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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001053 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/27/2014 |
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| NAME OF PROVIDER OR SUPPLIER VALLEY SURGERY CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 220 E VIRGINIA ST EVANSVILLE, IN 47711 |
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| S000000 | <p>This visit was for a standard licensure survey.</p> <p>Facility Number: 007651</p> <p>Survey Dates: 8/25/14 to 8/27/14</p> <p>Surveyor: Trisha Goodwin, RN BSE Public Health Nurse Surveyor</p> <p>QA: cloughlin 09/19/14</p> | S000000 | | |
| S000102 | <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(1)(A)</p> <p>The governing body shall do the following:</p> <p>(1) Ensure that the center: (A) meets all rules and regulations for licensure and certification, if applicable</p> <p>Based on document review and interview, the facility failed to comply with all applicable state laws for 2 of 2 unlicensed nursing assistant employee</p> | S000102 | Prior to the survey a license check was completed as is usual for any licensed hire, nothing was found on the Indiana website. nothing was noted in the employee file that a search was | 09/24/2014 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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| | <p>files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. IC 16-28-13-4, a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person ' s state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law. 2. Review of personnel file for employee #1 indicated he/she was hired on 8/20/12 as a care tech and lacked documentation of a nurse aide registry report. 3. Review of personnel file for employee #2 indicated he/she was hired on 5/1/14 as a nursing assistant and lacked documentation of a nurse aide registry report. 4. In interview on 8/27/14 at 12:35pm, employee #A1 indicated inability to obtain nurse aide registry reports and | | <p>attempted. Soon, the center began receiving routine emails from the Help Desk for the Indiana Nurse Aide Registry with names of aides a the list. This list was kept in a file to reference for new employees to maintain compliance. The surveyor informed the center manager that the list was not maintaing compliance. Neither the surveyor not the help desk could provide information on how to access the registry . On 8/27 a attempt to access the registry was done, showing no results, this was shared with the surveyor and place in the file. The surveyor did contact the center a few days later with a phone # 1-317-233-7612 to access the registry. When called a recording stated that the IDR system was no longer available. The website was accessed to check for any recent updates and none were found. A request to the help desk was resubmitted with no results. The results of the no search found from the Indiana Nurse Aide Registry was placed in each unlicensed personnel file. The Center Manager and Corporate Human Resources will be responsible for this. The checking of licensure status of all personnel, licensed or unlicensed is a component of the new hire checklist. A background check is completed on all new hires as defined in IC 16-28-13-4. This will be prevented from happening in</p> | | |

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| S000104 | <p>confirmed the above. 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)(2)</p> <p>The governing body shall do the following:</p> <p>(2) Adopt bylaws and function accordingly.</p> <p>Based on document review and interview, the surgery center failed to show evidence of reviewing and adopting governing body bylaws.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of facility documents indicated no adoption of bylaws by the current governing body at any time. 2. In interview on 8/27/14 at 4:30pm, employee #A1 indicated no governing body bylaws had been adopted since the merger. | S000104 | <p>the furute by completing the newhire checklist monitored quarterly by QAPI.(See Attached)</p> <p>Bylaw were not requested until end of survey. Center Manager was unable to locate updated Bylaws. They were located on 8/28/2014. They were reviewed by the Governing Body on 9/2/2014 The Governing Body is responsible for this. This wil be added to the agenda for the fourth quarter governing board meetings to ensure the review is completed annually.</p> | 09/02/2014 |

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| S000732 | <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based on document review and interview, the medical staff failed to triennially review the medical staff rules or the medical staff bylaws.</p> <p>Findings:</p> <p>1. Review of facility documents indicated there was no medical staff review of medical staff rules within the last 3 years.</p> <p>2. Review of the facility document titled MEDICAL STAFF BYLAWS indicated the most recent adoption as 5/17/11.</p> <p>3. In interview on 8/27/14 at 4:00pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p> | S000732 | <p>Medical Staff Bylaws were reviewed by the Medical Staff and Governing Board on 9/2/2014. The Governing Board will be responsible This will be added to the agenda for fourth quarter governing body board meetings to ensure an annual review.</p> | 09/02/2014 |
| S000826 | <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL</p> | | | |

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| 410 | <p>IAC 15-2.5-4(c)(1)(E)</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>(E) Safety training required of personnel. Based on document review and interview, the medical staff failed to write required safety training policies and procedures (P&P).</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of credential files for MD #1-5 indicated no safety training for any of the medical staff files reviewed. Review of P&P documents indicated no written P&P for safety training required of personnel. In interview on 8/26/14 at 3:45pm, employee #A1 indicated the facility had no P&P for safety training required of personnel and no further documentation was provided prior to exit | S000826 | <p>Training for employees and physicians was completed but filed in the in-service book which was shown to surveyor. Policy LD20 was updated to include safety and IC training for physicians. EC-14 attached for all associates including medical staff. Governing Body and the Center Manager are responsible to ensure and document safety and Infection Control training annually. All medical staff will have the documented educational training noted in their credentialing files.</p> | 09/24/2014 |

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| S001000 | <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6</p> <p>The center shall provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services. Pharmaceutical services must have the following: Based on observation and interview, the facility failed to provide drugs in a safe manner in accordance with accepted professional practice in two (2) instances.</p> <p>Findings:</p> <p>1. During patient observation on 8/26/14 at 10:15am, in the pre-op suite, in the presence of #A2 and #A3, medications as follows were observed being kept at bedside in an open plastic tray: Tropicamide 1.25%, label indicated keep refrigerated at 2-8 degrees Celsius, Proparacaine Hydrochloride (HCl) Ophthalmic Solution 0.5%, label indicated to protect from light, Besivance 0.6% and Betadine in pre-drawn syringe dated 8/26/14.</p> | S001000 | To ensure drugs and biologocals are provided in a safe and effective manner the following steps were taken: Consultant Pharmcist was called during the survery t on 8/28/14. She suggested storingthe medications in question in a portable cooler. Policy PH12 was updated to include medications removed from refrigerator for use at bedside"will be stored in a portable container to maintain proper temperature and protection from light". Small cooler containers and thermometers were purchased and tested for each area.This practice was started on 9/2/14 once the governing board had approved the policy revision. Center manager and the Consultant Pharmcist will be responsible to ensure this practice is maintained. An in-service was given and monthly compliance checks were added to the monthly quality checks. | 09/03/2014 |

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| | <p>2. In interview on 8/26/14 at 4:00pm, #A1 indicated the above medications were kept out at bedside without refrigeration or light protection throughout the day and returned to storage at the end of each day. Policy and procedures (P&P) were requested for this process at that time.</p> <p>3. In interview on 8/27/14 at 1:00pm, #A1 indicated the facility did not have a P&P or written recommendation for alternate storage of the above listed medications.</p> <p>4. In phone interview on 8/27/14 at 1:15pm, #P1 indicated he/she was affiliated with a contracted compounding pharmacy which provides the Tropicamide. He/she indicated the label instructions to keep refrigerated were placed according to their protocol and that they had no documentation of how long the medication could be left out unrefrigerated.</p> <p>5. In phone interview on 8/27/14 at 1:40pm, #P2, facility consultant pharmacist, indicated being unaware of the facility using the compounded</p> | | | |

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| | <p>Tropicamide. He/she further indicated the medication should not be left out throughout the day and should be kept refrigerated. He/she further indicated the Proparacaine HCl should be kept in an amber bag or its outer box/container to protect from light as per label instructions.</p> <p>6. Review of a dark blue plastic baggie stamped REFREGERATE in large letters with a sticker labeled as Tropicamide 0.5% Phenylephrine 1.25% 5-ml Multiple-Dose Dropper bottle indicated further on the label to Refrigerate at 2-8 C (36 - 46F).</p> <p>7. Review of package insert titled Alcaine (proparacaine hydrochloride ophthalmic solution, USP) 0.5% indicated Storage: Bottle must be stored in unit carton to protect contents from light. Store bottles under refrigeration at 2 degrees to 8 degrees Celsius.</p> <p>8. Review of the policy titled VALLEY SURGERY CENTER Policy Number: PH-11 in the section titled Procedure: indicated: The following are exceptions to the above procedures: Succinylcholine</p> | | | |

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| S001010 | <p>can only be kept at room temperature for 14 days. Rocuronium expires 28 days once opened and 60 days when unopened. No other exceptions were indicated.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, document review and interview, the facility failed to implement storage of medications in accordance with their policy and procedure (P&P) in four (4) instances.</p> <p>Findings:</p> <p>1. During facility tour on 8/26/14 at 2:30pm in the presence of #A1, in an unlocked drawer in the autoclave room, which had no door, the following was</p> | S001010 | <p>Drugs noted were moved from unlocked drawer to locked cabinet immediately. Center Manager is responsible to maintain this practice.. To prevent this from happening in the future and an in-service was given to staff. The practice will be monitored as part of the monthly quality checks.</p> | 08/28/2014 | |

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| | <p>observed: 11 vials of Marcaine 0.75% 30ml vials, 7 vials of Kenalog-40 200mg/5ml (4mg/ml) multi-dose vials, 37 vials Solu-medrol 40mg/vial, and 39 vials Cefazolin 1g/vial.</p> <p>2. In interview on 8/26/14 at 2:30pm employee #A1 confirmed the above and indicated the above medications could be accessed by unauthorized persons.</p> <p>3. Review of the facility P&P titled VALLEY SURGERY CENTER Policy Number PH-04 effective date 4/1/14 in the section titled Procedure indicated the following: Only authorized individuals will have access to medication storage areas ...If medication are stored in a separate medication room, that room will be locked at all times ...</p> | | | |