

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/19/2015
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NAME OF PROVIDER OR SUPPLIER  SAINT CHARLES SURGICAL PAVILLION	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SAINT CHARLES ST JASPER, IN 47546
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S 000  Bldg. 00	This visit was for a State licensure survey.  Facility Number: 002523  Dates: 03-18-15 to 03-19-15  QA: cjl 04/16/15  IDR Committee Meeting on 05-20-15: Tag S-230 deleted. JL.	S 000		
S 106  Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)  The governing body shall do the following:  (3) Review the bylaws at least triennially. Based document review and interview, the governing body (GB) failed to review the bylaws within the past three years.  Findings:  1. Review of Governing Board By-Laws indicated the by-laws were last reviewed 1-10-11, but it could not be determined	S 106	Correction: Governing Board bylaws will be reviewed and updated as required by the governing board. documentation will be recorded in the governing board meeting minutes. Attendees to meetings will be noted in the minutes. Bylaws will be reviewed at the next upcoming Governing Board meeting at the end of second quarter, June 30th.	06/30/2015

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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S 110 Bldg. 00	<p>by whom the by-laws were reviewed.</p> <p>2. Review of GB meeting minutes dated 12/17/14, 9/15/14, 6/30/14, and 3/30/14 lacked documentation of GB review of by-laws. GB meeting minutes dated 8/21/13 indicated by-laws were reviewed by the medical staff (MS), but lacked documentation of whose by-laws, i.e. GB or MS. The documents lacked indication of attendees.</p> <p>3. On 3/19/15 at 10:15am, A2, past administrator/CRNA, verified lack of documentation of triennial review of GB by-laws and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the governing body (GB) failed to review quality assessment and</p>	S 110	<p>Prevention: Every three years upcoming bylaw review will be provoked by calendar notification 3 months prior to due date. Responsible: The administrator will be responsible for making sure the Governing Board reviews and updates the bylaws as necessary. Date: 5/7/15</p> <p>Correction: All members of the governing board also receive the Medical Staff meeting minutes. All QA reports can be found in the</p>	05/07/2015			

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S 153 Bldg. 00	<p>improvement (QAPI) reports for 4 quarters of 2014.</p> <p>Findings:</p> <p>1. Review of documents titled GB Meeting dated 12/17/14, 9/15/14, 6/30/14, and 3/30/14 lacked documentation of attendees and lacked evidence of QAPI reports provided or reviewed.</p> <p>2. On 3/18/15 at 12:35pm, A1, administrator, verified QAPI reports were not included in GB meeting minutes. A1 also verified lack of documentation of attendees at meetings.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review and interview, the chief executive officer (CEO) failed to ensure orientation of all employees for 5 of 5 personnel files reviewed (P1, P2, P3, P4, &amp; P5).</p>	S 153	<p>Medical Staff meeting minutes and the governing board prefers to receive them this way. All members in attendance are now listed on the meeting minutes. Prevention: Governing Board Meeting Minutes will now say "please see report with Medical Staff meeting minutes". Person Responsible: The administrator Date: 5/7/15</p> <p>Correction: All personnel files will reflect documentation of facility orientation for all contracted employees as well as policies and procedures for the facility. All staff files are now up to date with</p>	05/07/2015			

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S 310 Bldg. 00	<p>Findings:</p> <p>1. Review of personnel files/documentation for contracted employees P1, P2, P3, P4, &amp; P5 lacked documentation of orientation to any center policies and procedures (P&amp;P).</p> <p>2. On 3/19/15 at 1:30pm A1, administrator, confirmed personnel records for P1, P2, P3, P4, &amp; P5 lacked documentation of orientation to center P&amp;P. No further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(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.</p> <p>Based on document review and interview, the quality assessment and performance improvement program (QAPI) failed to include 2 contracted services in its 2014 evaluation (Maintenance &amp; Transcription).</p>	S 310	<p>complete information.Prevention: All staff files will be reviewed quarterly for complete documentationResponsible: The administrator will be responsible for reviewing staff files and updating information.Date: 5/7/15</p> <p>Correction: QA has not been initiated for maintenance services provided by Brad Norris. Monthly evaluations will be made as to his job description of minor maintenance. Transcription QA has already been taking place as</p>	05/07/2015			

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S 320 Bldg. 00	<p>Findings:</p> <ol style="list-style-type: none"> <li>Review of QAPI meeting minutes and reports for calendar year 2014 lacked documentation of evaluation of contracted services for maintenance and transcription.</li> <li>On 3/19/15 at 3:30pm A1, administrator, confirmed the above 2 contracted services had not been included in QAPI evaluation for 2014. No further documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p>		<p>two different evaluations: "H&amp;P on Chart" and "Operative Report on Chart in 30 Days" This will continue as it is. Prevention: QA will be checked monthly. Responsible: The administrator will be responsible for conducting monthly QA on all contracted services. Date: 5/7/15</p>	

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S 442  Bldg. 00	<p>Based on document review and interview, the quality assessment and performance improvement program (QAPI) failed to include 4 functions in its 2014 evaluation evaluation (Discharge, Transfer, Infection Control, &amp; Medication Errors).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of QAPI meeting minutes and reports for calendar year 2014 lacked documentation of evaluation of the following functions: Discharge, Transfer, Infection Control, &amp; Medication Errors.</li> <li>On 3/19/15 at 3:30pm A1, administrator, confirmed the above 4 functions had not been included in QAPI evaluation for 2014. No further documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</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</p>	S 320	<p>Correction: Discharge QA is currently being performed as "Patient Discharge Procedure Patient Safety". This will continue as it was. Transfer QA is currently being performed as "Patient Transfer to Another Facility". This will continue as it was. Infection Control QA is currently completed monthly via spreadsheet form and is given to the medical staff and governing board quarterly. This is stored on the computer as it is ongoing. This will continue as it was. Medication Errors QA is performed monthly and reported in the Quality Assurance Report. In addition to this a form has been placed in the Quality Assurance Monitor Binder to show proof of completion. Prevention: These will all continue to be monitored monthly for completion. Person Responsible: The administrator Date: 5/7/15</p>	05/07/2015			

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	<p>programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on document review and staff interview, the facility failed to ensure staff members had a current PPD or completed a TB risk questionnaire for 1 of 7 staff members (staff member #N5) and failed to ensure documentation of disease history or immunization to Varicella, Rubella, Rubeola, and Hepatitis B for 2 of 7 staff members (staff members #N5 and N6).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The personnel file for staff member #N5 (hired 11/14) lacked documentation of a current PPD and disease history or immunization to Varicella, Rubella, Rubeola, and Hepatitis B.</li> <li>The personnel file for staff member #N6 (hired 9/14) lacked documentation of disease history or immunization to Varicella, Rubella, Rubeola, and Hepatitis B.</li> <li>Staff member #A1 (Administrator)</li> </ol>	S 442	<p>Correction: All missing staff information was obtained and placed in staff files. Immunization records are now up to date. Prevention: New hires will be reminded to provide their immunization records within 1 week of hire. Responsible: The administrator Date: 5/7/15</p>	05/07/2015

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S 446 Bldg. 00	<p>verified the above at 3:10 p.m. on 3/19/15.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(x)</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>(x) A program of linen management. Based on document review and observation, the infection control committee failed to assure proper linen management in 2 areas (the bulk storage and surgery suite entrance hall).</p> <p>Findings:</p> <p>1. Review of the Infection Control Policy: LINEN indicated under section A. CLEAN LINEN: 1. a. Processed linen will be stored on covered shelving provided in the area for clean linen storage.</p> <p>2. On 3/19/15 between 9am - 9:30am</p>	S 446	<p>Correction: Linen from bulk storage room is now kept on covered shelving in the hall outside of the OR. The doors on the shelves in the hallway across from the restroom are now kept closed at all times to keep linen covered. Prevention: Will continue to remind staff that clean linen must be covered or contained at all times. Responsible: The administrator will be responsible for evaluating linen storage monthly Date: 4/23/15</p>	04/23/2015

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S 630 Bldg. 00	<p>during tour of the center in the presence of A1, administrator, the following was observed: in a bulk storage room on uncovered wire shelves were 3 stacks of blankets, 2 stacks of sheets, 1 large stack of patient gowns and on a table in the same room was 1 stack red &amp; white towels with a cardboard box on top of the stack; on uncovered shelves in the hallway entrance of the surgery suite across from the restroom were small stacks of miscellaneous linens.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on document review and interview, the facility failed to ensure an accurate medical record was maintained for 1 of 2 transfer patients (patient #2).</p> <p>Findings include:</p>	S 630	Correction: Staff have been reminded that pre-populated operative progress notes are not an acceptable practice. If found they will be removed from the chart. We will ensure that all operative progress notes are accurately completed after the	05/07/2015

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S 704  Bldg. 00	<p>1. Patient #2 medical record contained a document titled "Operative Progress Note" dated 1/14/15 that indicated there were no specimens removed, the procedure was an "Open RTC repair L shoulder", the findings had been dictated, and the patient had minimal blood loss. The patient did not have surgery. He/she had a complication prior to the procedure and was transferred from the facility.</p> <p>2. Staff member #A1 (Administrator) verified the above at 3:30 p.m. on 3/19/15.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(1)</p> <p>The medical staff shall do the following:</p> <p>(1) Conduct outcome-oriented performance evaluations of its member at least biennially.</p> <p>Based on document review and interview, the Medical Staff (MS) failed to conduct biennial performance evaluations for 2 of 3 allied health (AH) MS members (AH#2 &amp; AH#3).</p> <p>Findings:</p>	S 704	<p>procedure has taken place.Prevention: Charts will be checked prior to surgery to make sure the operative progress note has not been filled out ahead of time.Responsible: The administrator and nursing staff will check the charts daily.Date: 5/7/15</p> <p>Correction: Performance evaluations will be done on an annual basis for all allied health providers by medical staff appointee.Prevention: Employee credential files will be check quarterly to ensure all paperwork is up to date.Responsible: The administrator will evaluate the employee files for paperwork and</p>	05/07/2015			

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S 728  Bldg. 00	<p>1. Review of 3 AH MS credential files for AH#1, AH#2, AH#3 indicated the following: Two year performance evaluation for AH#1 not yet needed. Reappointment for AH#2 was 10/15/14 and the most recent performance evaluation for AH#2 was dated 10-18-12. AH#3 was reappointed 10/15/14 and the file lacked evidence of a performance evaluation.</p> <p>2. On 3/18/15 at 12:20 A1, administrator, verified the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)</p> <p>(b) The medical staff shall adopt and enforce bylaws to carry out its responsibilities. These bylaws and rules must be as follows: Based on document review and interview, the Medical Staff (MS) failed to enforce by-laws for 2 MS members (MD#1 &amp; MD#4).</p> <p>Findings:</p> <p>1. Review of the document titled "Medical Staff By-Laws" indicated the following: in the section subtitled</p>	S 728	<p>make sure the appropriate medical staff appointee conducts an evaluation as needed. Date: 5/7/15</p> <p>Correction: Medical staff reappointment process will be followed with a spreadsheet to notify the privileging staff one quarter prior to the need for reappointment. All medical staff will be actively and currently privileged and staff files will accurately reflect that appointment. Prevention: All medical staff providers will submit a request for reappointment at</p>	05/07/2015			

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S 012  Bldg. 00	<p>"Reappointment", Active and Associate Medical Staff members must submit a written request for reappointment at the end of each two year appointment.</p> <p>2. Review of MS members credential files indicated the following: MD#1 was last appointed 1/30/15 with appointment expiration 1/15. MD#5 was last appointed 1/30/15 with appointment expiration 1/15. Both files lacked evidence of a reappointment application or other written request for reappointment.</p> <p>3. On 3/18/15 at 12:20pm A1, administrator, verified MD#1 and MD#5 had not submitted a reappointment application at the end of their two year appointments in 2013 and that each were practicing physicians within the center.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(B)</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>(B) Drug administration according to</p>		<p>least three months prior to the end of their 2 year appointment period. Responsible: The administrator will be responsible for reviewing staff files and updating information. Date: 5/7/15</p>		

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S 210  Bldg. 00	<p>established center policies and acceptable standards of practice. Based on document review and interview, the facility failed to ensure medications were administered according to physician order for 1 of 2 pediatric patients (patient #26) and failed to obtain an order for 1 of 5 patients (patient #15) receiving post operative medications (patients #15 and 26).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of patient #15 medical record indicated the patient received Zantac 50 mg and Benadryl 50 mg at 0917 hours on 3/8/15. The medical record lacked an order for the medications.</li> <li>2. Review of patient #26 medical record indicated the patient received Fentanyl 25 mcg at 1220 on 2/2/15. The order for the Fentanyl was for Fentanyl 12.5 mcg.</li> <li>3. Staff member #A1 (Administrator) verified the above at 3:30 p.m. on 3/19/15.</li> </ol>			S 012	<p>Correction: In both instances a verbal order was given by C. Gress, CRNA but the order was not transcribed. Order was given at the patients bedside. The charts have been updated to reflect this. Prevention: Meeting was held with all staff members reminding them of the need to transcribe any verbal order given. Charts will be reviewed at the end of the day to ensure everything is accurate. Responsible: Staff nurses will be responsible for reviewing charts. Date: 5/7/15</p>		05/07/2015
410 IAC 15-2.5-8 RADIOLOGY SERVICES		410 IAC 15-2.5-8(c)(1)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001103	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/19/2015
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NAME OF PROVIDER OR SUPPLIER  SAINT CHARLES SURGICAL PAVILLION	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SAINT CHARLES ST JASPER, IN 47546
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(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
	<p>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:</p> <p>(1) Radiology services must be supervised by a radiologist or radiation oncologist.</p> <p>Based on document review and interview, the center failed to ensure radiology services were under direct supervision of a radiologist or radiation oncologist.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of center documents lacked evidence of radiologist or radiation oncologist supervision of radiology services.</li> <li>2. On 3/19/15 at 3:30pm A1, administrator, indicated radiation badges were monitored by a contracted radiology service, and further MD#5, as the Medical Director, was over all services including radiology.</li> <li>3. Review of credential file for MD#5 lacked documentation of radiologist or radiation oncology licensure or certification.</li> </ol>	S 210	<p>Correction: Saint Charles Surgical Pavilion has a standing contract with Memorial Hospital and Health Care Center. The contract states that all digital x-rays and MRI's will be sent to the radiology department to be read by a radiologist. Prevention: This will continue as it is. Responsible: The physicians will send out their images to be read. Date: 5/7/15</p>	05/07/2015