

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001173		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/19/2012	
NAME OF PROVIDER OR SUPPLIER LAGRANGE SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2500 VENTURA WAY LAGRANGE, IN 46761			
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 012104</p> <p>Survey Date: 12-18-12 to 12-19-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/28/12</p>	S0000					

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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S0110	<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 board failed to perform a quarterly review of the center quality assessment (QA) program for 1 of 4 quarters and failed to ensure that all required functions and services were reviewed for its contracted services at the center.</p> <p>Findings:</p> <p>1. Center documentation indicated that governing board meetings were held on 11-28-11, 3-19-12, 5-14-12 and 11-06-12. The minutes failed to indicate that the board held a general meeting in the 3rd quarter of 2012 or that any contracted services were reviewed by the board. The minutes lacked documentation of the quarterly Quality Improvement Measures provided for review by the board.</p>	S0110	<p>Person Responsible: Governing Board/Chief Executive Officer. Similarly, meeting agenda templates for Quality Committee, Medical Staff and Governing Board meetings now include: "Quality Improvement Measures and Outcomes." These will be presented and reviewed for quality issues at all quarterly Quality Committee, Medical Staff and Governing Board meetings with follow up as needed. The Clinical Director will monitor meetings to address all required elements. The Quality Committee held a meeting on January 15, 2013 and these items were addressed. The next quarterly Medical Staff and Governing Board meetings are scheduled for February 11, 2013. The minutes of the meeting will reflect the review. To ensure the issue of contracted services is covered, on January 2, 2013, "Contracted services" was added as a</p>	02/11/2013	

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	2. During an interview on 12-19-12 at 1415 hours, staff A2 confirmed that the governing board held three regular meetings in 2012 and confirmed that the minutes failed to indicate that contracted services were reviewed by the board.		standing item to the agenda templates for all quarterly meetings of the Quality Committee, Medical Staff and the Governing Board. A form was developed on December 27, 2012 to review quality improvement issues with contracted services and was implemented on January 1, 2013. Finally, the Center did, in fact, have a Governing Board meeting on August 20, 2012. It was a board meeting to grant privileges to several physicians who needed to be re-credentialed with the Center.		

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S0156	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 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 policy and procedure review, employee file review, and staff interview, the facility failed to implement its policy related to performance reviews for 2 of 2 staff who had been employed long enough to be due for an evaluation (staff members P4 and P5).</p> <p>Findings: 1. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "Performance Reviews", with a policy number "AP - 02", and a review/revised date of 11/2012, that indicated: a. under "Guidelines", it reads: "...The Company will conduct a review of your job performance on an annual basis,..."</p>	S0156	<p>Person Responsible: Chief Executive Officer</p> <p>A spreadsheet was developed (January 10, 2013) that lists all employees and expiration dates for all required elements for employment. The Clinical Director is responsible for maintaining this spreadsheet on a monthly basis under the supervision of the Chief Executive Officer. The Chief Executive Officer will be responsible for quarterly review of this list to ensure that the policy and procedures relating to personnel are being followed.</p> <p>Evaluation for employee P4 was ready as of October 31, 2012. This employee is prn and has not worked since early October 2012.</p> <p>Evaluation was reviewed with employee on January 11, 2013 and</p>	01/11/2013			

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	<p>2. review of employee files at 11:40 AM on 12/19/12 indicated:</p> <p>a. staff member P4 was hired 10/2/11 and lacked documentation of an annual performance review in the employee file</p> <p>b. staff member P5 was hired 4/24/10 and had a last documented performance review dated 7/13/11 in the personnel file</p> <p>3. at 12:50 PM on 12/19/12, interview with staff member #50, the clinical director, indicated:</p> <p>a. this staff member was hired as administrator 8/14/12 and has not performed any employee evaluations since beginning employment here</p>		signed off. Evaluation for employee P5 was done on December 27, 2012 and reviewed with the employee on January 8, 2013.	

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S0162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on policy and procedure review, employee file review, and staff interview, the facility failed to implement its policy related to CPR (cardiopulmonary resuscitation) for 5 of 8 staff (staff members P1, P2, P5, P7, A12).</p> <p>Findings:</p> <p>1. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "CPR Certification", with a policy number "CC - 15", and a review/revised date of 11/2012, that indicated:</p> <p>a. under "Purpose", it reads: "To ensure BLS (basic life support) re-certification to all designated employees in a timely manner by BLS instructors, according to American Heart Association Guidelines."</p> <p>b. under "Policy", it reads: "All patient care employees will maintain current CPR</p>	S0162	<p>Person Responsible: Chief Executive Officer</p> <p>A class is scheduled with an AHA certified CPR instructor for January 22, 2013 to re-certify staff members who did online courses and those whose certification expires within the first six months of 2013. This will ensure compliance and classes will be held every two years or as needed for new hires.</p> <p>The policy and procedure "CPR Certification" has been revised as of January 7, 2013 to read:</p> <p>Guideline A. LSC will hire an outside agency that is certified in BLS and follows AHA guidelines. This will occur every other year and as needed for staff changes/new hires. Recertification by an online course will not be accepted.</p> <p>Guideline B. Re-certification will occur: 1. Every two years as recommended by the AHA. 2. During scheduled work hours based</p>	01/22/2013			

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	<p>certification..."</p> <p>c. under "Guidelines", in section B., it reads: "Re-certification will occur: 1. Every two (2) years as recommended by the AHA (American heart association)..."</p> <p>d. under "Guidelines", in section C., it reads: "Instructor responsibilities will include the following components:...3. clean up of manikins and materials. 4. Manikin disinfection. 5. Manikin maintenance..."</p> <p>e. under "Guidelines", in section D., it reads: "The initial instructor certification will be obtained from an external agency offering AHA certification courses when requested by the Center. 1. Instructor will obtain recertification before expiration. 2. The cost of instructor certification/re-certification will be covered by the Center."</p> <p>2. review of employee files at 11:40 AM on 12/19/12 indicated:</p> <p>a. staff RNs (registered nurses), P1 and P2 , were hired 9/24/12 and lacked any documentation of having current CPR certification in the employee files</p> <p>b. staff member P5, a LPN (licensed practical nurse), had documentation of completion of an on line CPR course called "International CPR Institute" that was done on 9/2/11</p> <p>c. staff member P7, a scrub/surg tech, had documentation of completion of an</p>		<p>on student/instructor availability. Guideline C. The cost of the instructor will be covered by the center.</p> <p>A special Medical Staff meeting and a Governing Board Meeting were held on January 11, 2013 to approve revised policies. The policy/procedure "CPR Certification" was approved by both committees January 11, 2013. Staff members P1 and P2 both have documentation of current CPR certification in their personnel files as of December 21, 2012. Expiration dates for these employees are May 12, 2013 and January 31, 2013. A spreadsheet was developed (January 10, 2013) that lists all employees and expiration dates for all required elements for employment, including CPR certification. The Clinical Director is responsible for maintaining this spreadsheet on a monthly basis under the supervision of the Chief Executive Officer. The Chief Executive Officer will be responsible for quarterly review of this form.</p>				

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	<p>on line CPR course called "ASHI (American Safety & Health Institute)", and "CPR Pro", that was taken 4/28/12</p> <p>3. at 12:50 PM on 12/19/12, interview with staff member #50, the clinical director, indicated:</p> <ul style="list-style-type: none"> a. it cannot be determined that the online courses taken by staff members P5 and P7 were AHA approved courses b. there is no "demonstration" of skills competencies with the online courses, which are required per standards of practice, to ensure CPR competency c. no documentation could be found related to CPR certification for staff members P1 and P2 d. the facility does not have a BLS instructor as required by the current facility policy <p>4. Review of the personnel file for one staff (A12) failed to indicate that the CPR training included skills performance to validate competency for CPR.</p> <p>5. During an interview on 12-19-12 at 1250 hours, staff A1 confirmed that the internet CPR training lacked skills validation for the staff (A12) and confirmed that the policy/procedure lacked the competency provision.</p>			

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S0164	<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 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 policy and procedure review, employee file review, and staff interview, the facility failed to implement its policy related to post offer physical examinations for 1 of 4 RNs (registered nurses) hired in 2011 and 2012 (staff member P4).</p> <p>Findings:</p> <p>1. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "Pre-Employment Physical Exam", with a policy number "AP - 15", and a review/revised date of 11/2012, that indicated:</p> <p>a. under "Policy", it reads: "All potential employees shall have a pre-employment physical exam provided by LaGrange Surgery Center's Medical Director..."</p> <p>2. review of employee health files at</p>	S0164	<p>Person Responsible: Chief Executive OfficerA pre-employment checklist, to include a pre-employment physical, was developed on January 11, 2013 and active by January 12, 2013 for all new hires. This checklist will have to be completed by the Clinical Director prior to employee start date. The Chief Executive Officer will be responsible for quarterly review of these checklists. A pre-employment physical exam for employee P4 was not obtained. A physical was completed on January 11, 2013 and put in employee's personnel file.</p>	01/12/2013			

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	<p>11:40 AM on 12/19/12 indicated:</p> <p>a. staff RN (P4), was hired 10/2/11 and lacked the presence of a post offer physical exam</p> <p>3. at 12:50 PM on 12/19/12, interview with staff member #50, the clinical director, indicated:</p> <p>a. no physical exam documentation for staff RN P4 could be found, as required by facility policy</p>			

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S0226	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</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>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review, the governing board failed to follow its bylaws and ensure that the center maintained a list of all contracted services, including the scope and nature of services provided, for 22 services.</p> <p>Findings:</p> <p>1. The Board of Managers Bylaws (approved 3-10) section IV indicated the following: " the board shall..ensure that the center maintains a list of all contracted services ... "</p> <p>2. On 12-18-12 at 1130 hours, staff A1 was requested to provide a list of all contracted services and none was provided prior to exit.</p> <p>3. Review of center documentation indicated alarm monitoring by V1, anesthesia machine service by V2, biohazardous waste disposal by</p>	S0226	<p>Person Responsible: Governing Board/Chief Executive Officer The Center's list was located on December 21, 2012. It was revised (vendors not being used were removed and new vendors added) and now is accessible on-line and a copy has been placed in the contracted services binder located in the clinical director's office. The Clinical Director is responsible for maintaining this list on a quarterly basis under the supervision of the Chief Executive Officer and reporting to the Governing Board.</p>	12/21/2012

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	<p>V3, biomedical engineering by V4, fire systems by V5, V6, V7, generator service by V8, heating/air conditioning service was provided by V9, laboratory services were provided by V10, laundry service by V11, medical credentialing by V12, medical gas by V13, medical vacuum by V14, medical records consulting by V15, medical transcription by V16, pest control by V17, physicist consulting by V18, radiation badge monitoring by V19, radiologist consulting by V20, sterilizer service by V21 and waste disposal service was provided by V22.</p> <p>4. On 12-18-12 at 1250 hours, staff A1 confirmed that the center failed to maintain a list of contracted services.</p>				

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S0310	<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. Based on document review and interview, the center failed to ensure that contracted services were evaluated through its quality assessment and improvement (QI) program.</p> <p>Findings:</p> <p>1. The policy/procedure Medical Quality Improvement Program (approved 11-12) and Quality Improvement Program (approved 11-12) failed to ensure that contracted services were evaluated through the QI program.</p> <p>2. The Quality Committee meeting minutes for 12-03-11, 2-10-12, 6-07-12 and 9-27-12 failed to indicate that any services provided by a contract or agreement were evaluated or discussed by the committee.</p> <p>3. The quarterly Quality Improvement Measures Reports for Q4 2011, Q1 2012</p>	S0310	<p>Person Responsible: Clinical Director</p> <p>Policy and Procedure "Quality Improvement Plan" has been revised to include monitoring of contracted services by Quality Improvement Committee, Medical Staff and the Governing Board. The agreements will be batched for review within an assigned quarter to ensure comprehensive review of all agreements annually.</p> <p>A special Medical Staff meeting and a Governing Board Meeting were held on January 11, 2013 to approve revised policies. The policy/procedure "Medical Quality Improvement Plan" was approved by both committees January 11, 2013. A Quality Committee was held on January 15, 2013 and five contracted services were reviewed for the fourth quarter of 2012. All indicators for all five contracted services were met without issues. A Medical Staff meeting and Governing Board meeting are scheduled for February 11, 2013 and</p>	02/11/2013			

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	<p>and Q2 2012 failed to indicate that any contracted service providers were reviewed using the report tool.</p> <p>4. During an interview on 12-19-12 at 1610 hours, staff A1 confirmed that the QI program failed to evaluate and document the effectiveness of each contracted service.</p>		<p>the contracted services reviewed by the Quality Committee will be reviewed at these meetings. "Contracted Services" has been added as a standing item on the agenda template for all Medical Staff, Governing Board and Quality Committee meetings to ensure review and outcome every quarter. A reporting tool for monitoring contracted services has been developed and was effective January 7, 2013.</p>		

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S0320	<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 center failed to ensure that the required functions of discharge, medication errors, and response to patient emergencies were evaluated by the Quality Improvement (QI) program.</p> <p>Findings:</p> <p>1. The Quality Committee meeting minutes for 12-03-11, 2-10-12, 6-07-12 and 9-27-12 failed to indicate that the committee reviewed and/or discussed the required program functions of discharges, medication errors and response to patient emergencies at each meeting.</p> <p>2. During an interview on 12-19-12 at 1610 hours, staff A1 confirmed that the QI minutes failed to indicate the required</p>	S0320	<p>Person Responsible: Clinical Director</p> <p>Discharge and transfer, infection control, medication errors, and response to patient emergencies have been added as standing items to quarterly agenda templates for the following committees: Quality Improvement Committee, Medical Staff and the Governing Board. The Quality Committee met on January 15, 2013 and these items were discussed and will be reported to the Medical Staff and Governing Board Meetings. A Medical Staff meeting and Governing Board meeting are scheduled for February 11, 2013. The Quality Committee, Medical Staff and Governing Board all meet on a quarterly basis.</p>	02/11/2013

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	functions had been evaluated through the QI program.				

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S0328	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the center failed to document the effectiveness of corrective action indicated by the QA Committee in response to an opportunity for improvement.</p> <p>Findings:</p> <p>1. The Quality Committee meeting minutes for 12-03-11, 2-10-12, 6-07-12 and 9-27-12 failed to indicate any follow-up regarding the effectiveness of an action when implemented in response to an identified issue or concern. The QI minutes for subsequent meetings failed to indicate that either issue was reviewed and resolved or required further committee action.</p> <p>2. During an interview on 12-19-12 at</p>	S0328	<p>Person Responsible: Clinical Director</p> <p>For all quarterly Quality Committee meetings, concerns from the previous meeting will be reviewed at the beginning of the meeting to ensure that the actions implemented produced the desired outcome. If an outcome is not met, the item will be placed on agenda for the next meeting, and a new plan of action documented. The Quality Committee met on January 15, 2013 and items from previous meeting were addressed first and acted upon.</p>	01/15/2013

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	1610 hours, staff A1 confirmed the QI program failed to ensure program accountability by not documenting the action follow-up and its effectiveness for the committee actions described in the minutes.				

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S0442	<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 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 policy and procedure review, employee health file review, and staff interview, the infection control practitioner failed to implement the policies related to TB (tuberculosis) testing and immunization history for 6 of 7 employees (P1, P2, P3, P4, P6 and P7).</p> <p>Findings:</p> <p>1. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "Tuberculosis Controls", with a policy number "IT - 03", and a review/revised date of 11/2012, that indicated:</p> <p>a. under "Procedure", it reads: "...4. TB monitoring of center personnel,...consists of Mantoux TB tests..."</p>	S0442	<p>Person Responsible: Infection Preventionist</p> <p>A pre-employment checklist was developed and adopted January 14, 2013 for all new hires. This checklist will have to be completed prior to employee start date and includes TB testing and immunization records. The Employee Health Nurse is responsible for maintaining this checklist on a quarterly basis. The Chief Executive Officer is responsible for monitoring the checklist on a quarterly basis.</p> <p>TB Vaccine ordered on January 2, 2013. TB testing of all active employee was done at the Mandatory Employee Health Day on January 18, 2013.</p> <p>A Mandatory Employee Health Day (for all active employees) was held</p>	01/18/2013			

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	<p>2. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "Infection Prevention and Control", with a policy number "IH - 03", and a review/revised date of 11/2012, that indicated:</p> <p>a. under section 6. "Control of Communicable Diseases", it reads: "...MQIC (medical quality improvement committee) screening: i. On hire this includes: Immunity testing for measles, mumps, rubella and chickenpox tuberculosis screening which is either with QFT or skin testing...ii. Once employed staff must have requisite screening or vaccination..."</p> <p>3. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "Immunizations of Healthcare Workers", with a policy number "IR - 07", and a review/revised date of 11/2012, that indicated:</p> <p>a. under "Purpose", it reads: "It is the policy of [facility] that all health care workers who are at risk for exposure to and possible transmission of vaccine-preventable diseases to provide proof of vaccination or history of disease for measles, mumps, rubella, and varicella."</p> <p>b. under "Guidelines", it reads: "1. Employees will do one of the following:</p>		<p>January 18, 2013. This included TB testing, Hepatitis B Vaccines/Titers and blood draws for titers of measles, mumps, rubella and chickenpox. New hires will have titers drawn, TB tests administered and read before allowed to begin work at LaGrange Surgery Center. TB tests will then be administered as per policy.</p> <p>Staff member P1 has documentation of TB testing done August 2012 in their personnel file as of December 27, 2012. Titers for this employee were drawn at Employee Health Day. Employee P2 & P3 had TB testing done January 18, 2013. Employee P4 has an immunization record in their personnel file as of January 11, 2013. Staff member P6 had TB testing done January 18, 2013. Employee P7 had TB testing done and titers drawn on January 18, 2013.</p> <p>A spreadsheet was developed (January 10, 2013) that lists all employees and expiration dates for all required elements for employment, including TB testing. The Clinical Director is responsible for maintaining this spreadsheet on a monthly basis. The Chief Executive Officer will be responsible for quarterly review of this form.</p>				

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	<p>a. Present written documentation of appropriate MMR and varicella vaccinations. b. Provide medically documented history of the diseases. c. Have titres drawn and present a copy of the lab report showing sufficient immunity to measles, mumps, rubella, and varicella..."</p> <p>4. review of employee health files at 11:40 AM on 12/19/12 indicated:</p> <p>a. staff member P1, a RN (registered nurse), was hired 9/24/12 and lacked any documentation of TB testing and lacked documentation of Rubella, Rubeola or Varicella history of disease, titer results, or dates of immunization</p> <p>b. staff member P2, a RN hired 9/24/12, had a most recent TB test dated 10/9/10</p> <p>c. staff member P3, a RN hired 9/4/12, had a most recent TB test dated 10/20/10</p> <p>d. staff member P4, a RN hired 10/2/11, lacked documentation of Rubella, Rubeola or Varicella history of disease, titer results, or dates of immunization</p> <p>e. staff member P6, a surgical tech hired 7/23/12, had a most recent TB test dated 10/7/10</p> <p>f. staff member P7, a surgical tech hired 6/29/12, had a most recent TB test dated 9/22/11 and lacked documentation of Varicella history of disease, titer results, or dates of immunization</p>			

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	<p>5. interview with staff member #50, the facility clinical director, at 12:50 PM on 12/19/12 indicated:</p> <p>a. TB testing has not been done since February 2012 as the facility was working towards completing, and having approved by the infection control committee, a low risk assessment tool which would negate the need for annual TB testing--this has not occurred, though, as of this survey date</p> <p>b. staff member P1 was still "trying to get their documentation of rubella, rubeola and varicella"</p> <p>c. it is unknown why there is a lack of documentation related to communicable diseases for staff members P3 and P7 as stated in 4. above</p> <p>d. per the facility policies and infection control plan, staff should be providing immunization information prior to starting employment</p>			

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S0526	<p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on policy and procedure review, employee file review, and staff interview, the facility failed to ensure that personnel performing laboratory testing have competencies documented indicating employee competency for the three CLIA waived tests performed at the center, Urine pregnancy testing, blood glucose testing, and Hemocue (for hemoglobin levels) testing.</p> <p>Findings:</p> <p>1. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "CLIA Waiver", with a policy number "CC - 05", and a review/revised date of 11/2012, that indicated:</p> <p>a. under "Guidelines", it reads that "A. Tests performed" are: "1. Urine pregnancy testing 2. Blood glucose...3. Hemocue..."</p> <p>2. review of employee files at 11:40 AM on 12/19/12 indicated there was no documentation of skills competency,</p>	S0526	<p>Person Responsible: Clinical Director Employee education and testing for the CLIA waived tests (glucometer, urine pregnancy testing and hemocue) were listed on the 2012 Employee Education Verification log that was presented to the surveyor and is complete for all employees, with the exception of three prn employees that have not worked since early October 2012. This Education Verification log is maintained by the Clinical Director on a quarterly basis. A return demonstration of these tests are documented on the test and signed off by the employee and the Clinical Director or charge nurse.</p>	12/20/2012			

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	<p>related to the 3 waived tests performed at the center, in the files for 7 of 7 employee files (P1 to P7)</p> <p>3. interview with staff member #50, the facility clinical director, at 10:15 AM on 12/19/12 indicated there is no observation or documentation of skills competencies performed by staff related to the three CLIA waived tests performed at the center</p>			

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S0606	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(b)(1)</p> <p>(b) The organization of the medical record service must be appropriate to the scope and complexity of the services provided as follows:</p> <p>(1) The services must be directed by a registered record administrator (RRA) or an accredited record technician (ART). If a full-time and/or part-time RRA or ART is not employed, then a consultant RRA or ART must be provided to assist the qualified person in charge. Documentation of the findings and recommendations of the consultant must be maintained.</p> <p>Based on document review and interview, the center failed to ensure that a qualified medical records administrator or consultant supervised the medical records (MR) service.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-18-12 at 1130 hours, staff A1 was requested to provide documentation indicating that the MR service was supervised by a qualified medical records administrator or consultant and none was provided prior to exit. On 12-19-12 at 1210 hours, staff A1 confirmed that the center lacked a 	S0606	<p>Person Responsible: Clinical Director Patricia Hart, MSN, RN at Pinnacle Hospital in Crown Point, Indiana was contacted on January 10, 2013 in regards to contracting a RHIT for LaGrange Surgery Center. A contract is being drawn up and is expected to be signed by January 23, 2013. The RHIT will be responsible for overseeing the Medical Records Service.</p>	01/31/2013	

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	qualified MR administrator or consultant for its MR service at the center.				

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S0612	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the accuracy of medical records for 3 of 9 patients (pts. N1, N6 and N7).</p> <p>Findings:</p> <p>1. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "Medical Records and Documentation", with a policy number "AM - 03", and a review/revised date of 11/2012, that indicated:</p> <p>a. under "Policy", it reads: "The Center shall maintain an accurate medical record on every patient admitted to the Center..."</p> <p>2. review of patient medical records at 2:40 PM on 12/18/12 and 1:50 PM on 12/19/12, indicated:</p> <p>a. pt. N1 had documentation:</p> <p>A. on the admission record form, the</p>	S0612	<p>Person Responsible: Clinical Director</p> <p>Education for staff regarding complete chart documentation was completed on January 8, 2013. Staff were presented with actual documentation errors and educated on what correct documentation is. The policy/procedure "Medical Records and Documentation" was given to staff at the staff meeting on January 15, 2013 and they were required to sign off. Specific items covered included: verifying allergies between all documents of the chart and the patient, making sure all orders are noted per policy which includes timing the order and charting repeat/verify when receiving a telephone or verbal order, verifying surgical site/procedure between all documents of the chart and the patient. Minutes from the Staff Meeting will be distributed to all staff members. Discrepancies will be</p>	02/08/2013			

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	<p>operating room record form, the anesthesia/physician order sheet, and the pre-op check list of an allergy to "Lipitor"</p> <p>B. on the surgery center pre admission orders of "NKDA's" (no known drug allergies)</p> <p>C. on the physician's dictated preoperative history and physical, in the "Allergies" section: "No known allergies to medications"</p> <p>D. on another physician's dictated history and physical, an "Allergy" to "Lipitor *ANTHYPERLIPIDEMICS*"</p> <p>b. pt. N6 had documentation:</p> <p>A. on the admission record form; the pre-op check list; the operating room record form; and the anesthesia record form of an allergy to "ASA" (aspirin)</p> <p>B. on the surgery center pre admission orders of "Lisinopril, Neurontin"</p> <p>c. pt. N7 had documentation:</p> <p>A. on the diagnostic summary sheet of a "R rotor cuff tear" and "R RCR" (right rotator cuff repair) procedure performed on 11/8/12</p> <p>B. of a "left shoulder scope with rotator cuff repair" noted on the surgical consent and the surgery center pre op order form; operation room record form and post operative dictated report</p> <p>3. interview with staff member #50, the facility clinical director, at 2:45 PM on</p>		<p>addressed with the physicians. All errors listed in citations S612 and S640 were reviewed with the staff members. The Charge Nurse is responsible for monitoring chart documentation completeness on a weekly basis and reporting issues to the Clinical Director.</p> <p>A memo to all physicians regarding complete documentation was sent on January 14, 2013. Physicians have been asked to review and follow the Center's Policy/Procedure of chart documentation and to sign off that they received and read the Policy and Procedure by February 8, 2013.</p>				

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	<p>12/19/12, indicated:</p> <ul style="list-style-type: none"> a. the surgery center pre admission orders are from the physician office and some times their information doesn't match that of the surgery center b. sometimes patients will tell one staff member of an allergy, but tell another staff member of a different, or no, allergy c. the "diagnostic summary" sheet on pt. N9's chart is not an "official" part of the chart d. it appears that inaccuracies are documented in the medical records for patients N1, N6, and N7 			

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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			
S0640	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on policy and procedure review, medical staff rules and regulations review, patient medical record review, and staff interview, the facility failed to ensure that medical records were legible and complete for 9 of 9 patient records (pts. N1 through N9).</p> <p>Findings: 1. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policies titled: a. "Medical Records and Documentation", with a policy number "AM - 03", and a review/revised date of 11/2012, that indicated: A. under "Procedure", it reads: "A...This record shall be reviewed periodically to ensure completeness..." b. "Verbal Orders", policy number "CV - 01", last reviewed/revised on 11/2012, indicated: A. under "Policy", in section 4., it reads: "All orders will be entered into the patient's chart and noted as a verbal or telephone order using the following format at the end of the order: a. Verbal</p>	S0640	<p>Person Responsible: Clinical Director Policy/Procedure "Verbal Orders" was reviewed at the staff meeting on January 15, 2013. The discussion included how to sign off on a verbal or telephone order when received. This policy will also be placed in the Mandatory Monthly Education binder for the month of February. The Charge Nurse is to monitor chart documentation completeness on a weekly basis and report issues to the Clinical Director. A memo to all physicians regarding complete documentation was sent on January 14, 2013. Physicians have been asked to review and follow the Center's Policy/Procedure of chart documentation and sign off on having read policy/procedure by February 8, 2013.</p>	02/08/2013			

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	<p>Orders: V.O.R.V. Dr. Smith/J. Doe, RN b. Telephone Orders: T.O.R.V. Dr. Smith/J. Doe, RN"</p> <p>2. at 3:00 PM on 12/19/12, review of the medical staff rules and regulations, last approved on 3/24/10, indicated: a. in section 8. "Medical Records", it reads in item c. "No medical record shall be filed until it is complete,..."</p> <p>3. review of patient medical records at 2:40 PM on 12/18/12 and 1:50 PM on 12/19/12, indicated: a. pt. N1 lacked completion of the "Anesthesia Record" form in the: A. pre op area for "Plan: General MAC Regional and Block (practitioner failed to mark the type of anesthesia selected for the patient); and in the "risks/benefits discussed with patient" B. in the area "Allergies:...", and in the area "Reassessed in OR" b. pt. N2 lacked completion of: A. the "Anesthesia Record" form in the "Machine checked" area B. the "Phase II Recovery" form in the "pain location" area c. pt. N3 lacked completion of: A. the "Anesthesia Record" form in the pre op "time" area; the "post op note" time; and the "Pt medically released at ____" time d. pt. N4 lacked completion of:</p>			

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	<p>A. the time of authentication of orders on the "Anesthesia/Physician Order Sheet" form</p> <p>B. the pre op exam "time" at the top of the "Anesthesia Record" form; the time of authentication for the post op exam; and "Pt medically released at ____" on the same form</p> <p>e. pt. N5 lacked completion of:</p> <p>A. the time of authentication of orders on the "Anesthesia/Physician Order Sheet"</p> <p>B. a date and time of the pre op exam on the "Anesthesia Record" form; the time of authentication for the post op note; and "Pt medically released at ____" on the same form</p> <p>f. pt. N6 lacked completion of:</p> <p>A. the "risks/benefits discussed with patient" during the pre op exam on the "Anesthesia Record" form</p> <p>B. the "Out of room time" and "Report to ____" on the "Phase I Recovery Record" form</p> <p>g. pt. N7 lacked completion or legibility of:</p> <p>A. the site of the "Rotator cuff tear" and repair of rotator cuff tear" on the "Diagnosis and Procedure" form</p> <p>B. had write overs on the "history and physical" form with R changed (written over) and made a L at the top and bottom of the form</p> <p>C. lacked a time with the</p>						

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	<p>authentication and dating of orders on the "Anesthesia/Physician Order Sheet"</p> <p>D. lacked a signature, date and time of the pre op physical exam on the top of the "Anesthesia Record" form</p> <p>E. lacked the amount of blood lost in the "estimated blood loss ___ml" section of the "Anesthesia Record" form</p> <p>F. lacked a time of authentication of the post op exam at the bottom of the "Anesthesia Record" form and "Pt medically released at ___" time</p> <p>G. the "Out of room time" and "Report to ___" on the "Phase I Recovery Record" form and a time of authentication by nursing staff on the same form</p> <p>h. pt. N8 lacked:</p> <p>A. a date of the history and physical form (in three areas)</p> <p>B. the "Procedure"; "Anesthesia Provider"; "Plan: General MAC Regional or Block"; "risks/benefits discussed with patient"; and signature, date and time - all in the pre op section of the "Anesthesia Record" form</p> <p>C. estimated blood loss; time of authentication of the post op exam; and "Pt medically released at ___" time on the "Anesthesia Record" form</p> <p>D. time with authentication of orders on the "Anesthesia/Physician Order Sheet"</p> <p>E. "Condition upon discharge" on the "Phase II Recovery" form</p>			

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	<p>i. pt. N9 lacked completion of:</p> <p>A. the time of authentication on the "Post Procedure Notes" (hand written)</p> <p>B. that the "risks/benefits discussed with patient" occurred in the pre op area of the "Anesthesia Record" form</p> <p>C. the time of authentication of the post op note on the "Anesthesia Record" form</p> <p>D. lacked the "T.O.R.V..." required by policy for documenting repeat and verify of two telephone orders taken by nursing staff</p> <p>4. interview with staff member #50, the facility clinical director, at 2:45 PM on 12/19/12, indicated:</p> <p>a. the patient medical records, as listed in 3. above, were missing documentation (lacked completion) as stated/written</p>			

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S0646	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(3)</p> <p>All entries in the medical record must be as follows:</p> <p>(3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule.</p> <p>Based upon document review and interview, the center failed to ensure all entries in the medical record (MR) were dated when authenticated.</p> <p>Findings:</p> <ol style="list-style-type: none"> The Lagrange Surgery Center Rules and Regulations of the Medical Staff (approved 3-10) indicated the following: " No medical record shall be filed until it is complete, signed and authenticated by the anesthesiologist and operating doctor ... " The Rule lacked the requirement to date each entry when authenticated. The policy/procedure Medical Records and Documentation (approved 11-12) lacked the requirement to date each entry when authenticated. During an interview on 12-19-12 at 1230 hours, staff A1 confirmed that the Medical Staff Rule and policy/procedure lacked the requirement to date each entry 	S0646	<p>Person Responsible: Clinical Director</p> <p>Medical Staff Rules and Regulations have been revised to read, "No medical record shall be filed until it is complete, signed, dated, timed and authenticated by the anesthesiologist and operating doctor. Policy/Procedure Medical Records and Documentation revised to require date and time when authenticating each entry. A specific Medical Staff meeting and a Governing Board Meeting were held on January 11, 2013 to approve revised policies. The policy/procedure "Medical Records and Documentation" was approved by both committees January 11, 2013. The Medical Staff Rules and Regulations will be presented at the Medical Staff meeting and the Governing Board meeting on February 11, 2013.</p> <p>The RHIT will be responsible for auditing medical records no less than monthly for compliance with the rules.</p>	02/11/2013	

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S0672	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(13) A copy of the transfer form, if the patient is referred to a hospital or other facility.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to implement its policy related to the completion of a transfer form (and inclusion in the medical record), for 1 of 1 patient transferred in 2012 (pt. N1).</p> <p>Findings:</p> <p>1. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "Transfers, Hospital", with a policy number "CT - 01", and a review/revised date of 11/2012, that indicated:</p> <p>a. under "Procedure", it reads: "Emergency Transfers:...3. One copy of the chart is made for the hospital. Transfer form will be completed and a copy will be retained for the Clinical Director..."</p> <p>2. review of patient medical records at 2:40 PM on 12/18/12 indicated:</p>	S0672	<p>Person Responsible: Clinical Director</p> <p>A transfer form was developed January 8, 2013. The transfer form was reviewed and approved by the Quality Committee on January 15, 2013. It will go to Medical Staff and Governing Board on February 11, 2013 for approval. Once approved a copy will accompany the policy/procedure in the Clinical Policy & Procedure Book. Staff will be educated on use of transfer form on February 12, 2013. All transfers will be reviewed quarterly by the Quality Committee.</p>	02/11/2013			

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	<p>a. pt. N1 was transferred to an acute care hospital on 9/6/12 and lacked documentation of the completion of a transfer form</p> <p>3. interview with staff member #50, the facility clinical director, at 10:15 AM on 12/19/12 indicated:</p> <p>a. no transfer form was completed for patient N1 on 9/6/12, as none could be found at the time of transfer</p>				

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S0780	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on the review of medical staff rules and regulations; patient medical records; and staff interview, the medical staff failed to implement their rules and regulations related to verbal orders for 1 of 1 patient who had verbal orders (pt. N9).</p> <p>Findings:</p> <p>1. at 3:00 PM on 12/19/12, review of the medical staff rules and regulations, with a last date of approval being 3/24/10, indicated:</p> <p>a. on page one under "Section 2. Orders", it reads: "...Verbal, including telephone, orders may be accepted...Signatures are required on the medical record by the physician...and on all orders within 24 hours..."</p>	S0780	<p>Person Responsible: Medical Director</p> <p>Medical Staff Rules and Regulations revised to read: "... Verbal, including telephone, orders may be accepted . . . Signatures are required on the medical record by the physician . . . and on all orders within 30 days." The Medical Staff Rules and Regulations will be presented at the Medical Staff Meeting and the Governing Board Meeting on February 11, 2013 for review and approval.</p> <p>Policy/Procedure "Verbal Orders" revised to read: "All orders will be repeated and verified with the ordering physician". A specific Medical Staff meeting and a Governing Board Meeting were held on January 11, 2013 to approve revised policies. The</p>	02/12/2013			

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	<p>2. review of patient medical records at 2:40 PM on 12/18/12 and 1:50 PM on 12/19/12, indicated:</p> <p>a. pt. N9 had telephone orders written at 1550 hours on 10/30/12 that were not authenticated by the physician</p> <p>3. interview with staff members #50, the facility clinical director, and #51, the infection control nurse, indicated:</p> <p>a. the telephone orders written on 10/30/12 should have been signed by the physician within 24 hours, as per medical staff rules and regulations</p>		<p>policy/procedure "Verbal Orders" was approved by both committees January 11, 2013. Staff was educated at the staff meeting on January 15, 2013.</p> <p>The RHIT will be responsible for auditing medical records no less than monthly for compliance with the rules.</p>				

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S1010	<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 policy and procedure review, observation, and staff interview, the nursing staff failed to implement facility policy related to pharmaceutical refrigerator temperatures.</p> <p>Findings:</p> <p>1. at 11:55 AM on 12/18/12, review of the facility policy and procedure manual indicated a policy titled: "Pharmaceutical Services", with a policy number "CP - 10", and a review/revised date of 11/2012, that indicated:</p> <p>a. under "Procedure", it reads: "...3. Refrigerator temperatures are monitored daily and recorded. Any discrepancies are noted, action taken is recorded, if discrepancy continues it is reported immediately to the QIC (quality improvement committee) Coordinator for assistance..."</p>	S1010	<p>Person Responsible: Clinical Director</p> <p>A new refrigerator/freezer temperature log was developed and put in use on January 1, 2013. It includes the initials of staff member with date and time of initial check. If temperature is out of range, the staff member must document action taken and temperature rechecked in one hour and if still out of range the Clinical Director is to be notified. The log includes date and time of re-check. Staff was educated on use of log on December 27, 2012. This log is currently being monitored monthly by the Clinical Director but will go to the Quality Coordinator the second quarter of 2013. Policy/Procedure "Refrigerator Freezer Temperature Monitoring" was revised to list correct temperature ranges for medications. It also includes the use of the new temperature log. A</p>	01/15/2013	

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	<p>2. at 11:00 AM on 12/19/12, while touring the nursing station in the surgical corridor, it was observed that:</p> <p>a. the medication refrigerator temperature logs were outside the "Acceptable range" of "<40" degrees on the following dates: 12/3/12; 12/12/12; 12/18/12; 11/12/12; 11/15/12; 11/27/12; and 10/11/12</p> <p>b. there was no documentation on any of the dates above that any action was taken to adjust the temperature of the refrigerator when noted as being too warm, and lacked a subsequent re-check of the temperature, as required by the log sheet (except for 12/18/12 when a re-check was done)</p> <p>3. interview with staff member #50, the facility clinical director, at 11:05 AM on 12/19/12 indicated:</p> <p>a. staff is not following the policy and temperature log sheet in regards to documenting action taken and temperature re-checks for the medication refrigerator in the surgical nursing station</p>		<p>specific Medical Staff meeting and a Governing Board Meeting were held on January 11, 2013 to approve revised policies. The policy/procedure "Refrigerator Freezer Temperature Monitoring" was approved by both committees January 11, 2013. Staff was educated on the policy change at the staff meeting held January 15, 2013</p>	

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S1020	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(D)</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>(D) Reporting of adverse reactions and medication errors to the practitioner responsible for the patient and the appropriate committee, and documented in the patient's record.</p> <p>Based on document review and interview, the center failed to ensure that all medication errors were documented in the patient record.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Pharmaceutical Services (approved 11-12) lacked the requirement to document all medication errors in the patient record. 2. During an interview on 12-19-12 at 1500 hours, staff A1 and A2 confirmed that the policy/procedure failed to ensure that all medication errors were documented in the patient record. 	S1020	<p>Person Responsible: Clinical Director</p> <p>Policy/Procedure "Pharmaceutical Services", under Procedure following a medication error, was revised on January 8, 2013 to read: "The error will be documented in the patient's medical record and on a quality monitor report and reviewed by the QIC coordinator." This is currently being monitored monthly by the Clinical Director but will go to the Quality Coordinator the second quarter of 2013.</p> <p>A special Medical Staff meeting and a Governing Board Meeting were held on January 11, 2013 to approve revised policies. The policy/procedure "Pharmaceutical Services" was approved by both committees January 11, 2013. The staff was educated on policy change at the staff meeting January 15,</p>	01/15/2013	

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NAME OF PROVIDER OR SUPPLIER LAGRANGE SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 VENTURA WAY LAGRANGE, IN 46761
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			2013.	

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S1146	<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, review of manufacturer's package insert, and staff interview, the facility failed to ensure that no condition occurred that might result in a hazard to patients in relation to a possible error in blood glucose testing.</p> <p>Findings: 1. at 12:50 PM on 12/19/12, review of the TrueTrack blood glucose test strip instructions/package insert indicated: a. under the section "Caring for Test Strips", it reads: "...Write date opened on vial label when removing first strip. Discard all unused Strips in Vial after date printed on the Strip vial label, or 120 days after date opened, if either date has passed..." b. under the section "Blood Glucose Testing", it reads: "... 3. Check EXP (expiration) on Strip vial. Do not use if</p>	S1146	<p>Person Responsible: Clinical Director</p> <p>The manufacturing recommendations for "Caring for Test Strips" were placed in Mandatory Monthly Education binder on January 2, 2013. Staff to read and sign off on the education. Staff were re-educated at the staff meeting held January 15, 2013. The Clinical Director is responsible for monitoring on an annual basis. A policy/procedure was written on January 17, 2013 for the glucometer. The policy includes the use of the machine, dating of vials and cleaning of the unit per manufacturer's recommendations. This policy will be presented for approval at the Medical Staff and Governing Board meetings on February 11, 2013.</p>	02/11/2013			

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	<p>past either written date or date printed on the Test Strip vial..."</p> <p>2. at 4:05 PM on 12/18/12 while on tour of the PACU (post anesthesia care unit), in the company of staff member #50, the clinical director, it was observed that the glucometer test strips in the carry case with the glucometer, lacked any written information/dating on the vial</p> <p>3. interview with staff members #50, the facility clinical director, and #51, the infection control nurse, at 4:20 PM on 12/19/12 indicated:</p> <p>a. the test strip vial was not dated when opened, as was observed on 12/18/12</p> <p>b. it was known that the glucometer strips expired 120 days after opening the vial</p> <p>c. there is no policy/procedure related to the need for staff to write on the strip vial when opening so that the strips will be discarded 120 days after opening</p>			

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S1170	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review, observation and interview, the center failed to ensure that defibrillator inspection and testing was performed as recommended by the manufacturer.</p> <p>Findings:</p> <p>1. The Zoll M Series Operator ' s Guide (2010) section 10 General Maintenance indicated the following: " The following operational checks should be performed at the beginning of every shift ...Refer to the Operator ' s Shift Checklist at the end of this section. Copy and distribute the</p>	S1170	<p>Person Responsible: Clinical Director</p> <p>Policy/Procedure developed January 15, 2013 on maintaining/discharging of Zoll M Series defibrillator. The policy will follow defibrillators "Operator's Guide". Instructions for daily checking/discharging of defibrillator have been laminated and posted on the crash cart for staff reference. A new daily log/checklist will be developed by January 18, 2013 and staff will be educated on January 18, 2013. This checklist to be put in use January 18, 2013. This policy will be presented at the Medical Staff and Governing</p>	02/11/2013			

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	<p>appropriate sheet to all individuals responsible for the device ' s use and readiness. "</p> <p>2. On 12-18-12 at 1130 hours, staff A1 was requested to provide a policy/procedure indicating the process for checking the defibrillator according to the manufacturer's recommendations and none was provided prior to exit.</p> <p>3. During a center tour on 12-18-12 at 1630 hours, the center defibrillator Zoll Model M was observed on the top of the Crash Cart with the document Crash Cart Checklist. The check sheet documentation failed to indicate the recommended checks listed in Section 10 General Maintenance or the Operator ' s Shift Checklist and was not observed elsewhere on the Crash Cart.</p> <p>4. During an interview on 12-19-12 at 1230 hours, staff A1 reviewed the operator ' s guide for the Zoll Model M defibrillator and confirmed that the daily defibrillator checks were not being performed according to the manufacturer's recommendations.</p>		<p>Board meetings on February 11, 2013. The Clinical Director is responsible for monitoring the log on a monthly basis.</p>		

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S1180	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on document review and interview, the center lacked documentation of an organized safety management program that included a review of safety functions by a committee appointed by the chief executive officer and included representatives from administration and patient care services.</p> <p>Findings:</p> <p>1. The Board of Managers Bylaws (approved 3-10) indicated the following: " Ensure that the center and its medical staff has an approved quality assurance, safety, and infection control plan and that the results of those plans and their actions are documented and regularly reported to the board. "</p> <p>2. On 12-18-12 at 1130 hours, staff A1 was requested to provide documentation of a safety management program</p>	S1180	<p>Person Responsible: Chief Executive Officer A Safety Program has been developed. The program will be brought to the Medical Staff and Governing Board Meetings on February 11, 2013 for approval of program and members of a committee to be made up of representatives from administration and patient care services. Once approved, the program will be put in place according to program guidelines. Program information will be placed in the Mandatory Monthly Education binder for the month of February 2013. This committee will report to the Quality Improvement Committee, Medical Staff and the Governing Board quarterly. The Center will be conducting emgency drills on a regular (semi-annual) basis.</p>	02/11/2013			

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	<p>including committee responsibilities, membership and meeting minutes and none was provided prior to exit.</p> <p>3. Review of the administrative and clinical policy/procedures table of contents (approved 11-12) failed to indicate an entry corresponding to a Safety Program /Plan or Safety Committee within the section for Safety.</p> <p>4. The policy/procedure Medical Quality Improvement Program (approved 11-12) and Quality Improvement Program (approved 11-12) failed to indicate the safety committee requirements and functions to be reviewed through the program.</p> <p>5. The Quality Committee meeting minutes for 12-03-11, 2-10-12, 6-07-12 and 9-27-12 failed to indicate that the committee reported, reviewed and/or discussed safety program functions at each meeting.</p> <p>6. During an interview on 12-19-12 at 1415 hours, staff A2 confirmed that the center lacked an organized safety management program.</p>			

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S1196	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAc 15-2.5-7(c)(5)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(5) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with center policy and state and local regulations.</p> <p>Based upon document review and interview, the center lacked documentation of inspection and approval by State or local fire control agencies.</p> <p>Findings:</p> <p>1. On 12-18-12 at 1130 hours, staff A1 was requested to provide documentation of a recent fire inspection report by a State or local fire agency and none was provided prior to exit.</p> <p>2. During an interview on 12-19-12 at 1620 hours, staff A1 confirmed that the center lacked documentation of a recent fire inspection.</p>	S1196	<p>Person Responsible: Clinical Director The State Fire Marshall's office contacted on January 7, 2013 for inspection to be completed. Inspection was completed on January 10, 2013 with four violations listed: 1. (Sec. 315.2 2088 Edition IFC 675 IAC 22-2.4) Storage of combustible materials in buildings shall be orderly. Storage shall be separated from heaters or heating devices by distance or shielding so that ignition cannot occur. Remove combustible items as discussed. ACTION: This was completed January 10, 2013. All items have been moved to a storage room off site. 2. (Sec. 901.4.1 2008 IFC 675 IAC 22-2.4) Fire protection systems required by this code or the International Building Code shall be installed, repaired, operated, tested and maintained in accordance with this code. NFPA 25 requires 6 spare heads be available in wrench box. Add 3</p>	01/16/2013			

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			heads. ACTION: Viking Fire contacted on January 10, 2013 to mail three additional spare heads. Three spare heads received on January 16, 2013 and were placed in the box with wrench and other three heads. 3. (Sec. 906.1 2008 Edition IFC 675 IAC 22-2.4) Portable fire extinguishers shall be installed where required by TABLE 906.1 and where required by local ordinance. Add extinguisher in attic equipment room. ACTION: Fire extinguisher placed in attic equipment room on January 16, 2013. 4. (Sec. 605.3 2008 Edition IFC 675 IAC 22-2.4) A working space of not less than 30 inches (762mm) in width, 36 inches (914mm) in depth and 78 inches (1981mm) in height shall be provided in front of electrical service equipment. Where the electrical service equipment is wider that 30 inches (762mm), the working space shall not be less than the width of the equipment. No storage of any materials shall be located within the designated working space. Exception: Where other dimensions are required or allowed by the ICC Electrical Code. Maintain required clearances in front of all panels. ACTION: This was completed January 10, 2013. All items have been moved to a storage room off site. The Center is now on a regular schedule (annual) for inspection by the State Fire	

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S1198	<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 upon document review and interview, the center lacked documentation of emergency preparedness drills in association with community, state and federal emergency and disaster preparedness agencies.</p> <p>Findings:</p> <p>1. On 12-18-12 at 1130 hours, staff A1 was requested to provide documentation of emergency preparedness drills performed in 2012 and none was provided prior to exit.</p> <p>2. During an interview on 12-19-12 at 1600 hours, staff A1 confirmed that the center lacked documentation of a recent emergency preparedness drill.</p>	S1198	<p>Marshall.</p> <p>Person Responsible: Safety Officer/Policy/Procedure developed on January 15, 2013 regarding Emergency Preparedness. A special Medical Staff meeting and a Governing Board Meeting were held on January 11, 2013 to approve revised policies. The policy/procedure "Emergency Preparedness" was approved by both committees January 11, 2013. Policy to go to Medical Staff and Governing Board for approval on February 11, 2013. The approved policy will be placed in the Mandatory Monthly Education binder for the month of February 2013. A letter was sent to the appropriate agencies on January 18, 2013, relating to coordination of emergency services and drills. The Center will be conducting emergency drills on a regular (semi-annual) basis.</p>	02/11/2013			

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S1210	<p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1)</p> <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 upon document review and interview, the center failed to ensure that its radiology services were supervised by a radiologist.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-18-12 at 1130 hours, staff A1 was requested to provide documentation indicating that the radiologic services were supervised by a credentialed radiologist and none was provided prior to exit. Review of 2012 radiation dosimetry reports, radiology equipment calibration or radiology safety policy/procedures failed to indicate that a review by a radiologist had been performed. During an interview on 12-19-12 at 1230 hours, staff A1 confirmed that the center lacked documentation of radiology 	S1210	<p>Person Responsible: Clinical Director LaGrange Surgery Center's radiation program is overseen by Dr. Anil Kothari, a radiologist. He is privileged through July 31, 2013. Dosimetry reports, radiation safety P&P, and radiology equipment calibrations were sent to Dr. Kothari for review on January 15, 2013 and subsequent documents will be sent quarterly. Quality reports received from Dr. Kothari will be presented to the Quality Committee quarterly. The Quality Committee met Jan 15, 2013 and was informed that the above items were being sent to Dr. Kothari for review and his findings would be presented at the next quarterly meeting. The Clinical Director is currently monitoring this on a monthly basis but will go to the Quality Coordinator the second quarter of 2013</p>	01/15/2013			

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	services supervision by a radiologist.			

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S1222	<p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(e)</p> <p>(e) Safeguards for patients, personnel, and public must be specified, including, but not limited to, the following:</p> <p>(1) Proper safety precautions must be maintained against radiation hazards in accordance with the center's radiation and safety program(s).</p> <p>(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.</p> <p>Based on document review, the center failed to ensure that radiation safety precautions were maintained to ensure services were provided in a safe and effective manner for patients and staff and reported through the safety program.</p> <p>Findings:</p> <p>1. On 12-18-12 at 1130 hours, staff A1 was requested to provide a policy/procedure ensuring that all female patients of childbearing age were screened for risk of exposure to ionizing radiation or anesthesia and none was provided prior to exit. Staff A1 was</p>	S1222	<p>Person Responsible: Clinical Director</p> <p>Policy/Procedure "Pre-operative Care" was revised on January 11, 2013 to include urine pregnancy testing for patients. The policy now reads: "Patients will be asked to void. A pregnancy test shall be performed on all female patients who have reached menarche age unless they are post-menopausal for 1 year, have had a permanent sterilization procedure or a total hysterectomy". A special Medical Staff meeting and a Governing Board Meeting were held on January 11, 2013 to approve revised policies. The policy/procedure "Pre-operative Care" was approved by both</p>	01/15/2013			

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	<p>requested to provide documentation of periodic testing of lead protective devices for effectiveness and none was provided prior to exit.</p> <p>2. During an interview on 12-19-12 at 1535 hours, staff A1 confirmed that no policy/procedure was available regarding the urine pregnancy testing performed at the center.</p> <p>3. During an interview on 12-19-12 at 1245 hours, staff A1 confirmed that no documentation of periodic testing of lead protective devices was available for the lead aprons and thyroid collars in use at the center.</p> <p>4. The policy/procedure Radiation Safety (approved 11-12) lacked a provision ensuring that health care worker radiation exposure monitoring reports were reviewed by a qualified person and reported through the safety program for the center.</p> <p>5. Dosimetry reports for 2012 lacked an indication or validation that they had been reviewed by a qualified person or the consultant radiologist for the center.</p> <p>6. During an interview on 12-19-12 at 1430 hours, staff A1 confirmed that the center lacked documentation of radiation</p>		<p>committees January 11, 2013. Staff was educated on this policy change at the staff meeting on January 15, 2013.</p> <p>Policy/Procedure "Radiation Safety" (under Procedure 4b) has been revised to read, "Leaded protective devices are tested for effectiveness semi-annually, or . . ." The test results will be recorded on the X-ray Lead Inspection log. Results will be reported to the Safety Committee and the supervising Radiologist. Concerns will be addressed at Medical Staff and Governing Board meetings and action plans will be developed as needed.</p> <p>Policy/Procedure "Radiation Safety" (under Procedure 5) revised to read, "monitor device reports will be reviewed by the radiologist quarterly and reported to the safety committee. Dosimetry reports will be sent to the supervising radiologist on a quarterly basis for review and report back to the safety committee. This is currently being monitored by the Clinical Director on a quarterly basis but will go to the Safety Officer the second quarter of 2013. A special Medical Staff meeting and a Governing Board Meeting were held on January 11, 2013 to approve revised policies. The policy/procedure "Radiation Safety" was approved by both committees January 11, 2013.</p>				

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NAME OF PROVIDER OR SUPPLIER LAGRANGE SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 VENTURA WAY LAGRANGE, IN 46761
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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
	exposure monitoring review by a radiologist or qualified person and reported through the safety program.			