse is completing the physical exam portion of H&P form if there is an H&P or the patient is completing a health history form.</p> <p>410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on document review and staff interview, the facility failed to have orders signed by a physician or use physician stamp according to policy for 7 of 7 patients under the care of M.D. #5.</p> <p>Findings include;</p> <p>1. Facility policy titled "Medication Administration" last reviewed/revised 9/15/11 states under policy on page 1: "Medication will only be administered on the order of a physician....." Page 2</p>	S0780	The physician will authenticate records by written signature or personally applying their rubber stamp to the record. The medical record policy will be revised and updated to reflect this change. Medical staff and medical record staff will be in-serviced by 12/7/11. The DON or designee will monitor daily for 2 weeks then monthly times 3 then quarterly.	12/12/2011

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	<p>states: "1. All medication orders must include the name of the drug, dose, route, frequency, and the licensed physician's signature."</p> <p>2. Facility policy titled "Medical Record: Physician Documentation" last reviewed/revised 1/11 states "8. Physicians may use rubber stamps to authenticate signatures."</p> <p>3. Review of patients #N9-N11, N18-N20, and N26 indicated the following: (A) The order sheet had a stamped physician signature for M.D. #5.</p> <p>4. Staff member #B4 indicated in interview at 1:40 p.m. on 11/1/11 that he/she stamps M.D. #5's records "about 99% of the time".</p>				

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S0830	<p>410 IAC 15-2.5-4(c)(1)(F)(i)</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> <p>(F) The delineation of preanesthesia, intra-operative, and post-anesthesia responsibilities as follows:</p> <p>(i) The completion, within forty-eight (48) hours before surgery, of a preanesthesia evaluation for each patient by an individual qualified to administer anesthesia for all types of anesthetics other than local and updated according to center policy (when more than forty-eight (48) hours) before surgery.</p> <p>Based on document review and observation, the facility failed to ensure anesthesia policies included a pre-anesthesia examination for all types of anesthesia other than local and failed to ensure a pre-anesthesia evaluation was performed by a person qualified to administer anesthesia for 1 patient observed (patient #N30).</p> <p>Findings include:</p> <p>1. Facility policy titled "Anesthesia Responsibilities" last reviewed/revised 8/17/10 only requires the anesthesia provider to perform a pre-anesthesia assessment if the patient receives general,</p>	S0830	<p>A pre-anesthesia examination will be conducted on all patients receiving anesthesia. The anesthesia policy and procedure has been revised and updated. Medical staff and nursing staff will be in-serviced by 12/7/11. The DON or designee will monitor daily times 2 weeks then weekly times 4 then quarterly. The Date of Correction is 11/30/11 when the policy was revised and updated. All staff will be in-serviced and the policy changes implemented over the next 30 days.</p>	11/30/2011			

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S1000	<p>conductive, or local anesthesia with stand by.</p> <p>2. Observation of patient #N30 throughout his/her stay at facility indicated the following: (A) He/she arrived at 11:30 a.m. for cataract removal by M.D. #5. (B) The patient received Versed sublingual prior to surgery and anesthesia provider #1 monitored the patient throughout surgery. (C) The physician or other qualified practitioner did not examine the patient prior to the procedure.</p> <p>410 IAC 15-2.5-6</p> <p>The center shall provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services. Pharmaceutical services must have the following: Based on document review and observation, the facility failed to remove expired medications from patient stock for one crash cart observed and failed to follow facility policy for wastage of narcotics.</p> <p>Findings include:</p>	S1000	The pharmacy nurse or designee will review all supplies in the crash cart monthly with the pharmacy consultant. All medications will be removed a month prior to their expiration date so all supplies will remain current. All nurses will follow the narcotics wastage policy and procedure. Nursing staff will be in-serviced by 12/7/11. The DON	12/01/2011	

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	<p>1. Facility policy titled "Medication Storage" last reviewed/ revised 1/26/11 states on page 1: "6. Medications shall not be kept in stock after the expiration date on the label."</p> <p>2. Facility policy titled "Narcotics Management" last reviewed/ revised 1/26/11 states on page 2: "7. Wastage will be witnessed and co-signed by a second RN, MD, or CRNA."</p> <p>3. Observation of the crash carts contents at 1:15 p.m. on 11/1/11 revealed the following expired items: (A) One (1) bag of sodium chloride .9% with an expiration date of 3/11 (B) One (1) 10 ml. vial of Dopamine with an expiration date of 10/1/11.</p> <p>4. Observation of narcotic waste at 12:15 p.m. on 11/1/11 indicated the following: (A) RN #N5 prepared a syringe of Versed and had to waste the remainder of contents of two (2) vials of Versed. He/she put the vials in the sharps container. After putting the vials in the sharps container, he/she summoned RN #N7 and requested he/she to initial as a witness. (B) RN #N7 initialed the wastage, however he/she did not witness the</p>		<p>or designee will monitor every month times 6 months. The Date of Correction is 12/01/11. All outdated medications and supplies were removed, discarded and reordered as needed by 11/3/11. Staff will be in-serviced and changes implemented over the next 30 days.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001102	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/01/2011
NAME OF PROVIDER OR SUPPLIER VISION SURGICAL CENTER AT SPRINGHILL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 302 W 14TH ST STE 100 B JEFFERSONVILLE, IN47130		
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S1010	<p>wastage of the narcotic.</p> <p>410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on document review and observation, the facility failed to discard single dose vials after use and failed to discard multi-dose vials within specified time frames.</p> <p>Findings include:</p> <p>1. Facility policy titled "Medication Storage" last reviewed/ revised 1/26/11 states on page 1: "6. Medications shall not be kept in stock after the expiration date on the label. and 8. Multidose vials of injectable medications are to be dated and initialed when opened. The vials</p>	S1010	All single dose vials will be discarded immediately after use and all multi-dose vials will be discarded on or by the 28th day. Nursing staff will be rein-serviced on the Medication Storage policy and procedure by 12/7/11. The DON or designee will monitor daily for 2 weeks then weekly for one month then quarterly. The Date of Correction is 12/1/11. All single dose vials have been discarded after use since 11/3/11. All outdated multi-dose vials were removed and discarded 11/3/11. Staff will be in-serviced by 12/7/11.	12/01/2011	

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	<p>shall be destroyed when expired per manufacturer guidelines or 28 days, whichever is first." Page 2 states: "9. All single dose vials or vials without preservations must be discarded at time of use and not reserved for further use."</p> <p>2. Observation of refrigerated medication storage in the clean storage room at 1:40 p.m. on 11/1/11 indicated the following: (A) One (11) vial of sodium chloride had not been discarded after use per policy. The vial labeled as single dose was dated as opened on 10/24/11. (B) One (1) vial of Lidocaine had not been discarded after 28 days per policy. The vial was labeled as multi-dose and opened on 10/3/11. (C) One (1) vial of Marcaine had not been discarded after 28 days per policy. The vial was labeled as multi-dose and opened on 10/3/11.</p>				

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S1146	<p>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 observation and interview, the facility created a conditions that may result in a hazard to employees.</p> <p>Findings include:</p> <p>1. While touring the facility on 11-1-11 at 1320 hours with B#3, it was observed that multiple bags of trash were lying directly on the floor in the soiled workroom; it was not possible to enter/walk into the room, creating a hazardous condition for employees attempting to reach the sink or supplies.</p> <p>2. Interview with B#3 on 11-1-11 at 1320 hours confirmed this situation creates a possible hazardous condition for employees attempting to reach the sink or supplies in the soiled workroom.</p>	S1146	<p>All trash will be placed directly in trash containers. If the trash containers become full, they will be emptied into the outdoor trash receptacle. The policy and procedure, Cleaning of Operating Rooms Between Cases has been revised and updated. All staff will be in-serviced by 12/7/11. The DON or designee will monitor daily times 2 weeks then weekly times 4 weeks then quarterly. The Date of Correction is 12/01/11. The policy and procedure was updated and revised on 11/30/11. The policy and procedure changes will be implemented over the next 30 days.</p>	12/01/2011	

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S1164	<p>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> <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 include all patient care equipment on a schedule of preventative maintenance to ensure it's safety for patient care.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of facility documents on 11-1-11 lacked evidence that preventative maintenance was provided during 2010 or 2011 for the emergency nurse call system, wheelchairs, or patient stretchers. Interview with B#2 on 11-1-11 at 1310 hours confirmed the facility does not provide preventative maintenance service 	S1164	<p>Wheelchairs and stretchers have been added to the semi-annual preventive maintenance schedule and will be checked by our contractor on 12/1/11. A Nurse Call System log has been created. The nurse call system will be checked by nursing staff every month and documented. Staff will be in-serviced by 12/7/11. The DON is responsible to monitor contracted services. The DON or designee will monitor the in-house nurse call system pm check every month times 6 then quarterly. Wheelchairs and stretchers were added to PM checks and inspected 12/01/11. A new Nurse Call System log was developed. Our policy on the</p>	12/01/2011	

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	for the emergency nurse call system, wheelchairs, or patient stretchers to ensure they are safe for patient care.		communication system was revised and updated on 11/30/11. Staff will be in-serviced and new system implemented over the next 30 days.		