

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001005	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2015
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NAME OF PROVIDER OR SUPPLIER SURGICAL CENTER OF NEW ALBANY	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 GREEN VALLEY RD NEW ALBANY, IN 47150
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S 000 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005386</p> <p>Survey Dates: 02/09-10/15</p> <p>Surveyors: Trisha Goodwin, RN BS Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 03/13/15</p>	S 000		
S 110 Bldg. 00	<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,</p>			

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 153 Bldg. 00	<p>actions taken, and follow-up. Based on document review and interview, the governing body (GB) of the center failed to function according to their bylaws and meet at least quarterly in the past 12 months.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of Governing Body Bylaws indicated the following: The Governing Body shall meet at least quarterly. A record of these meetings shall be maintained. These Bylaws were last reviewed/approved 12/4/13 Review of 12 months of Governing Body/Board Meeting minutes indicated the board met and reviewed reports of management operations on 11/5/14, 4/30/14 and 2/5/14. On 2/10/15 A1, administrator, indicated the GB did not meet for one quarter of 2014 due to change in administration. No further documentation was provided prior to exit. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p>	S 110	<p>A GB/MAC meeting was held in the third quarter, however no documentation was completed Going forward, GB/MAC will meet quarterly and the administrator will complete the documentation The next GB/MAC meeting is scheduled for April 27, 2015 and the bylaws will be approved at that meeting and documentation by the administrator will be completed</p>	04/27/2015

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S 156 Bldg. 00	<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 to the center and personnel policies for 3 of 3 contracted employees (housekeeper, consultant pharmacist, & medical records consultant)</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of 3 contracted personnel files lacked documentation of orientation to the center and personnel policies for the 3 contracted employees of housekeeper, consultant pharmacist, & medical records consultant. On 2/10/15 at 1:30pm A1, administrator, indicated there was no documentation of contracted employees being oriented to the center and/or personnel policies since they were not direct employees. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES</p>	S 153	Orientation and documentation of such for contract personnel will be completed by the administrator by April 17, 2015 Going forward, the administrator will audit the files to assure compliance and will report the audits to the QA committee	04/17/2015

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S 164 Bldg. 00	<p>410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and staff interview, the facility failed to maintain job descriptions for 3 (#N1, N3, and N5) of 5 personnel files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Staff members #N1, N3, and N5 personnel files lacked evidence of a job description. Staff member #N1 verified the above in interview beginning at 4:00 p.m. on 2/10/14. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H)</p> <p>Require that the chief executive</p>	S 156	As of February 16, 2015 the employees' files contain job descriptions and the administrator will assure that all employee files old and new will contain job descriptions The job description will be signed upon hire and the administrator will be responsible to assure that job descriptions are signed and included in the employees' files	02/16/2015

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	<p>officer develop and implement policies and programs for the following:</p> <p>(H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program.</p> <p>Based on document review and interview, the chief executive officer failed to ensure the facility had evidence of post offer history and physical examinations per policy for 5 of 5 personnel files (staff members #N1-N5) reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "CONFIDENTIALITY OF EMPLOYEE HEALTH RECORDS" last reviewed/revised 11/5/14 states on page 1: "2. The employee health records will contain the following: immunization acceptance or declination, the history and any physical,....." 2. Personnel files for staff members #N1-N5 lacked evidence of a history and physical. 3. Staff member #N1 verified the above in interview beginning at 4:00 p.m. on 2/10/14. 	S 164	History and Physical exams will be completed on 5 personnel by April 15, 2015 Post Offer History and Physicals will be completed on all future new hires. The administrator and infection control nurse will oversee for compliance	04/15/2015

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S 172 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(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.</p> <p>Based on document review and staff interview, the chief executive officer failed to ensure current tuberculin test (PPD) were performed for 2 of 5 (staff members #N3 and N5) personnel files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Staff member #N3 was hired 7/30/14. His/her personnel file contained a PPD dated 5/21/13. 2. Staff member #N5 was hired 11/1/14. His/her personnel file contained a PPD 	S 172	Staff members will have TB testing done on April 8, 2015 and placed in their health file In the future all prospective employees will initially receive a baseline test according to policy A TB risk assessment will be completed yearly according to policy The administrator and the infection control nurse will be responsible for compliance	04/10/2015	

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S 176 Bldg. 00	<p>dated 6/27/12.</p> <p>3. Staff member #AA1 verified in interview at 3:00 p.m. on 2/10/15 that the PPD's were not current as indicated above.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on document review interview and interview, the facility failed to ensure evidence of personnel competency for point of care (POC) testing for 2 of 3 registered nurses.</p> <p>Findings include:</p> <p>1. Personnel files for staff members #N4 and N5 lacked evidence of competencies to perform POC testing.</p> <p>2. Staff member #N1 indicated in interview beginning at 3:50 p.m. on 2/10/14 that glucose and pregnancy test</p>	S 176	<p>POC testing for glucometer and pregnancy competency will be completed on all nursing staff performing glucometer and pregnancy tests before April 15, 2015 The administrator will oversee the competencies, compliance and audit the nursing staff periodically</p>	04/15/2015	

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S 230 Bldg. 00	<p>are performed at the facility. He/she verified that staff members #N4 and N5 personnel files lacked evidence of competency to perform the POC testing.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>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:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the governing body failed to ensure for periodic review of the center by a utilization review committee in any instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 2/10/15 at 9:45am, utilization review (UR) committee meeting minutes were requested of A1, administrator. 2. Review of facility documents lacked documentation of meetings by a UR 	S 230	On April 27, 2015 the GB will appoint a Utilization Review Committee This committee in addition will include the medical director and the administrator The administrator will be responsible for compliance	04/27/2015	

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S 320 Bldg. 00	<p>committee.</p> <p>3. On 2/10/15 at 11:00am, A1 indicated the UR minutes were likely at corporate office and a request had been sent. At 5:45pm, A1 indicated UR minutes were not available and 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)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the quality assessment and performance improvement committee (QAPI) failed to include evaluation of 4 functions (discharge, infection control, medication errors and response to patient emergency).</p>	S 320	Discharge, infection control, medication errors, response to patient emergency or no findings of such will be addressed and documented in the QAPI committee meetings and minutes starting with the meeting on March 20, 2015. The administrator will oversee the committee and assure the documentation	03/20/2015

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S 332 Bldg. 00	<p>Findings:</p> <p>1. Review of QAPI meeting minutes dated February 5, 2014 and November, 2014 lacked documentation of committee evaluation for the following functions: discharge, infection control, medication errors and response to patient emergencies.</p> <p>2. On 2/10/15 at 1:15pm A1, Administrator, confirmed the above functions had not been included in QAPI review and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the center: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent;</p>				

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

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	<p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events: (i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center.</p> <p>(D) The following care management events: (i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a</p>			

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	<p>medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events: (i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p>			

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	<p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient: (AA) contains the wrong gas; or (BB) is contaminated by toxic substances. (iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center. (iv) Patient death or serious disability associated with a fall while being cared for in the center. (v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center. (F) The following criminal events: (i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider. (ii) Abduction of a patient of any age. (iii) Sexual assault on a patient within or on the grounds of the center. (iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p> <p>Based on document review and interview, the center's quality assurance and performance improvement (QAPI) program failed to include reportable events in the QAPI program.</p> <p>Findings:</p> <p>1. Review of QAPI meeting minutes dated February 5, 2014 and November, 2014 lacked documentation of committee evaluation of reportable events.</p>	S 332	Reportable events will be included in the QAPI program meetings and documentation beginning with the meeting on 3/20/2015. The administrator will oversee this meeting and documentation to assure compliance	03/20/2015

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S 400 Bldg. 00	<p>2. On 2/10/15 at 1:15pm A1, Administrator, confirmed reportable events had not been included in QAPI review and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 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 provide an environment that minimized risk to health care workers in 1 observation.</p> <p>Findings include:</p> <p>1. During observation of procedure performed on patient #19 beginning at 10:20 a.m. on 2/10/15, M.D. #1 was observed performing trigger point injections on the patient's back/neck area. He/she recapped one of two contaminated needles after the injections.</p>	S 400	The administrator addressed the physician and staff of the no recapping needle protocol A discussion to ensure this doesn't happen again will be addressed in the next GB/MAC meeting on April 27, 2015 The circulating nurse, pre-op nurse, PACU nurse and administrator will oversee the physician to assure that he or anyone else will not recap needles The administrator will develop an audit form to periodically monitor the doctors for compliance	02/13/2015
S 432	410 IAC 15-2.5-1			

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Bldg. 00	<p>INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation and document review, the infection control committee failed to ensure staff followed label instructions for disinfection of surfaces during 1 observation.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During observation of cleaning of operating room #3 beginning at 10:37 a.m. on 2/10/15, staff member #N6 was observed cleaning horizontal surfaces after a procedure. He/she sprayed the product (Regimen germicidal solution) on surfaces and immediately wiped it off with a dry towel. 2. Label instructions for Regimen germicidal solution indicated that the surface must remain wet for 6 minutes for the product to be effective. 	S 432	Starting immediately the center no longer keeps or uses Regimen for cleaning The center as of 2/13/2015 uses Cavicide exclusively for cleaning between cases The administrator and infection control nurse will oversee the use of the cleaners to maintain compliance	02/13/2015	

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S 658 Bldg. 00	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(6)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(6) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and interview, the facility failed to provide evidence of informed consent for exact procedure performed for 2 of 3 pediatric patients (patients #4 and #10).</p> <p>Findings include;</p> <p>1. Facility policy titled "CONSENT FOR PROCEDURES" last reviewed/ revised states "It is required that patients and/or legal guardians, patient representative or surrogate be informed of the procedure that will be performed, the expected outcome, and possible complications....."</p> <p>2. Review of patient #4 medical record</p>	S 658	<p>The computer software system was updated to allow the office staff to manually enter the procedures so that the actual procedure would print onto the consent as opposed to the codes This will continue to be the process for consents for the procedure The pre-op nurse and circulator will confirm that the consent is correct and consistent with the procedure to be performed. It will be overseen by the business office, business office director and the administrator</p>	02/13/2015

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	<p>indicated the following:</p> <p>(A) The patient (2 years old) had procedure performed on 7/16/14.</p> <p>(B) The consent for surgery listed the procedure as "unlisted procedure, dentoalveolar structures, general anesthes dental caries, unspecified." The consent failed to list the exact procedures to be performed.</p> <p>(C) The operative note indicated that after general anesthetic, dental x-rays were obtained and three (3) crowns were applied, two (2) teeth were extracted, 3 teeth had resin applied, and one (1) tooth had sealant applied.</p> <p>3. Review of patient #10 medical record indicated the following:</p> <p>(A) The patient (5 years old) had procedure performed on 7/30/14.</p> <p>(B) The consent for surgery listed the procedure as "unlisted procedure, dentoalveolar structures, general anesthes unspecified disease of hard tissues of teeth." The consent failed to list the exact procedures to be performed.</p> <p>(C) The operative note indicated that after general anesthetic, dental x-rays were obtained and 2 crowns were applied, 5 teeth had resin applied, and one (1) tooth had sealant applied.</p>			

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S 704 Bldg. 00	<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) of the center failed to conduct outcome-oriented performance evaluations of its members at least biennially for 6 physicians (MD1, MD2, MD3, MD4, MD5, MD 6) and 2 allied health (AH1 &AH2).</p> <p>Findings:</p> <p>1. Review of MS credential files for 6 physicians, MD1, MD2, MD3, MD4, MD5, & MD6, and 2 allied health, AH1 & AH2, lacked documentation of performance reviews at any time.</p> <p>2. On 2/9/15 at 2:45pm A1, administrator, indicated performance reviews were not conducted for the MS. No further documentation was provided prior to exit.</p>			S 704	Peer review forms along with reappointment review forms and allied health review forms will be used to evaluate physicians and allied health The reviews will be conducted by the medical director and peer review physicians The review forms will become operational at the GB/MAC meeting on 4/27/2015 The Medical Director and Administrator will oversee the compliance		04/27/2015
S 772	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND						

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Bldg. 00	<p>SURGICAL 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 document review, observation and interview, the medical staff failed to ensure a history and physical (H&P) was documented per policy for 3 of 26 closed medical records reviewed (patients #2, 3, and 24) and for 1 patient observation (patient #19).</p> <p>Findings include:</p>	S 772	Administrator discussed the H&P issue with the physician and nursing staff The physician will not be able to perform the procedure without a current History and Physical The pre-op nurse and circulator will oversee the physician's chart to assure that the H&P is performed preoperatively The administrator and Medical Director will oversee	02/13/2015

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	<p>1. Facility policy titled "HISTORY AND PHYSICAL" last reviewed/revised 11/5/14 states on page 1: "4. A history and physical can be completed prior to admission, but must be no older than thirty (30) days from the date of the procedure admission. It must be updated on the date of the procedure. If the history and physical is completed greater than thirty (30) days from the date of the procedure, a completely new history and physical, not an update, is required by regulation."</p> <p>2. Patient #2 had a procedure performed on 12/23/14. His/her H&P was dated 12/8/14 and the record lacked evidence of an update per policy.</p> <p>3. Patients #3 and #24 medical records lacked evidence of an H&P.</p> <p>4. Observation of patient #19 beginning at 10:05 a.m. on 2/10/15 indicated the following: (A) M.D. #1 talked with the patient in the pre-operative area at 10:25 a.m. He/she touched the patient's back to determine areas of pain. No further assessment was performed. (B) The history and physical exam form on the medical record was blank prior to the procedure.</p>		the compliance		

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S 790 Bldg. 00	<p>5. Review of patient #19 medical record at the end of the day on 2/10/15 indicated that the history and physical form was completed by M.D. #1 and indicated that the patient's general appearance, head, ears, nose, throat, heart, lungs, abdomen, pelvis, rectum, skin and nodes were all normal.</p> <p>6. Staff member #N1 verified medical record information beginning at 4:30 p.m. on 2/10/15.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)</p> <p>(c) The anesthesia services of the center must meet the needs of the patient, within the scope of the services offered, in accordance with acceptable standards of practice, and must be under the direction of a licensed physician with specialized training or experience in the administration of anesthetics. The anesthesia service is responsible for all anesthesia administered in the center as follows: Based on document review and interview, the medical staff (MS) of the center failed to provide anesthesia services under the direction of licensed physician with training or experience in</p>	S 790	The anesthesia service is a contract service They are licensed anesthesiologists licensed by the State of Indiana Review of their service will be completed in peer review, their reappointment review, the	04/27/2015

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S 834 Bldg. 00	<p>the administration of anesthetics in any instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a credentialed MS members list lacked documentation of any being the anesthesia director. 2. On 2/9/15 at 2:00pm, A1, administrator, indicated the center did not have a Director of Anesthesia and no further documentation was provided prior to exit. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(iii)</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 postanesthesia as follows:</p> <p>(iii) The completion of a postanesthetic evaluation for proper anesthesia recovery of each patient prior to discharge in accordance with written policies and procedures approved by the medical staff.</p> <p>Based on document review and staff</p>	S 834	<p>medical director and the board The Medical Director and the administrator will monitor compliance In addition the anesthesia director will be confirmed at the next GB/MAC meeting on April 27, 2015</p> <p>A discussion was held with anesthesia to reinforce the</p>	02/13/2015

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	<p>interview, the medical staff failed to ensure post anesthesia evaluations were completed per policy for 1 of 2 patient transfers (patient #1) and 1 of 3 pediatric patients (patient #25).</p> <p>Findings include;</p> <p>1. Facility policy titled "DOCUMENTATION OF ANESTHESIA CARE" last reviewed/revised 11/5/14 states on page 2: "3. Postanesthesia a. Patient evaluation on admission and discharge from the post anesthesia care unit. b. A time based record of vital signs and level of consciousness. c. All drugs administered, their dosages, and route of administration. d. Type and amount of all intravenous fluids used. e. Any unusual events including postanesthesia or postprocedural complications. g. Evaluation of the patient by a physician or by an anesthesiologist for proper anesthesia recovery...."</p> <p>2. Facility policy titled "ANESTHESIA CARE PROTOCOL" last reviewed/revised 11/5/14 states on page 1: "6. the anesthesia provider will accompany the patient to the post anesthesia room following the operation, will advise the personnel responsible of the post anesthetic care about problems</p>		<p>importance of documentation. The PACU nurse and administrator will oversee that the documentation is performed by the physicians</p>	

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S 100 Bldg. 00	<p>presented by the patient's post anesthetic condition, and will record pertinent information in the patient's medical record."</p> <p>3. Review of patient #1 medical record indicated the following: (A) He/she had procedure performed on 10/10/14 under general anesthesia by M.D. #1. The medical record lacked evidence of a post anesthesia evaluation. The post anesthesia section of the medical record was left blank.</p> <p>4. Review of patient #25 medical record indicated the following: (A) He/she had procedure performed on 12/5/14 under general anesthesia by M.D. #1. The medical record lacked evidence of a post anesthesia evaluation. The post anesthesia section of the medical record was left blank.</p> <p>5. Staff member #N1 verified medical record information beginning at 4:30 p.m. on 2/10/15.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(a)(1)</p>				

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	<p>(a) The center shall be constructed, arranged, and maintained to ensure the safety of the patient and to provide facilities for services authorized under the center license as follows:</p> <p>(1) The plant operations and maintenance service, equipment maintenance, and environmental services must be as follows:</p> <p>(A) Staffed to meet the scope of the services provided.</p> <p>(B) Under the direction of a person or persons qualified by education, training, or experience according to center policy, approved by the governing body.</p> <p>Based on document review and interview the center failed to provide periodic inspection/preventive maintenance (PM) by qualified personnel of appropriate training or experience for 1 piece of equipment (the back-up generator).</p> <p>Findings:</p> <p>1. On 2/10/15 at 1:00pm during tour of the physical plant A1 indicated he/she to be facility personnel responsible for weekly PM of the back-up generator.</p> <p>2. Review of documentation titled Generator Test dated 12/1/14, 12/8/14, 12/15/14, 12/29/14, 1/5/15, 1/12/15, 1/19/15, 1/26/15, 2/2/15, & 2/9/15</p>	S 100	The PM of the generator is performed by a qualified contract service with 2 inspections a year The administrator verifies that the generator runs on a weekly schedule and a monthly schedule During the scheduled runs, the administrator documents the times and the gauge readings	02/11/2015

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S 142 Bldg. 00	<p>indicated A1 to have performed PM generator checks on those dates.</p> <p>3. Review of personnel file for A1 lacked documentation of training or experience for PM of the generator.</p> <p>4. On 2/10/15 at 5:45pm A1 confirmed lack of training documentation for maintenance of the back-up generator.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)</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>(1) No condition in the center or on the grounds may be maintained which may be conducive to the harboring or breeding of insects, rodents, or other vermin.</p> <p>Based on observation, the center failed to maintain the overall condition of the physical plant in a cleanly manner for the one area of the kitchen/break room.</p> <p>Findings:</p>	S 142	The administrator met with the cleaning contractor to go over the house checklist and assure that all areas are addressed The employee break room was added to the housekeeping check off log The center staff and administrator will oversee the quality of the cleaning service and	02/13/2015

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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
S 146 Bldg. 00	<p>1. On 2/9/15 and 2/10/15 in the area of the kitchen/break room, the following was observed: heavy dust on an end table which housed the telephone, visible dust and a dead insect on a window sill, brown dried appearing droplets on the water dispenser housing and in the drip tray.</p> <p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the center failed to maintain the condition of the physical plant in a manner to ensure safety to patients or employees in 3 areas (office area, break room, & corridors)</p>	S 146	<p>a monthly walk through with the cleaning contractor will be performed</p> <p>An evaluation of the floor condition will be done by a flooring contractor by April 15th At that time the board will review the recommendations of the flooring contractor to repair the issue and schedule the repairs</p>	05/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001005		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/10/2015	
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S 166 Bldg. 00	<p>Findings:</p> <p>1. On 2/10/15 between 12:45pm and 1:15pm during tour of the facility and at times of ingress and egress to the surveyor review area (the break room) the following was noted: In the office area, in the presence of A1, administrator, multiple dips/pits approximately 4" - 8" in diameter were noted in the flooring below the carpet. In the break room near the back window beside the table was a large dip which caused twiting of the ankle when stepped into, also in that area hard raised rounded areas under the carpet approximately 5" in diameter were observed when walking, these areas followed a line pattern approximately every 2 feet and extended into the corridors.</p> <p>2. On 2/10/15 at 2:00pm, A1 indicated the building was old, the flooring was concrete below the carpeting and there were dips and bumps.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and</p>		according to the contractor schedule The deficiency will be corrected by May 15, 2015				

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	<p>maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on document review and interview, the center failed to maintain preventive maintenance (PM) on all patient care equipment for 5 of 12 pieces of equipment (emergency call/code system, suction machine, surgical table, & wheel chair).</p> <p>Findings:</p> <p>1. Review of the policy titled SUBJECT: EQUIPMENT REPAIR AND MAINTENANCE indicated under the Procedure 1. a. Equipment used on or for patients will be checked by a qualified biomedical person at least twice a year. Documents will be kept on each item to include the testing performed and the results. The policy was approved 11/5/14.</p> <p>2. Review of preventive maintenance documents for 12 selected pieces of patient care equipment lacked</p>	S 166	A new preventative maintenance company has been obtained to oversee our biomedical checks and equipment servicing. The company will do their first check on April 6, 2015 and the administrator will assure that the equipment is all listed for the checks and current. The administrator and staff will oversee that the checks are current. The administrator will monitor the new PM company.	04/06/2015

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S 198 Bldg. 00	<p>documentation of PM for the emergency call/code system, patient stretcher(s), suction machine(s), surgical table(s), and wheel chair(s).</p> <p>3. On 2/10/15 at 2:45 A1, administrator, indicated the above pieces of patient care equipment had not been included in PM inspections.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the safety management program failed to coordinate emergency and disaster preparedness with appropriate community, state, and federal agencies on a regular basis.</p> <p>Findings:</p> <p>1. Review of the document on letterhead title Floyd County Emergency Management Agency indicated the Center "does not participate in the</p>	S 198	The administrator completed information requested by the Floyd County Emergency Management Agency on December 12, 2014 Floyd County is in the process of updating their plans A new Emergency Management Plan will be reviewed and approved by the GB/MAC committee at the next meeting on April 27, 2015 Once the plan is approved, the administrator will be responsible to oversee the plan	04/27/2015

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	<p>community emergency disaster preparedness plan drills in Floyd County." The document lacked a date stamp.</p> <p>2. On 2/10/15 at 1:45pm, A1, administrator, indicated the above referenced letter was the only coordination/interaction the center has had with an appropriate agency and no further documentation was provided prior to exit.</p>			