STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001003	A. BUILDING 00 B. WING	10/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER SURGERY CENTER	11141 PARKVIEW PLAZA DRIVE, SUITE 200 FORT WAYNE, IN 46845

(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
Q0000	The visit was for a re-certification survey. Facility Number: 005385 Survey Date: 10-15-12 to 10-17-12 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 11/08/12	O0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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NAME OF PROVIDER OR SUPPLIER
PREMIER SURGERY CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
11141 PARKVIEW PLAZA DRIVE, SUITE 200
FORT WAYNE, IN 46845

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Q0141	416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. Based on policy and procedure review, patient medical record review, and staff interview, the nursing director failed to ensure that nursing staff documented appropriately when verbal or telephone orders were received, and failed to document verbal/telephone orders in the correct area of the physician order forms for patient care given to 4 of 10 patients (Pts. #1, #2, #3 and #7). Findings: 1. at 10:30 AM on 10/15/12, review of the policy and procedure PC 338 "Medicine and/or Physician's Orders", with a last "Review/Revision" date of 6/2012, indicated: a. under "Procedure", in section B. 8., it reads: "Verbal orders are to be indicated with a V.O. and signed with the ordering physician's name and followed by the transcribing nurse's signature. The date and time that the order was given is to be documented with the order. The order is to be repeated and verified by the transcribing nurse. After the order is repeated and verified the transcribing	Q0141	1, 2, 3 & 4. The deficiency has been corrected through A. Center employee documentation- The Center is transparent with staff regarding survey findings; identified deficiencies regarding past documentation has been reviewed at clinical staff meeting. Policy review with staff regarding identified deficiencies related to specific policies occurred at last staff meeting; Policy PC 338-Medicine and/or Physician's Orders has been posted in Center's Education Room and Employee Lounge. Staff education nurse, Melissa Hammond is developing 'policy tests' as part of 2013 annual nurse competencies as an additional method of reinforcing staff member's knowledge of selected patient care policies from the Center. Elements from policy PC 338 will be a part of the competency. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'A'. B. Transparency- The Center has provided transparency of the survey	11/21/2012

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NAME OF PROVIDER OR SUPPLIER PREMIER SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11141 PARKVIEW PLAZA DRIVE, SUITE 200 FORT WAYNE, IN 46845	

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	nurse should indicate so by writing R/V and their signature..." 2. review of patient medical records through out the survey process of 10/15/12 to 10/17/12 indicated: a. Pt. #1 had: I. written notes by the RN (registered nurse) on the back side (page 2 of 2) of the "Recovery Room Record" form that read: A. "3/16/12 1909 Narcan 0.2 mg IV (intravenous) given x i per order Dr..." B. "3/16/12 1914 Narcan 0.1 mg IV given per V.O. Dr..." C. "2040 Dr...called & orders received" II. physician "Post Anesthesia Orders" that were authenticated by the anesthesiologist at 1615 hours on 3/16/12 had nursing verbal orders for Narcan written in after the physician had already authenticated the standing orders (the first order "Narcan 0.4 mg dilute 1:4 & give half..." was lacking a time for the order--the second order had a time of 1913 and read "Give another 1 cc of Narcan mix"---the nurse documented 0.2 mg given at 1909 and 0.1 mg at 1914--these would not represent 1/2 of mixture as the doses were different) III. physician standing "ENT (ear, nose and throat) Physician Orders...PACU (post anesthesia care unit) Orders" were		findings to all surgeons and staff members. Posted in the surgeon and employee lounge is a copy of the survey findings with an example of an appropriately documented verbal order. Survey findings were also reviewed with staff during staff last staff meeting. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'B'. C. Maintaining Compliance- Survey findings specific to documentation were thoroughly reviewed with staff responsible for verifying chart completeness prior to 'filing' medical records by The Business Office Manager (BOM), Candace Schweizer. First (1st) quarter 2013, BOM will begin random chart audits to check chart completeness and will report findings to Quality Committee, Medical Executive Committee, and Governing Body. The Center's contracted third-party external auditor, Mary Kay Sterrett will be provided survey findings, Center's plan of corrective action and will be enlisted to facilitate the auditing of survey findings. Candace Schweizer, Business Office Manger will assume responsibility of elements in 'C'.	

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	authenticated by the surgeon at 1755 hours and had a note written later by the nurse to "Admit Pt for 23 hour" [hold] (lacking a time of order and nursing signature of verbal order taken at 2040 hours) b. Pt. #2 had nursing documentation of telephone orders written in the "Post Anesthesia Orders" standing orders form at 1020 hours--the anesthesiologist has signed off on these orders at 0745 hours c. Pt. #3 had: I. nursing documentation in the "Anesthesia Standing Orders" form in the "Pre-Anesthesia Orders" section that read: "Versed 2 mg IV now", but lacked the verbal orders documentation/notation with time of order and nursing signature with R/V noted II. nursing documentation of OFIRMEV (acetaminophen IV medication) 1000 mg given at 1506 hours on 4/18/12 (on the "Recovery Room Record" form on page 1) with no order written by the physician or a verbal/telephone order noted by the nurse for this medication d. Pt. #7 had nursing documentation on page 19 of the medical record ("Post Anesthesia Recovery Room Nurse Record" form) that reads: "2/23/12 1105			

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	Received order to remove nasal packing. Packing removed without difficulty..."--no verbal or telephone order was written on the physician order form/forms by either the physician or the nurse as a verbal/telephone order for this procedure 3. interview with staff member #50 , the Surgery Center Director, at 11:30 AM and 4:15 PM on 10/16/12 and 10:15 AM on 10/17/12 indicated: a. nursing staff wrote verbal orders on physician standing order forms for patients #1 and #2 after already authenticated by the physicians--these should have been written on the back side of the order forms in the appropriate area and not added after physicians had already signed off on the standing order form b. nursing staff wrote a verbal order for Versed for pt. #3 after, or at the time, of authentication by the physician--this should have been written as a verbal order on the reverse side of the physician order form c. there was no written order for pt. #3 for OFIRMEV d. nursing failed to write a verbal or telephone order for the removal of the nasal packing for pt. #7			

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Q0162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis.			
	Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the legibility and completion of medical records for 8 of 10 medical records (pts. #1, 2, 3, 4, 5, 6, 7, and 10). Findings: 1. at 10:30 AM on 10/15/12, review of the policy and procedure MR 16 "Authentication and Completion of Medical Records" (dated as "Review/Revision 6/1996"), indicated: a. under "Procedure", B. "Timing and Dating of Documentation:", it reads in	O0162	1, 2, 3 & 4. The deficiency has been corrected through A. Center employee documentation- The Center is transparent with staff regarding survey findings; identified deficiencies regarding past documentation has been reviewed at clinical staff meeting. Policy review with staff regarding identified deficiencies occurred at last staff meeting; Policies MR 16- Authentication and Completeness of Medical Records and MR 02 Documentation: Charting and Charts. Policies MR 16 & MR 02 have been posted in Center's Education Room and Employee	11/21/2012

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	section 3. "All chart orders and sections must be completed and signed-off within thirty days of service." b. under "Procedure", B. "Timing and Dating of Documentation:", it reads in section 4. "All documentation in the chart must be accurate, concise, and legible." 2. at 9:15 AM on 10/17/12, review of the policy and procedure MR 02 "Documentation: Charting and Charts" (no date of review/revision), indicated: a. under "Procedure", in section A. "General Information", it reads: "...3. Fill in all spaces. If no information is to be recorded, designate with a line, "-O-", or "N/A"." b. under "Procedure", in section A. "General Information", it reads: "...4. If a correction needs to be made in the medical record, one line should be neatly drawn through the error, leaving the incorrect material legible, and then it should be initialized and "error" written so it will be obvious that it was a corrected mistake..." 3. review of patient medical records through out the survey process of 10/15/12 to 10/17/12, indicated: a. pt. #1 had: A. write overs on the "Recovery Room Record" form in the section for medication administration in the "site"		Lounge. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'A'.B. Anesthesia- elements identified as deficiencies around contracted anesthesia documentation will be reviewed with Dr. Edward Tompa, anesthesia liaison for Center by December 12, 2012. Posted in physician's lounge will be copies of Medical Staff Rules and Regulations and a copy of the anesthesia record with highlighted areas which were identified chart incompleteness resulting in Center deficiency during time of Survey. The Center has provided transparency of the survey findings to all surgeons; posted in the surgeon's lounge is a copy of the survey findings. Brandy Miller, MSN, RN, CNOR will be responsible for elements in 'B'.C. Maintaining Compliance- Survey findings specific to documentation were thoroughly reviewed with staff responsible for verifying chart completeness prior to 'filing' medical records by The Business Office Manager (BOM), Candace Schweizer. First (1st) quarter 2013, BOM will begin random chart audits to check chart completeness and will report findings to Quality Committee, Medical Executive Committee, and Governing Body. The Center's contracted third-party external auditor, Mary Kay Sterrett will be provided survey	

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	area where "R FA" (forearm) and "L FA" (forearm) were written over related to the site medications were given on 3/16/12 B. lack of completion of documentation on the "Anesthesia Record' form in the areas of "Time" in the pre operative anesthesia evaluation area at the top of the page; whether the patient had any "Anesth. Hx" (anesthesia history) and whether the patient was NPO (nil per os--without oral food or drink) at the top of the page; the "Pre-op Equip Checked" area lacked completion; and "the Surgery Performed" area at the bottom of the page was blank b. pt. #2 lacked completion of the "Anesthesia Record" form in the "Intra operative" area in regards to "Antibiotic" and "Time" of the Kefzol 1 mg given at 7:43 AM in the pre op area before the patient went to the OR (operating room) suite; and on the bottom of the page in the "Postoperative Anesthesia Note" area as to whether the patient was "Extubated" in the "OR" or "PACU" (post anesthesia care unit) c. pt. #3 lacked completion of the "Anesthesia Record" form in the "Postoperative Anesthesia Note" area: whether there were "Anesthesia Complications" "Yes" or "No"; "Extubated" in the "OR" or "PACU"; and "Date" and "Time" of the physician signature		findings, Center's plan of corrective action and will be enlisted to facilitate the auditing of survey findings. Candace Schweizer, Business Office Manger will assume responsibility of elements in 'C'.	

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	d. pt. #4 lacked completion of the "Anesthesia Record" form in the "Pre operative anesthesia evaluation" section regarding whether the patient had any "Allergies" and lacked a physician signature; in the "Postoperative Anesthesia Note" area documentation was lacking as to whether the patient was "Extubated" in the "OR" or "PACU" e. pt. #5 had write overs on the "Recovery Room Record" in the "Time Out:" area on the top of the page where the time written was obliterated with a new time written and no initials of the staff who made the correction noted; in the "I.V. (intravenous) fluids" section in the "Total Amount Administered" area where the amount was written over and is illegible f. pt. #6 lacked completion of the "Anesthesia Record" form in the "Post operative Anesthesia Note" section in regards to the "SPO2 (oxygen level), HR (heart rate), B/P (blood pressure), and RR (respiratory rate)" at the conclusion of the surgery; and on the "Recovery Room Record" form, the "Time out" time was absent g. pt. #7 on the "Recovery Room Record" form lacked the day of service in the top left of the page (reads "4/ /12"), had write overs in the PAR (post anesthesia recovery) scoring area with the discharge scoring, and on the "Anesthesia			

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	Record" form in the "Pre operative anesthesia evaluation" section the patient's "Anesth. Hx." was absent h. pt. #10 lacked nursing documentation on the "Pre-op Record" form in the medications given section in regards to the "Dose" of Versed given at 9:27 AM on 1/23/12; on the "Anesthesia Record" form the "Anesth Hx" of the patient is blank, the time of administration of the pre op antibiotic is lacking, and the the 'Gas off" time is missing 4. interview with staff member #50, Surgery Center Director, at 10:15 AM on 10/17/12 indicated the medical records listed in #3. above were lacking complete documentation required by facility policy and had write overs/illegibility in some medical records as noted/written			

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Q0202	416.49(b) RADIOLOGIC SERVICES (1) The ASC must have procedures for obtaining radiological services from a Medicare approved facility to meet the needs of patients. Based on document review and interview, the center failed to ensure that female patients were screened to avoid fetal exposure to ionizing radiation and failed to ensure that the reproductive organs of all patients were protected from radiology imaging equipment in surgery. Findings: 1. The policy/procedure Fluoroscopy - Safety and Protection (revised 2-12) failed to ensure that a urine pregnancy test was performed prior to fluoroscopy for all potentially pregnant patients and failed to ensure that reproductive organs for all patients were shielded from ionizing radiation when possible during fluoroscopy. 2. During an interview on 10-16-12 at 1045 hours, staff A1 confirmed that the radiology safety policy/procedure lacked the indicated provisions.	O0202	1, 2, 3 & 4. The deficiency has been corrected through A. Center policy revision- Center policy PC 138- Urine Pregnancy Test was revised to include the requirement that all menstruating females undergoing procedures that include ionizing radiation are required to have a pregnancy test performed and documented on patient chart prior to the start of the procedure.The Center is transparent with staff regarding survey findings; identified deficiency regarding policy PC 138- Urine Pregnancy and the corrective action taken by Center has been reviewed at clinical staff meeting. Policy is posted in Center's Education Room and Employee Lounge. Staff education nurse, Melissa Hammond is developing 'policy tests' as part of 2013 annual nurse competencies as an additional method of reinforcing staff member's knowledge of selected patient care policies from the Center. Elements from policy PC 138 will be a part of the competency. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'A'. B. Transparency- The Center has	11/21/2012

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			provided transparency of the survey findings to all surgeons and staff members. Posted in the surgeon and employee lounge is a copy of the survey findings with a revised PC 138 policy. Survey findings were also reviewed with staff during staff last staff meeting. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'B'. C. Maintaining Compliance- Policy will be reviewed annually. Survey findings specific to documentation and this particular policy were thoroughly reviewed with staff responsible for verifying chart completeness prior to 'filing' medical records by The Business Office Manager (BOM), Candace Schweizer. First (1st) quarter 2013, BOM will begin random chart audits to check chart completeness and will report findings to Quality Committee, Medical Executive Committee, and Governing Body. The Center's contracted third-party external auditor, Mary Kay Sterrett will be provided survey findings, Center's plan of corrective action and will be enlisted to facilitate the auditing of survey findings. Candace Schweizer, Business Office Manger will assume responsibility of elements in 'C'.	

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Q0221	416.50(a)(1) NOTICE OF RIGHTS 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. Based on document review and interview, the center policy/procedure failed to ensure that patient rights information provided before the start of the surgical procedure included notice of all patient rights for 10 of 14 required rights. Findings: 1. The policy/procedure Notification of Patient Rights and Responsibilities (reviewed 5-12) indicated the following: " At a minimum, the Premier Surgery Center brochure and copy of the Statement of Patient Rights & Responsibilities will include information on notice of patient rights, advance directives, how to file a grievance and physician ownership in the center. " The policy/procedure failed to indicate or reference by attachment all 14 patient rights and ensure that full notice was provided to the patient, the patient's representative or the patient ' s surrogate. 2. During an interview on 10-17-12 at 1000 hours, staff A1 confirmed that the policy/procedure failed to ensure that the patient rights information provided to the patient or the patient ' s representative included all 14 patient rights.	O0221	1, 2. This deficiency is being corrected by revising policy ADM 23- Notification of Patients Rights & Responsibilities to include an addendum that has a verbatim copy of "PREMIER SURGERY CENTER STATEMENT OF PATIENT RIGHTS" and "PREMIER SURGERY CENTER PATIENT RESPONSIBILITIES". The policy is to be reviewed at minimum, annually. The Business Office Manager, Candace Schweizer will be responsible for ensuring any future changes to "PREMIER SURGERY CENTER STATEMENT OF PATIENT RIGHTS" and "PREMIER SURGERY CENTER PATIENT RESPONSIBILITIES" are consistent with State and Federal requirements and that the Director, Brandy Miller, MSN, RN, CNOR is notified.3. The Director, Brandy Miller, MSN, RN, CNOR and the Business Office Manager, Candace Schweizer will assume joint responsibility for ensuring the policy and pamphlets maintain currency and are updated as needed.	12/20/2012

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Q0222	4166.50(a)(1)(i) NOTICE - POSTING 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 document review and interview, the center failed to ensure that the posted patient rights information included notice of the website for the Office of the Medicare Beneficiary Ombudsman. Findings: 1. Review of the posted bill of rights located in the reception area failed to indicate the web site of the Office of the Medicare Beneficiary Ombudsman. 2. During an interview on 10-17-12 at 1005 hours, staff A1 confirmed that the posted information lacked the Ombudsman ' s website.	O0222	1, 2. This deficiency is being corrected by the updating of "PREMIER SURGERY CENTER STATEMENT OF PATIENT RIGHTS" and "PREMIER SURGERY CENTER PATIENT RESPONSIBILITIES" poster that is located in the reception area to include the website for the Office of the Medicare Beneficiary Ombudsman.The Business Office Manager, Candace Schweizer will be responsible for ensuring any future changes to "PREMIER SURGERY CENTER STATEMENT OF PATIENT RIGHTS" and "PREMIER SURGERY CENTER PATIENT RESPONSIBILITIES" are consistent with State and Federal requirements and that the Director, Brandy Miller, MSN, RN, CNOR is notified.	12/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF PROVIDER OR SUPPLIER PREMIER SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11141 PARKVIEW PLAZA DRIVE, SUITE 200 FORT WAYNE, IN 46845	

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Q0223	416.50(a)(1)(ii) NOTICE - PHYSICIAN OWNERSHIP 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. Based on document review and interview, the center failed to ensure that written notice of physicians with ownership or financial interest in the center was available to patients if requested. Findings: 1. The policy/procedure Notification of Patient Rights & Responsibilities (reviewed 5-12) and Premier Surgery Center Statement of Patient Rights document (no approval date) failed to indicate the physicians with ownership in the surgery center or indicate that a list of physicians with financial interest will be provided by the center staff upon request. 2. During an interview on 10-17-12 at 1010 hours, staff A1 confirmed that the policy/procedure and brochure lacked the indicated information.	Q0223	1, 2. This deficiency is being corrected by the updating of "PREMIER SURGERY CENTER STATEMENT OF PATIENT RIGHTS" and "PREMIER SURGERY CENTER PATIENT RESPONSIBILITIES" brochure to clearly communicate which specific surgeon groups have ownership in our Center. The Business Office Manager, Candace Schweizer will be responsible for ensuring any future changes to "PREMIER SURGERY CENTER STATEMENT OF PATIENT RIGHTS" and "PREMIER SURGERY CENTER PATIENT RESPONSIBILITIES" are consistent with State and Federal requirements and that the Director, Brandy Miller, MSN, RN, CNOR is notified.	12/20/2012

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Q0242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.			
	Based on policy and procedure review, employee personnel health file review, and staff interview, the infection control practitioner failed to implement the policy related to employee health for 1 of 2 surgical techs (staff member P7). Findings: 1. at 9:15 AM on 10/17/12, review of the policy and procedure TM 02 (Employee Laboratory & Health Screening", with a last date of "Review/Revision" on 01/2012, indicated: a. under "Procedure", section B., it reads: "B As of January 2012, all employees will receive on-going health screening as follows: 1. Annual tuberculosis symptom screen 2. Completion of annual Health Record..." 2. at 5:15 PM on 10/16/12, review of two surgical tech files indicated staff member P7 had: a. an "Annual Tuberculosis Symptom Screen" form dated 5/24/11	O0242	1. The deficiency was corrected on 10-18-12-employee file was updated to reflect current policy. 2 & 3. All employee files were checked on 10-18-12 to verify completeness; no other deficiencies were identified. The deficiency will be prevented in the future by the Director, Brandy Miller, MSN, RN, CNOR and the Business Office Manager, Candace Schweizer, annually verifying all annual requirements are met for each employee file through a checklist that must be completed prior to employee annual evaluation/appraisal.	10/18/2012

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	b. an "Employee Health..." screening form dated 5/24/11 3. interview with staff member #50, the Surgery Center Director and infection control practitioner, at 10:15 AM on 10/17/12 indicated: a. the annual tuberculosis symptom screening form and employee health screening form for 2012 for staff member P7 could not be found b. it cannot be determined that staff member P7 completed the required forms for 2012, per facility policy			

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	15C0001003		10/17/2012

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S0000	The visit was for a licensure survey. Facility Number: 005385 Survey Date: 10-15-12 to 10-17-12 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 11/08/12	S0000		

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S0122	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3) The governing body shall do the following: (3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body. Based on document review and interview, the center governing board failed to review and approve the medical staff bylaws within the past three years. Findings: 1. On 10-15-12 at 1030 hours, staff A1 was requested to provide documentation indicating governing board approval of the medical staff bylaws, rules and regulations and none was provided prior to exit. 2. The Premier Surgery Center Governing Body Bylaws (last reviewed 11-01-11) indicated the following: " The Medical Staff Bylaws, Rules and Regulations, along with amendments thereto, shall not be final until reviewed by the Governing Body and signed by its Chairman, and approved by the Director. "	S0122	1. The deficiency is in process of being corrected-during the October 18, 2012 Board Meeting, the Medical Staff Bylaws and Medical Staff Rules and Regulations were reviewed and approved. The Medical Director and Director will sign off on the approval before December 20, 2012.2.Maintaing Compliance-Medical Staff Rules and Regulations shall be reviewed annually through MEC, Governing Body and signed off by Medical Director and Director. 3. The Director, Brandy Miller, MSN, RN, CNOR will be responsible for the above.	12/20/2012

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	3. Review of the Premier Surgery Center Medical Staff Bylaws failed to indicate review and approval by the governing board following the medical staff approval on 11-01-11. 4. Review of Governing Board minutes for 2011 indicated that the 11-17-11 meeting was cancelled and the 12-15-11 minutes failed to indicate that the governing board reviewed and approved the medical staff bylaws, rules and regulations in 2011. 5. During an interview on 10-17-12 at 1040 hours, staff A1 confirmed that the governing board minutes failed to indicate board approval of the medical staff bylaws.			

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S0153	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on review of the contracted housekeeping personnel files and staff interview, the facility failed to ensure orientation to the facility for 2 of 2 housekeepers (staff members P5 and P6). Findings: 1. at 4:50 PM on 10/16/12, review of housekeeping staff files indicated: a. staff member P5 was hired 4/12 and lacked any documentation of orientation to the facility with instruction on cleaning methods and policies specific to the surgery center b. staff member P6 was hired 3/11 and lacked any documentation of orientation to the facility with instruction on cleaning methods and policies specific to the surgery center 2. interview with staff member #50, the Surgery Center Director, at 5:10 PM on 10/16/12 indicated:	S0153	1. The deficiency will be corrected by the Director of the Center, Brandy Miller, MSN, RN, CNOR reviewing survey findings and correcting deficiencies identified by surveyors with contracted Environmental Services House Supervisor, Paula Phillips. Premier Surgery Center will require that Environmental Services employees that work within the Center to have an on-site employee file. The Director of the Center, Brandy Miller, MSN, RN, CNOR will be responsible for ensuring required elements are present in the contracted staff's employee file. A policy will be developed by December 20, 2012 addressing the orientation of contracted Environmental Services staff, encompassing the process currently in place, but in written form.2 & 3. The deficiency will be prevented from occurring again by requiring the Environmental Services staff members to have files on-site; the	12/20/2012

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	a. the documents found in the personnel files for staff members P5 and P6 were titled "...Contracted Staff Orientation" and dated 3/15/11 but were not authenticated by surgery center staff to indicated who had provided this orientation--P6 had signed this form, but P5 had not signed the form--(the form had an area for the "Preceptor" signature as well as for the "Director Signature", in which both areas were blank 3. there was no policy/procedure related to housekeeping orientation that was provided		Director, Brandy Miller, MSN, RN, CNOR will be responsible for annual review of the files to ensure accuracy and completeness.	

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S0172	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L) Require that the chief executive officer develop and implement policies and programs for the following: (L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable. Based on policy and procedure review, employee personnel health file review, and staff interview, the chief executive officer failed to implement the policy related to employee health for 1 of 2 surgical techs (staff member P7). Findings: 1. at 9:15 AM on 10/17/12, review of the policy and procedure TM 02 (Employee Laboratory & Health Screening", with a last date of "Review/Revision" on 01/2012, indicated: a. under "Procedure", section B., it reads: "B As of January 2012, all employees will receive on-going health screening as follows: 1. Annual tuberculosis symptom screen 2. Completion of annual Health Record..."	S0172	1. The deficiency was corrected on 10-18-12-employee file was updated to reflect current policy. 2 & 3. All employee files were checked on 10-18-12 to verify completeness; no other deficiencies were identified. The deficiency will be prevented in the future by the Director, Brandy Miller, MSN, RN, CNOR and the Business Office Manager, Candace Schweizer, annually verifying all annual requirements are met for each employee file through a checklist that must be completed prior to employee annual evaluation/appraisal.	10/18/2012

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	2. at 5:15 PM on 10/16/12, review of two surgical tech files indicated staff member P7 had: a. an "Annual Tuberculosis Symptom Screen" form dated 5/24/11 b. an "Employee Health..." screening form dated 5/24/11 3. interview with staff member #50, the Surgery Center Director, at 10:15 AM on 10/17/12 indicated: a. the annual tuberculosis symptom screening form and employee health screening form for 2012 for staff member P7 could not be found b. it cannot be determined that staff member P7 completed the required forms for 2012, per facility policy			

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S0228	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4) The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following: (4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.			
	Based on document review and interview, the center failed to maintain its transfer agreement with an area hospital for patients that require a higher level of care. Findings: 1. The center transfer agreement with the affiliate hospital failed to indicate the current address for the surgery center and failed to indicate the address for the attached hospital where patients were transferred when ordered by the physician.	S0228	1. The deficiency is in the process of being corrected; the transfer agreement has been sent back to Parkview Health Systems for update of addresses for both parties involved with the contract. 2 & 3. This form of deficiency will be prevented in the future by a more thorough review of contracts and agreements prior to renewal. Candace Schweizer, Business Office Manager is currently working with Parkview Health Systems on an audit of the entire Contract and Agreement Book to ensure no further errors occur. Candace Schweizer, Business Office Manager and	12/20/2012

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	2. On 10-16-12 at 1515 hours, staff A1 confirmed that the center failed to maintain its transfer agreement.		Brandy Miller, MSN, RN, CNOR will be responsible persons for ensuring future compliance.	

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S0616	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(3) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows: (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. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that physicians authenticated entries in the medical record per facility policy for 5 of 10 patient records (pts. #2, 3, 4, 5, and 6). Findings: 1. at 10:30 AM on 10/16/12, review of the policy and procedure MR 16 "Authentication and Completion of Medical Records" with a last review/revision date of 6/1996, indicated: a. under "Procedure", in item B., it reads: "Timing and Dating of Documentation: 1. All H&P's (history and physicals), physician order sheets, consents, dictation sheets, Operative, and Post-procedure reports must include the	S0616	1, 2, 3 & 4. The deficiency has been corrected through A. Correction -The updating of the Center's Medical Staff Rules and Regulations to clearly specify the Center's expectations of all orders within a patient chart having a signature, date and time. The Center's Medical Executive Committee (MEC) and Governing Body approved the updated Medical Staff Rules and Regulations by November 2012 meetings and copies of updated Medical Staff Rules and Regulations were posted in the surgeon's break room. A copy of the Medical Staff Rules and Regulations were sent to each surgeon's office that has privileges at this Center November of 2012. Policy MR 16- "Authentication and Completion of Medical Records" was reviewed	11/21/2012

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	physician's signature, the date, and time the document is signed..." 2. review of patient medical records through out the survey process of 10/15/12 to 10/17/12 indicated: a. pt. #2 had: A. physician "Pre-op Laparoscopic Cholecystectomy" standing orders that lacked the time of authentication on 10/18/11 B. two separate physician telephone orders of 10/18/11 that were authenticated by the physician, but lacked a date and time of authentication b. pt. #3 had: A. a history and physical done the day of surgery that lacked a time of authentication by the physician c. pt. #4 had: A. verbal orders written on 4/12/12 that were authenticated, but lacked a date and time by the physician d. pt. #5 had: A. standing orders "Pre-operative LOCAL Anesthetic/Sedation" that were authenticated, but lacked the time of authentication by the physician B. 12 different verbal order entries that were taken on 5/22/12 that were authenticated, but lacked a date or time of the authentication e. pt. #6 had: A. standing "Pre-op Laparoscopic		and is being sent through January 2013 MEC and Governing Body; a copy of MR 16 is posted in physician's and employee's lounge. The Director, Brandy Miller, MSN, RN, CNOR, is responsible for elements in 'A'. B. Transparency- The Center has provided transparency of the survey findings to all surgeons; posted in the surgeon's lounge is a copy of the survey findings with a blank patient chart that has highlighted elements that were found not complete during the survey. Survey findings were also shared with all staff during staff meetings. . Policy MR 16 "Authentication and Completion of Medical Records" posted in physician's lounge. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'B'. C. Maintaining Compliance- Survey findings specific to documentation were thoroughly reviewed with staff responsible for verifying chart completeness prior to 'filing' medical record by The Business Office Manager (BOM), Candace Schweizer. First (1st) quarter 2013, BOM will begin random chart audits to check chart completeness and will report findings to Quality Committee, Medical Executive Committee, and Governing Body. The Center's contracted third-party external auditor, Mary Kay Sterrett will be provided survey findings, Center's plan of corrective action and will be	

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	Cholecystectomy" orders that were authenticated, but lacked a date and time of authentication by the physician 3. interview with staff member #50, the surgery center director, at 11:30 AM on 10/16/12 and 10:15 AM on 10/17/12 indicated: a. authentication of the medical records for pts. #2, 3, 4, 5 and 6 are lacking either a date or time (or both) when authenticated by the practitioner b. facility policy requires dating and timing of physician authentication		enlisted to facilitate the auditing of survey findings. Candace Schweizer, Business Office Manger will assume responsibility of elements in 'C'.D. Maintaining Compliance- Medical Staff Rules and Regulations shall be reviewed annually through MEC, Governing Body and signed off by Medical Director and Director. The Director, Brandy Miller, MSN, RN, CNOR is responsible person for elements in 'D'.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001003	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/17/2012
NAME OF PROVIDER OR SUPPLIER PREMIER SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11141 PARKVIEW PLAZA DRIVE, SUITE 200 FORT WAYNE, IN 46845	

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S0640	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1) (e) All entries in the medical record must be as follows: (1) Legible and complete. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the legibility and completion of medical records for 8 of 10 medical records (pts. #1, 2, 3, 4, 5, 6, 7, and 10). Findings: 1. at 10:30 AM on 10/15/12, review of the policy and procedure MR 16 "Authentication and Completion of Medical Records" (dated as "Review/Revision 6/1996"), indicated: a. under "Procedure", B. "Timing and Dating of Documentation:", it reads in section 3. "All chart orders and sections must be completed and signed-off within thirty days of service." b. under "Procedure", B. "Timing and Dating of Documentation:", it reads in section 4. "All documentation in the chart must be accurate, concise, and legible." 2. at 9:15 AM on 10/17/12, review of the policy and procedure MR 02 "Documentation: Charting and Charts" (no date of review/revision), indicated:	S0640	1, 2, 3 & 4. The deficiency has been corrected through A. Center employee documentation- The Center is transparent with staff regarding survey findings; identified deficiencies regarding past documentation has been reviewed at clinical staff meeting. Policy review with staff regarding identified deficiencies occurred at last staff meeting; Policies MR 16- Authentication and Completeness of Medical Records and MR 02 Documentation: Charting and Charts. Policies MR 16 & MR 02 have been posted in Center's Education Room and Employee Lounge. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'A'.B. Anesthesia- elements identified as deficiencies around contracted anesthesia documentation will be reviewed with Dr. Edward Tompa, anesthesia liaison for Center by December 12, 2012. Posted in physician's lounge will be copies of Medical Staff Rules and Regulations and a copy of the anesthesia record with	12/12/2012

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	a. under "Procedure", in section A. "General Information", it reads: "...3. Fill in all spaces. If no information is to be recorded, designate with a line, "-O-", or "N/A"." b. under "Procedure", in section A. "General Information", it reads: "...4. If a correction needs to be made in the medical record, one line should be neatly drawn through the error, leaving the incorrect material legible, and then it should be initialized and "error" written so it will be obvious that it was a corrected mistake..." 3. review of patient medical records through out the survey process of 10/15/12 to 10/17/12, indicated: a. pt. #1 had: A. write overs on the "Recovery Room Record" form in the section for medication administration in the "site" area where "R FA" (forearm) and "L FA" (forearm) were written over related to the site medications were given on 3/16/12 B. lack of completion of documentation on the "Anesthesia Record' form in the areas of "Time" in the pre operative anesthesia evaluation area at the top of the page; whether the patient had any "Anesth. Hx" (anesthesia history) and whether the patient was NPO (nil per os--without oral food or drink) at the top of the page; the "Pre-op Equip Checked"		highlighted areas which were identified chart incompleteness resulting in Center deficiency during time of Survey. The Center has provided transparency of the survey findings to all surgeons; posted in the surgeon's lounge is a copy of the survey findings. Brandy Miller, MSN, RN, CNOR will be responsible for elements in 'B'.C. Maintaining Compliance- Survey findings specific to documentation were thoroughly reviewed with staff responsible for verifying chart completeness prior to 'filing' medical records by The Business Office Manager (BOM), Candace Schweizer. First (1st) quarter 2013, BOM will begin random chart audits to check chart completeness and will report findings to Quality Committee, Medical Executive Committee, and Governing Body. The Center's contracted third-party external auditor, Mary Kay Sterrett will be provided survey findings, Center's plan of corrective action and will be enlisted to facilitate the auditing of survey findings. Candace Schweizer, Business Office Manger will assume responsibility of elements in 'C'.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/17/2012

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	area lacked completion; and "the Surgery Performed" area at the bottom of the page was blank b. pt. #2 lacked completion of the "Anesthesia Record" form in the "Intra operative" area in regards to "Antibiotic" and "Time" of the Kefzol 1 mg given at 7:43 AM in the pre op area before the patient went to the OR (operating room) suite; and on the bottom of the page in the "Postoperative Anesthesia Note" area as to whether the patient was "Extubated" in the "OR" or "PACU" (post anesthesia care unit) c. pt. #3 lacked completion of the "Anesthesia Record" form in the "Postoperative Anesthesia Note" area: whether there were "Anesthesia Complications" "Yes" or "No"; "Extubated" in the "OR" or "PACU"; and "Date" and "Time" of the physician signature d. pt. #4 lacked completion of the "Anesthesia Record" form in the "Pre operative anesthesia evaluation" section regarding whether the patient had any "Allergies" and lacked a physician signature; in the "Postoperative Anesthesia Note" area documentation was lacking as to whether the patient was "Extubated" in the "OR" or "PACU" e. pt. #5 had write overs on the "Recovery Room Record" in the "Time Out:" area on the top of the page where			

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	the time written was obliterated with a new time written and no initials of the staff who made the correction noted; in the "I.V. (intravenous) fluids" section in the "Total Amount Administered" area where the amount was written over and is illegible f. pt. #6 lacked completion of the "Anesthesia Record" form in the "Post operative Anesthesia Note" section in regards to the "SPO2 (oxygen level), HR (heart rate), B/P (blood pressure), and RR (respiratory rate)" at the conclusion of the surgery; and on the "Recovery Room Record" form, the "Time out" time was absent g. pt. #7 on the "Recovery Room Record" form lacked the day of service in the top left of the page (reads "4/ /12"), had write overs in the PAR (post anesthesia recovery) scoring area with the discharge scoring, and on the "Anesthesia Record" form in the "Pre operative anesthesia evaluation" section the patient's "Anesth. Hx." was absent h. pt. #10 lacked nursing documentation on the "Pre-op Record" form in the medications given section in regards to the "Dose" of Versed given at 9:27 AM on 1/23/12; on the "Anesthesia Record" form the "Anesth Hx" of the patient is blank, the time of administration of the pre op antibiotic is lacking, and the the 'Gas off" time is missing			

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	4. interview with staff member #50, Surgery Center Director, at 10:15 AM on 10/17/12 indicated the medical records listed in #3. above were lacking complete documentation required by facility policy and had write overs/illegibility in some medical records as noted/written			

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S0780	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (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. Based upon document review and interview, the center failed to ensure that all orders were authenticated by the physician within 30 days. Findings: 1. The Medical Staff Rules and Regulations (approved 11-11) and the policy/procedure Medicine and/or Physician ' s Orders (revised 6-12) failed to indicate a requirement to date the entry when the order was authenticated to validate compliance in completing the medical record within 30 days. 2. During an interview on 10-17-12 at 0945 hours, staff A1 confirmed that the Rules and Regulations and	S0780	1, 2, 3 & 4. The deficiency has been corrected through: A. Correction -The updating of the Center's Medical Staff Rules and Regulations to clearly specify the Center's expectations of all orders within a patient chart having a signature, date and time upon time of order entry to validate compliance in completing the medical record within 30 days. The Center's Medical Executive Committee (MEC) and Governing Body approved the updated Medical Staff Rules and Regulations by November 2012 meetings and copies of updated Medical Staff Rules and Regulations were posted in the surgeon's break room. A copy of the Medical Staff Rules and Regulations were sent to each surgeon's office that has	11/21/2012

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	policy/procedure lacked a requirement to date the entry when authenticated by the physician.		privileges at this Center November of 2012. Policy MR 16- "Authentication and Completion of Medical Records" was reviewed and verification that wording of policy correctly reflects Medical Staff Rules and Regulations. Policy MR 16 is being sent through January 2013 MEC and Governing Body; a copy of MR 16 is posted in physician's and employee's lounge. The Director, Brandy Miller, MSN, RN, CNOR, is responsible for elements in 'A'. B. Transparency- The Center has provided transparency of the survey findings to all surgeons. Survey findings were also shared with all staff during staff meetings. Policy MR 16 "Authentication and Completion of Medical Records" posted in physician's lounge. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'B'. C. Maintaining Compliance- Survey findings specific to documentation were thoroughly reviewed with staff responsible for verifying chart completeness within 30 days prior to 'filing' medical record by The Business Office Manager (BOM), Candace Schweizer. First (1st) quarter 2013, BOM will begin random chart audits to check chart completeness and will report findings to Quality Committee, Medical Executive Committee, and Governing Body. The Center's contracted third-party	

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			external auditor, Mary Kay Sterrett will be provided survey findings, Center's plan of corrective action and will be enlisted to facilitate the auditing of survey findings. Candace Schweizer, Business Office Manger will assume responsibility of elements in 'C'.D. Maintaining Compliance- Medical Staff Rules and Regulations shall be reviewed annually through MEC, Governing Body and signed off by Medical Director and Director. The Director, Brandy Miller, MSN, RN, CNOR is responsible person for elements in 'D'.	

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S0788	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(R) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (R) A requirement that a physician shall be available to the center during the period any patient is present in the center. Based on document review and interview, the center failed to ensure that a physician was available to the center whenever a patient was present. Findings: 1. The Medical Staff Rules and Regulations (approved 11-11) failed to indicate a requirement for a physician to be available during the period any patient is present in the center. 2. During an interview on 10-17-12 at 1020 hours, staff A1 confirmed that the Rules and Regulations lacked the indicated requirement.	S0788	1, 2, 3 & 4. The deficiency has been corrected through A. Correction -The updating of the Center's Medical Staff Rules and Regulations to clearly specify the Center's expectations that a physician shall be available to the Center during the period any patient is present in the Center. The updated Medical Staff Rules and Regulations change will go through next quarter's Medical Executive Committee (MEC) and Governing Body meetings. Copies of updated Medical Staff Rules and Regulations were posted in the surgeon's break room November 2012. A copy of the Medical Staff Rules and Regulations were sent to each surgeon's office that has privileges at this Center November of 2012. The Director, Brandy Miller, MSN, RN, CNOR, is responsible for elements in 'A'. B. Transparency- The Center has provided transparency of the	01/15/2013

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			survey findings to all surgeons; posted in the surgeon's lounge is a copy of the survey; survey findings were also shared with all staff during staff meetings. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'B'. C. Maintaining Compliance- Medical Staff Rules and Regulations shall be reviewed annually through MEC, Governing Body and signed off by Medical Director and Director. The Director, Brandy Miller, MSN, RN, CNOR is responsible person for elements in 'C'.	

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S0908	410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(a)(3) (a) Patient care services must require the following: (3) That a registered nurse serves as head nurse supervising patient care services personnel. Based on policy and procedure review, patient medical record review, and staff interview, the nursing director failed to ensure that nursing staff documented appropriately when verbal or telephone orders were recieved, and failed to document verbal/telephone orders in the correct area of the physician order forms for patient care given to 4 of 10 patients (Pts. #1, #2, #3 and #7). Findings: 1. at 10:30 AM on 10/15/12, review of the policy and procedure PC 338 "Medicine and/or Physician's Orders", with a last "Review/Revision" date of 6/2012, indicated: a. under "Procedure", in section B. 8., it reads: "Verbal orders are to be indicated with a V.O. and signed with the ordering physician's name and followed by the transcribing nurse's signature. The date and time that the order was given is to be documented with the order. The order is to be repeated and verified by the transcribing nurse. After the order is	S0908	1, 2, 3 & 4. The deficiency has been corrected through A. Center employee documentation- The Center is transparent with staff regarding survey findings; identified deficiencies regarding past documentation has been reviewed at clinical staff meeting. Policy review with staff regarding identified deficiencies related to specific policies occurred at last staff meeting; Policy PC 338-Medicine and/or Physician's Orders has been posted in Center's Education Room and Employee Lounge. Staff education nurse, Melissa Hammond is developing 'policy tests' as part of 2013 annual nurse competencies as an additional method of reinforcing staff member's knowledge of selected patient care policies from the Center. Elements from policy PC 338 will be a part of the competency. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'A'. B. Transparency- The Center has provided	11/21/2012

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	repeated and verified the transcribing nurse should indicate so by writing R/V and their signature..." 2. review of patient medical records through out the survey process of 10/15/12 to 10/17/12 indicated: a. Pt. #1 had: I. written notes by the RN (registered nurse) on the back side (page 2 of 2) of the "Recovery Room Record" form that read: A. "3/16/12 1909 Narcan 0.2 mg IV (intravenous) given x i per order Dr..." B. "3/16/12 1914 Narcan 0.1 mg IV given per V.O. Dr..." C. "2040 Dr...called & orders received" II. physician "Post Anesthesia Orders" that were authenticated by the anesthesiologist at 1615 hours on 3/16/12 had nursing verbal orders for Narcan written in after the physician had already authenticated the standing orders (the first order "Narcan 0.4 mg dilute 1:4 & give half..." was lacking a time for the order--the second order had a time of 1913 and read "Give another 1 cc of Narcan mix"---the nurse documented 0.2 mg given at 1909 and 0.1 mg at 1914--these would not represent 1/2 of mixture as the doses were different) III. physician standing "ENT (ear, nose and throat) Physician Orders...PACU		transparency of the survey findings to all surgeons and staff members. Posted in the surgeon and employee lounge is a copy of the survey findings with an example of an appropriately documented verbal order. Survey findings were also reviewed with staff during staff last staff meeting. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'B'. C. Maintaining Compliance- Survey findings specific to documentation were thoroughly reviewed with staff responsible for verifying chart completeness prior to 'filing' medical records by The Business Office Manager (BOM), Candace Schweizer. First (1st) quarter 2013, BOM will begin random chart audits to check chart completeness and will report findings to Quality Committee, Medical Executive Committee, and Governing Body. The Center's contracted third-party external auditor, Mary Kay Sterrett will be provided survey findings, Center's plan of corrective action and will be enlisted to facilitate the auditing of survey findings. Candace Schweizer, Business Office Manger will assume responsibility of elements in 'C'.	

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	(post anesthesia care unit) Orders" were authenticated by the surgeon at 1755 hours and had a note written later by the nurse to "Admit Pt for 23 hour" [hold] (lacking a time of order and nursing signature of verbal order taken at 2040 hours) b. Pt. #2 had nursing documentation of telephone orders written in the "Post Anesthesia Orders" standing orders form at 1020 hours--the anesthesiologist has signed off on these orders at 0745 hours c. Pt. #3 had: I. nursing documentation in the "Anesthesia Standing Orders" form in the "Pre-Anesthesia Orders" section that read: "Versed 2 mg IV now", but lacked the verbal orders documentation/notation with time of order and nursing signature with R/V noted II. nursing documentation of OFIRMEV (acetaminophen IV medication) 1000 mg given at 1506 hours on 4/18/12 (on the "Recovery Room Record" form on page 1) with no order written by the physician or a verbal/telephone order noted by the nurse for this medication d. Pt. #7 had nursing documentation on page 19 of the medical record ("Post Anesthesia Recovery Room Nurse			

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	Record" form) that reads: "2/23/12 1105 Received order to remove nasal packing. Packing removed without difficulty..."--no verbal or telephone order was written on the physician order form/forms by either the physician or the nurse as a verbal/telephone order for this procedure 3. interview with staff member #50 , the Surgery Center Director, at 11:30 AM and 4:15 PM on 10/16/12 and 10:15 AM on 10/17/12 indicated: a. nursing staff wrote verbal orders on physician standing order forms for patients #1 and #2 after already authenticated by the physicians--these should have been written on the back side of the order forms in the appropriate area and not added after physicians had already signed off on the standing order form b. nursing staff wrote a verbal order for Versed for pt. #3 after, or at the time, of authentication by the physician--this should have been written as a verbal order on the reverse side of the physician order form c. there was no written order for pt. #3 for OFIRMEV d. nursing failed to write a verbal or telephone order for the removal of the nasal packing for pt. #7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/17/2012

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S1222	410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(e) (e) Safeguards for patients, personnel, and public must be specified, including, but not limited to, the following: (1) Proper safety precautions must be maintained against radiation hazards in accordance with the center's radiation and safety program(s). (2) Hazards and faulty equipment identified must be promptly corrected in accordance with current standards of practice and applicable federal and state rules, including, but not limited to, collimation and filtration and evaluations of equipment performance. Based on document review and interview, the center failed to ensure that female patients were screened to avoid fetal exposure to ionizing radiation and failed to ensure that the reproductive organs of all patients were protected from radiology imaging equipment in surgery. Findings: 1. The policy/procedure Fluoroscopy - Safety and Protection (revised 2-12) failed to ensure that a urine pregnancy test was performed prior to fluoroscopy for all potentially pregnant patients and failed to	S1222	1, 2, 3 & 4. The deficiency has been corrected through A. Center policy revision- PC 138- Urine Pregnancy Test was revised to include the requirement that all menstruating females undergoing procedures that include ionizing radiation are required to have a pregnancy test performed and documented on patient chart prior to the start of the procedure.The Center is transparent with staff regarding survey findings; identified deficiency regarding policy PC 138- Urine Pregnancy and the corrective action taken by Center has been reviewed at clinical staff meeting. Policy is posted in Center's Education Room and	11/21/2012

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	ensure that reproductive organs for all patients were shielded from ionizing radiation when possible during fluoroscopy. 2. During an interview on 10-16-12 at 1045 hours, staff A1 confirmed that the radiology safety policy/procedure lacked the indicated provisions.		Employee Lounge. Staff education nurse, Melissa Hammond is developing 'policy tests' as part of 2013 annual nurse competencies as an additional method of reinforcing staff member's knowledge of selected patient care policies from the Center. Elements from policy PC 138 will be a part of the competency. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'A'. B. Transparency- The Center has provided transparency of the survey findings to all surgeons and staff members. Posted in the surgeon and employee lounge is a copy of the survey findings with a revised PC 138 policy. Survey findings were also reviewed with staff during staff last staff meeting. The Director, Brandy Miller, MSN, RN, CNOR is responsible for elements in 'B'. C. Maintaining Compliance- Policy will be reviewed annually. Survey findings specific to documentation and this particular policy were thoroughly reviewed with staff responsible for verifying chart completeness prior to 'filing' medical records by The Business Office Manager (BOM), Candace Schweizer. First (1st) quarter 2013, BOM will begin random chart audits to check chart completeness and will report findings to Quality Committee, Medical Executive	

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			Committee, and Governing Body. The Center's contracted third-party external auditor, Mary Kay Sterrett will be provided survey findings, Center's plan of corrective action and will be enlisted to facilitate the auditing of survey findings. Candace Schweizer, Business Office Manger will assume responsibility of elements in 'C'.	