

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001065	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/06/2015
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NAME OF PROVIDER OR SUPPLIER  SURGERY CENTER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7900 W JEFFERSON BOULEVARD, SUITE 102 FORT WAYNE, IN 46804
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S 0000  Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility #: 009566</p> <p>Survey Dates: 10/05-06/15</p> <p>QA: JIC 10/27/15</p> <p>IDR Committee held on 10-30-15, no change to tag S0320, tags S0328 &amp; S0410 deleted. JL</p>	S 0000		
S 0116  Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES</p> <p>410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their</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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	<p>individual training, experience, and other qualifications. (D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on document review and interview, the governing board failed to ensure that requests for appointment and reappointment were acted upon with the recommendations of the medical staff for 15 of 15 medical staff credential files reviewed (MDs #20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33 and 34).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Bylaws (approved 3-1-14) indicated the following: Article V Procedure for Appointment and Reappointment to the Medical Staff of the ASC. Section 5.01(e) The completed application shall be submitted to the chairperson of the credentials committee of the ASC... After review, the credentials committee shall make its recommendation to the governing body of the ASC. The Medical Staff Bylaws failed to indicate the credentialing committee function was to be performed by the Quality Improvement/Safety &amp; Infection Control (QSIC) committee and failed to indicate a Medical Executive Committee was authorized to act on the behalf of the</p>	S 0116	<p>As specified in the Medical Staff Bylaws of ENT Realty, the medical staff will be involved in the appointment/credentialing process as follows: The Present of ENT Realty will appoint three members (all of whom will be members of the current medical staff) to serve as the Credentials Committee. The Credentials Committee and the CEO of the corporation will apprise members of the medical staff the reappointment process is underway and share with the medical staff the names of the physicians and any allied professionals under consideration for appointment or reappointment. The communication to the medical staff will include a due date for feedback. The Credentials Committee will consider the application, medical staff input and any other information it deems relevant and formulate a recommendation to the Board of Directors (all of whom are members of the medical staff) for their consideration, deliberation, and determination. This process will be completed by January 31, 2016. Responsible person: Bill Ehinger, Facility CEO</p>	01/31/2016

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	<p>medical staff and make recommendations to the governing board regarding the requests for appointment and reappointment.</p> <p>2. Review of the 2nd Quarter 2015 QSIC reporting form and minutes dated 7-15-15 indicated a list of medical staff candidates for reappointment including MDs #20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33 and 34 and the meeting documentation failed to indicate a committee recommendation for the candidates.</p> <p>3. Review of the Executive Committee minutes dated 7-20-15 indicated the following: The recommendations of the clinical quality committee, including medical staff appointments, were reviewed and affirmed. The Executive Committee recommends approval by the board of directors.</p> <p>4. Review of the Board of Directors minutes dated 7-28-15 indicated the recommendations of The Surgery Center (TSC) QSIC committee concerning re-credentialing members of the TSC medical staff was unanimously approved.</p> <p>5. The Recommendation for Privileges document contained in the credential files for MDs #20, 21, 22, 23, 24, 25, 26, 27,</p>			

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	<p>28, 29, 30, 31, 32, 33 and 34 indicated that the governing board appointment was granted and signed by physician MD20, the Chief Medical Officer, on 5-19-15. The appointment notices failed to indicate a date corresponding to the medical staff recommendation by the Executive Committee on 7-20-15 or to the Board of Directors approval on 7-28-15 and the appointment notices failed to indicate the signature of a representative of the Board of Directors.</p> <p>6. During an interview on 10-7-15 at 1240 hours, staff A1, the center administrator, confirmed the reappointment documentation for the 15 physicians dated 5-19-15 failed to indicate that the reappointments were based on the 7-20-15 medical staff or executive committee recommendations or the 7-28-15 Board of Directors approvals to demonstrate compliance with the Medical Staff and Governing Board Bylaws. The staff A1 confirmed the Medical Staff Bylaws failed to indicate the credentialing committee function was to be performed by the QSIC committee and failed to indicate a medical executive committee was authorized to make recommendations to the governing board on behalf of the medical staff and no further documentation was provided prior to exit.</p>			

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S 0320  Bldg. 00	<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 its patient transfers were evaluated and reviewed through its quality assessment and performance improvement (QAPI) program for 9 transfers identified in 2015 program documentation.</p> <p>Findings include:</p> <p>1. Review of the policy/procedure Quality Assessment Performance Improvement Program (revised 12-13) indicated the QAPI committee would evaluate all patient transfers.</p> <p>2. The 1st quarter 2015 Quality Improvement/Safety &amp; Infection Control (QSIC) committee reporting form and</p>			S 0320	<p>Starting 1st quarter 2016, the QSIP committee reporting form will have documentation validating committee member participation for reviewing, discussing, or providing any recommendations for Center patient transfers during the committee meetings. Responsible person: Center Director, Brandy Miller, MHA, MSN, RN, CNOR</p>		01/31/2016

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S 0526 Bldg. 00	<p>minutes dated 4-22-15 indicated 2 hospital transfers occurred during the period. The QSIC report and minutes failed to indicate any narrative entries to validate the committee review and member participation in the defined areas for documenting a discussion, action, recommendation or plan for follow-up during the committee meeting.</p> <p>3. The 2nd quarter 2015 QSIC reporting form and minutes dated 7-15-15 indicated 7 hospital transfers occurred during the period and no documentation indicated a discussion and determination or plan for follow-up to validate a review of the transfers by the QAPI committee.</p> <p>4. During an interview on 10-7-15 at 1140 hours, staff A2, the director of nursing, confirmed that the quarterly QSIC reporting form and minutes failed to indicate documentation of committee member participation associated with a review of the patient transfers reported in the QAPI documentation and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)  (h) All nursing and other center</p>			

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S 0606  Bldg. 00	<p>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 document review and interview, the facility failed to ensure that nursing staff performing laboratory testing, (point of care testing), had annual competency assessed for 5 of 5 RN (registered nurse). (Files Reviewed: RNs N1, N2, N3, N4, and N5.)</p> <p>Findings Include:</p> <p>1. Review of the employee files for RNs N1, N2, N3, N4, and N5, pre and/or post op nurses, indicated there was no competency documentation for pregnancy testing and blood glucose testing was present.</p> <p>2.. At 11:15 AM on 10/7/15, interview with staff member #50, the facility administrator, confirmed all of the above and no other documentation was provided prior to exit.</p> <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</p>	S 0526	Center will implement employee annual competency testing for all end-users of point of care testing- pregnancy testing and blood glucose testing by December 31, 2015 Responsible person: Brandy Miller, MHA, MSN, RN, CNOR	02/29/2016			

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	<p>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 medical records administrator or consultant supervised and reviewed the medical records (MR) services at the center.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 10-5-15 at 1130 hours, staff A2, the director of nursing, was requested to provide documentation indicating a periodic review of the center MR services was provided by a medical records administrator or consultant and no documentation was presented prior to exit.</li> <li>The 3rd and 4th quarter 2014 and 1st quarter 2015 utilization review documentation presented as evidence of compliance indicated the MR review by staff A8, an accredited MR consultant,</li> </ol>	S 0606	<p>The Center has identified and initiated a relationship with an independent contractor for Health Information Consultation who will provide the service of comprehensive medical record review on a quarterly basis and as requested. The service will start with review of 4th quarter 2015 Center medical charts.</p> <p>Responsible person: Brandy Miller, MHA, MSN, RN, CNOR</p>	12/31/2015

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	<p>was limited to a review of the following: if the MR indicated a pathology specimen was sent to a lab (or not), if the pathologist and surgeon diagnoses were consistent, and if the patient was discharged to home (or transferred to a hospital). Staff A2, the director of nursing, was requested to provide additional documentation indicating the 2nd quarter 2015 utilization review was completed by the consultant A8 and none was provided prior to exit.</p> <p>3. No documentation provided for review indicated a comprehensive MR review was conducted periodically by a MR consultant to determine if a statistically significant number of sample records were reviewed for compliance with State licensure requirements in accordance with the standards of practice for medical record reviewing at ambulatory surgery centers.</p> <p>4. During an interview on 10-7-15 at 1100 hours, staff A7, the center medical record specialist, confirmed the Medical Record/Peer Review/Utilization Review Worksheet (revised 4-12) failed to indicate the MR consultant reviewed the MR for completeness and accuracy except for the (3) areas identified above. Staff A7 confirmed that staff A8, the accredited MR consultant did not</p>			

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S 0612 Bldg. 00	<p>perform a substantial MR review to determine compliance with State licensure requirements and confirmed that no other MR review documentation was available.</p> <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 document review and interview the facility failed to document the accuracy of medical records for 2 of 14 patients, (Patients #7 and #12).</p> <p>Findings Include:</p> <p>1. Review of the medical staff rules and regulations, with an effective date of 3/1/14, indicated on page 6., in section 3.16: (a) medical records are documented accurately and in a timely manner.</p> <p>2. Review of medical records indicated: A. Documentation in the Post Procedure Note section of the Physician's</p>	S 0612	<p>Individuals responsible for the errors were informed and the medical records identified have been corrected. Education and re-iteration is out to staff and surgeons regarding the importance of accurate medical record documentation and State Survey findings. The Center has identified and initiated a relationship with an independent contractor for Health Information Consultation who will provide the service of assisting with staff communication and the development and conducting of in-service training programs for Center employees as identified through quarterly medical record reviews. Responsible person:</p>	12/31/2015

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S 0640  Bldg. 00	<p>Post Op Orders and Post Procedure form for Pt. #7 indicated that the patient had a MAC (monitored anesthesia care), while the Operative Record form indicated the patient had a General anesthesia, and the anesthesia record form indicated a General anesthesia was used for the surgical procedure of 8/10/15.</p> <p>B. Documentation in the Post Procedure Note section of the Physician's Post Op Orders and Post Procedure form for Pt. #12 indicated that the patient had a Local anesthesia, while the Operative Record form indicated the patient had a General anesthesia, and the operative note, by the physician, indicated a Local anesthesia was used for the surgical procedure of 8/14/15.</p> <p>3. At 11:15 AM on 10/7/15, interview with staff member #50, the facility administrator, indicated the medical records for patients #7 and #12 were documented inaccurately with regard to the type of anesthesia utilized. No other documentation was provided prior to exit.</p>				Brandy Miller, MHA, MSN, RN, CNOR		
	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)						

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	<p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on document review and interview the facility failed to ensure that documentation was complete for 4 of 14 medical records reviewed, (Pts. #4, #10, #11, and #14).</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of the medical staff rules and regulations, with an effective date of 3/1/14, indicated on page 7 under section 3.18, all entries in the medical record must be legible and complete.</li> <li>Review of the medical staff rules and regulations, with an effective date of 3/1/14, indicated on page 8 in section 3.19, [there should be] documentation in a prominent part of the medical record whether or not the patient has executed an advance directive.</li> <li>Review of patient medical records indicated:               <ol style="list-style-type: none"> <li>Pt. #4 had a portion of the transfer form (page 2) titled Progress Note that was not completed and authenticated (in the Physician Signature section).</li> <li>Pt. #10 lacked documentation on the form General Admission And Rights Policy whether the patient had executed advance directives: Yes No, as neither</li> </ol> </li> </ol>	S 0640	<p>Individuals responsible for the errors were informed and the medical records identified have been corrected. Education and re-iteration is out to staff and surgeons regarding the importance of accurate medical record documentation and State Survey findings. The Center has identified and initiated a relationship with an independent contractor for Health Information Consultation who will provide the service of assisting with staff communication and the development and conducting of in-service training programs for Center employees as identified through quarterly medical record reviews. Responsible person: Brandy Miller, MHA, MSN, RN, CNOR</p>	12/31/2015

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S 0708 Bldg. 00	<p>the yes, nor the no, was marked.</p> <p>C. Pt. #11 lacked a date and time of anesthesiologist authentication of post operative standing orders.</p> <p>D. Pt. #14 lacked a time of the pre operative anesthesia evaluation on 8/13/15.</p> <p>4. At 11:15 AM on 10/7/15, interview with staff member #50, the facility administrator, indicated:</p> <p>A. Currently there is no medical record review taking place to check for legibility, completeness, and accuracy of the medical records.</p> <p>B. Pt. medical records #4, #10, #11, and #14 were lacking documentation as indicated above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(3)</p> <p>The medical staff shall do the following:</p> <p>(3) Make recommendations to the governing body on the appointment or reappointment of the applicant for a period not to exceed two (2) years. Based upon document review and interview, the medical staff failed to</p>	S 0708	The Credentialing Committee will, as part of its review, when	01/31/2016	

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	<p>follow its bylaws, rules and regulations and ensure that the recommendations for medical staff appointment and reappointment were for a period of no more than two (2) years for 15 of 15 medical staff candidates reviewed (MDs #20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33 and 34).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The Medical Staff Bylaws (approved 3-1-14) indicated the following: Article III Medical Staff Membership ...Section 3.04 Conditions and Duration of Appointment ...(b) Appointment and Reappointment Periods. Appointments shall be effective until the next regularly scheduled time for reappointments for membership and privileges. Reappointments shall occur on a biennial basis and therefore shall be for a period of two (2) Medical Staff years. For the purpose of these Medical Staff Bylaws, the Medical Staff year commences on the first day of January and ends on the thirty-first day of December of each year. Date of Biennial appointments to the Medical Staff and assignment of privileges shall be the month of January.</li> <li>Review of the credential files for MDs #20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33 and 34 indicated an</li> </ol>		<p>recommending approval of requested privileges, establish a period of privileges that will not exceed two (2) years. Correspondingly, final action by the Governing Board will approve appointment/reappointment for a period of time equal to or less than two (2) years. Responsible person: Bill Ehinger, Facility CEO</p>	

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S 0734 Bldg. 00	<p>appointment/reappointment period of three (3) years as follows: Appointment for Calendar Years: 2015-2017 and was signed on 5-19-15. The documentation failed to indicate a two (2) year (re)appointment period in accordance with the Medical Staff Bylaws and no other documentation was provided to confirm the 15 physicians were reappointed for no more than a two year period prior to exit.</p> <p>3. During an interview on 10-7-15 at 1040 hours, staff A2, the director of nursing, confirmed the above.</p> <p>4. During an interview on 10-7-15 at 1230 hours, staff A1, the administrator, confirmed the above.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(A)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(A) A description of the medical staff organization structure. If the organization calls for an executive committee, a majority of the members must be practitioners on the active medical staff.</p>			

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	<p>Based upon document review and interview, the medical staff failed to maintain its bylaws and ensure the description of the medical staff organizational structure was consistent with current practice for conducting medical staff meetings at the center.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The Medical Staff Bylaws (approved 3-1-14) indicated the following: Article XII Meetings of the Medical Staff. Section 12.02 Medical Staff Meetings (a) Regular Meetings. Medical Staff meetings shall occur no less frequently than quarterly ... Further review of the medical staff bylaws did not indicate a provision for establishing and authorizing an Executive Committee to act on the behalf of the medical staff.</li> <li>2. During an interview on 10-5-15 at 1345 hours, staff A1, the administrator, indicated that an Executive Committee based on the Articles of Incorporation associated with the medical practice group responsible for the surgery center met monthly and conducted business activity consistent with the function of a medical advisory or medical executive committee. Staff A1 confirmed that with the exception of an annual medical staff meeting, no other documentation of</li> </ol>	S 0734	Effective January 2016, the Medical Staff will meet no less frequently than quarterly. Responsible person: Bill Ehinger, Facility CEO	01/31/2016

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S 0736 Bldg. 00	<p>medical staff meetings was available to demonstrate compliance with the current version of the medical staff bylaws.</p> <p>3. During an interview on 10-7-15 at 1230 hours, staff A1, the administrator, confirmed that the medical staff bylaws failed to indicate a provision establishing an Executive Committee to act on the behalf of the medical staff and confirmed the bylaws had not been maintained.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based upon document review and interview, the medical staff failed to follow its bylaws and ensure that the medical staff met quarterly for 3 of 4 quarters in 2014 and 2015.</p> <p>Findings include:</p>	S 0736	Effective January 2016, the Medical Staff will meet no less frequently than quarterly. Responsible person: Bill Ehinger, Facility CEO	01/31/2016

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	<p>1. The Medical Staff Bylaws (approved 3-1-14) indicated the following: Article XII Meetings of the Medical Staff. Section 12.02 Medical Staff Meetings (a) Regular Meetings. Medical Staff meetings shall occur no less frequently than quarterly ... Further review of the medical staff bylaws did not indicate a provision for establishing and authorizing an Executive Committee to act on the behalf of the medical staff.</p> <p>2. On 10-5-15 at 0930 hours, staff A2, the director of nursing, was requested to provide documentation of quarterly medical staff meetings and documentation of an annual medical staff meeting held in May of 2014 and 2015 was provided in response.</p> <p>3. During an interview on 10-5-15 at 1345 hours, staff A1, the administrator, indicated that other than the annual medical staff meeting scheduled in May, no documentation of quarterly medical staff meetings was available.</p> <p>4. During an interview on 10-7-15 at 1230 hours, staff A1, the administrator, confirmed that the medical staff failed to conduct quarterly medical staff meetings in accordance with the medical staff bylaws for 3 of 4 quarters in 2014 and 2015.</p>			

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S 0772 Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND 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 and interview, it could not be determined that the history and physical was performed prior to the start of surgery for 14 of 14 medical records reviewed, (Medical Records #1 through #14).</p>	S 0772	Individuals responsible for the errors were informed. Education and re-iteration out to staff and surgeons regarding the importance of signing, dating and timing hand-written medical record documentation as well	12/31/2015

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	<p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. Review of the medical staff rules and regulations, last approved 3/1/14, indicated on page 9 under Article IV Surgery (b) An appropriate history and physical workup must be in the medical record of every patient before surgery.</li> <li>2. Review of the policy General Rules", in section VIII.A, on page 7, indicated II. Procedure: A. All clinical entries in the patient's medical record shall be accurately dated and authenticated.</li> <li>3. Review of medical records for patients #1 through #14 indicated that all were authenticated and dated by the physicians, but lacked a time of the authentication, thus it could not be determined if history and physicals were performed prior to the start of the surgical procedure(s).</li> <li>4. At 12:30 PM on 10/5/15 and 11:15 AM on 10/7/15, interview with staff member #50, the facility administrator, confirmed that physicians do not put a time on the authentication of the performance of the history and and physicals and no other documentation was provided prior to exit.</li> </ol>		<p>as State Survey findings. In November 2015, Center changed out all 'stamps' that requested surgeon and date to additionally include a requisite to place the time of documentation. The Center has identified and initiated a relationship with an independent contractor for Health Information Consultation who will provide the service of assisting with staff communication and the development and conducting of in-service training programs for Center employees and surgeons as identified through quarterly medical record reviews. Responsible person: Brandy Miller, MHA, MSN, RN, CNOR</p>	

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S 0782 Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(O)</p> <p>These bylaws and rule must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(O) A provision for personnel authorized to take a verbal order. Based on document review and interview, the facility failed to follow its policy for verbal and telephone orders, for 4 of 14 patient records, (Pts. #2, #4, #11 and #13).</p> <p>Findings Include: 1. Review of the policy Medication Administration, no policy number, originated 12/2012, indicated verbal and phone orders will be repeated and verified by the RN (registered nurse) to the prescribing physician. Verbal orders repeated and verified will be signed by the physician within thirty (30) days of the verbal order. If the verbal order is not listed as repeated and verified, the physician must sign within forty-eight (48) hours of the verbal order...the physician will need to date and time his signature of the verbal orders including verbal orders repeated and verified.</p>	S 0782	<p>State survey findings posted and shared with all staff and surgeons. Individuals responsible for the errors were informed. Center policy for Verbal Orders posted in clinical areas with education and re-iteration out to staff and surgeons regarding Center policy on verbal and telephone orders. The Center has identified and initiated a relationship with an independent contractor for Health Information Consultation who will provide the service of assisting with staff communication and the development and conducting of in-service training programs for Center employees and surgeons as identified through quarterly medical record reviews. Responsible person: Brandy Miller, MHA, MSN, RN, CNOR</p>	12/31/2015

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	<p>2. Review of medical records indicated:</p> <p>A. Pt. #2 had verbal orders written at 1650 hours and 1725 hours that had no authentication by the physician after the 1550 hours verbal orders were authenticated.</p> <p>B. Pt. #4 had:</p> <p>(1). A telephone order written at 1910 hours on 7/22/15 that was authenticated by the physician, but lacked a date and time of the authentication.</p> <p>(2). A hand written order (on a Post Operative standing orders form) for Demerol 50 mg IM (intramuscularly) Q (every) 3 - 4 hours prn (as needed) pain that:</p> <p>a. Lacked a date and time of the order by the receiving RN, and lacked a repeated and verified notation.</p> <p>b. Lacked authentication by the physician of the Demerol order, as the standing orders were authenticated at 1647 hours and the Demerol was given at 1745 hours, indicating the Demerol order was given after authentication of the standing orders at 1647 hours.</p> <p>C. Pt. #11 lacked a date and time of authentication, by the anesthesiologist on 8/11/15, on the operative anesthesia standing orders.</p> <p>D. Pt. #13 had a hand written order (on a Post Operative standing order form) for Versed may give 2 mg IV (intravenous) now that was authenticated by the</p>			

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S 0888 Bldg. 00	<p>anesthesiologist, but lacked a date and time.</p> <p>3. At 11:15 AM on 10/7/15, interview with staff member #50, the facility administrator, confirmed all of the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review and interview, the facility failed to ensure that operative notes were dictated within the</p>	S 0888	State survey findings shared with all surgeons. Individuals responsible for identified errors from survey were individually	12/31/2015

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	<p>time frame of the medical staff rules and regulations for 5 of 14 patients, (Patients #1, #4, #6, #9, and #11).</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of the medical staff rules and regulations, with an effective date of 3/1/14, indicated on page 8 under Article IV Surgery, it reads in section 4.07, operative reports shall be dictated or written the same day as surgery and shall be in full description of the procedure performed.</li> <li>Review of patient medical records indicated: <ol style="list-style-type: none"> <li>Pt. #1 had surgery on 1/19/15 with the operative note created on 1/20/15.</li> <li>Pt. #4 had surgery on 7/22/15 with the operative note created on 7/23/15.</li> <li>Pt. #6 had surgery on 7/24/15 with the operative note created on 7/26/15.</li> <li>Pt. #9 had surgery on 8/10/15 with the operative note created on 8/11/15.</li> <li>Pt. #11 had surgery on 8/11/15 with the operative note created on 8/14/15.</li> </ol> </li> <li>At 12:30 PM on 10/5/15, 9:00 AM and 11:15 AM on 10/7/15, interview with staff member #50, the facility administrator, confirmed all of the above and no other documentation was provided prior to exit.</li> </ol>		<p>informed. Review of medical staff rules and regulations requirements regarding dictation of operative reports provided to all surgeons. Additionally, Center Front Office staff is verifying morning of next business day that all patient charts have either a dictated or already transcribed operative note. Any patient chart that does not have a dictated or already transcribed operative note is presented to the Center Director to inform surgeon and Director of Medical Records, Cindy Baker. The Center has identified and initiated a relationship with an independent contractor for Health Information Consultation who will provide the service of comprehensive medical record review on a quarterly basis and as requested to facilitate in identifying and following upon any non-compliant surgeons. The service will start with review of 4th quarter 2015 Center medical charts. Responsible person: Brandy Miller, MHA, MSN, RN, CNOR</p>	

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S 0920 Bldg. 00	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following: Based on document review and interview, it could not be determined the facility followed the manufacturer's instructions for glucometer test strips in one area toured.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of the Bayer Contour Meter instructions provided by the pre op nursing staff from a binder in the pre op work area, indicated, check the expiration dates on your test strips and control solution. It is important to not use the test strips or control solution if the expiration date printed on the bottle label and carton has passed or it has been six months (180) days since you first opened the bottle.</li> <li>At 11:45 AM on 10/6/15, while on tour of the recovery area in the company of staff member #51, the infection control practitioner, review of the test strip bottle indicated it did not have any date noted that the container was opened.</li> </ol>	S 0920	<p>Test strip bottle was discarded and new one opened with corresponding expiration dates (six months) documented on test strip bottle. State survey findings shared with all staff members and reiteration of documentation and manufacturer's requirements during employee annual competency testing for point of care testing occurring before December 31, 2015. The Center Infection Preventionist, Matt Slayer, will be responsible for monitoring this as part of his monthly rounds for the Center Responsible person: Brandy Miller, MHA, MSN, RN, CNOR</p>	12/31/2015

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S 1012 Bldg. 00	<p>3. At 12:00 PM on 10/6/15, interview with staff member #51 confirmed it could not be determined when the test strip bottle was first opened, or when a 180 day of expiration might occur, and no other documentation was provided by exit.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(B)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(B) Drug administration according to established center policies and acceptable standards of practice. Based on document review and interview, the facility failed its medication policy for for 3 of 14 patients, (patients #4, #6, and #9).</p> <p>Findings Include: 1. Review of the document Patient Care Manual Drug Medication Administration, originated 12/2012, indicated under Policy, Center will implement the medication use process. Prescribe and Transcribe: all medications will be</p>	S 1012	State survey findings posted and shared with all staff and surgeons. Individuals responsible for the errors identified during survey were informed. Center policy regarding all medications being administered by physician order including time, drug, dose and route of administration by licensed personnel within the medical record re-communicated with staff. The Center has identified and initiated a relationship with an independent contractor for Health Information Consultation who will provide the	01/31/2016

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	<p>administered by physician order, and on page two under Procedure, document the time, drug, dose and route of administration by licensed personnel within the medical record.</p> <p>2. Review of medical records indicated:  A. Pt. #4 had a septoplasty done on 7/22/15 with:  (1). Pre op orders for Afrin: One spray per nostril every 5 minutes for 3 doses, with nursing documentation on the Pre-Operative Nursing Assessment form that reads: 1455 Afrin 3 puffs each nostril.  (2). Post op orders for: Demerol 50 mg IM (intramuscularly) Q (every) 3 - 4 hours prn (as needed) pain, with nursing documenting on the Post Anesthesia Care Record that Demerol was given at 1745 hours and that 25 was crossed out and error written, but no other dosage noted.  B. Pt. #6 had a septoplasty done on 7/24/15 with Pre op orders for Afrin: One spray per nostril every 5 minutes for 3 doses, with nursing documentation on the Pre-Operative Nursing Assessment form that indicated at 1340 hours that Afrin 3 puffs each was dosed, and in the Route section, nostrils was documented.  C. Pt. #9 had a septoplasty on 8/10/15 with Pre op orders for Afrin: One spray per nostril every 5 minutes for 3 doses, with nursing documentation on the</p>		<p>service of assisting with staff communication and the development and conducting of in-service training programs for Center employees and surgeons as identified through quarterly medical record reviews.  Responsible person: Brandy Miller, MHA, MSN, RN, CNOR</p>		

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S 1172  Bldg. 00	<p>Pre-Operative Nursing Assessment form that indicated at 1045 hours, Afrin nasal spray q (every) 5 (minutes) x 3 was documented with Route noted as nasal.</p> <p>3. At 2:20 PM on 10/5/15 and 11:15 AM on 10/7/15, interview with staff member #50, the facility administrator, indicated:</p> <p>A. Nursing staff is not documenting the 3 Afrin doses every 5 minutes, as ordered by the physician, but lumping them together in one documentation, making unclear exactly what time each dose was given.</p> <p>B. It was agreed that a dosage amount for the Demerol given to pt. #4 was not documented by the nurse after crossing out the "25" dose and writing "error".</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)</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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with</p>						

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	<p>current standards of practice, including the following: Based on document review, observation, and interview, the facility failed to ensure that cleanliness was maintained in the facility for six areas where an accumulation of dust was observed.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. Review of the housekeeping policies in section XV.A titled Housekeeping Services, indicated on page 5., section 8. Staff Dressing Areas, was listed as an area to be cleaned by housekeeping staff.</li> <li>2. Review of the housekeeping policies in section XV.A under Housecleaning Schedule, indicated on page 8., III. Procedure, that Daily, contracted cleaners are to 4. Dust all surfaces.</li> <li>3. Review of the form OR Monthly Staff Cleaning - 2015 indicated that OR #3 - &amp; all equipment in it was last documented as having been cleaned on 9/9/15.</li> <li>4. At 10:50 AM on 10/6/15, while on tour of the facility in the company of staff member #50, the administrator, it was observed that there was an accumulation of dust on top of the bank of lockers in the women's dressing room.</li> <li>5. At 10:55 AM on 10/6/15, while on</li> </ol>	S 1172	<p>State survey findings posted and shared with all staff and surgeons. Contracted Environmental Services manager met with Center Infection Preventionist in October shortly after survey was conducted to address findings during walk-through with State Surveyors. Infection Preventionist added the identified areas to quarterly rounds to ensure areas are being dusted and checked on a routine basis. Staff responsible for cleaning of areas where findings occurred was informed of surveyor findings with reiteration of facility cleanliness expectations. Ventilation grille cleaning was performed in the Center November of 2015 and ventilation grilles will be monitored by Center Infection Preventionist and service rendered as needed. Responsible Person: Brandy Miller, MHA, MSN, RN, CNOR</p>	12/08/2015

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	<p>tour of the facility in the company of staff member #50, the administrator, it was observed that there was an accumulation of dust on top of the cabinets located in the hallway between the staff break room and the surgery hallway.</p> <p>6. At 11:00 AM on 10/6/15, while on tour of the facility in the company of staff member #50, the administrator, it was observed that there was an accumulation of dust on top of the stationary overhead light in OR (operating room) #3 (which is used for equipment storage).</p> <p>7. At 10:50 AM, 10:55 AM, and 11:00 AM on 10/6/15, interview with staff member #50 confirmed:</p> <p>A. The tops of the lockers in the women's dressing room had not been cleaned in some time.</p> <p>B. The accumulation of dust on the hallway cabinets indicated a lack of attention by cleaning staff.</p> <p>C. Nursing staff had last cleaned OR #3 approximately one month ago, and with the accumulation of dust present on the overhead light, it had been neglected.</p> <p>8. Review of the policy/procedure Criteria for Cleaning of Areas (approved 3-14) indicated the following: In order to maintain a clean environment in the Center, the following criteria will be used to evaluate cleanliness ... HVAC Vents:</p>			

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	<p>Free of lint and dust.</p> <p>9. Review of the policy/procedure Housekeeping Schedule (approved 3-14) indicated the following: In order to maintain a clean and sterile environment, housekeeping will follow a schedule for cleaning the facility ... Weekly: Wash HVAC vents in OR. Further review of the policy/procedure failed to indicate a responsibility for cleaning other HVAC ventilation grilles in the restricted surgical areas or other areas of the center.</p> <p>10. Review of the Safety and Infection Control rounding documentation dated 4-30-15, 6-1-15, 6-30-15, 8-18-15 and 9-3-15 failed to indicate the ventilation grilles in the restricted access and patient care areas were routinely inspected for compliance with the established standard for evaluating cleanliness of HVAC vents.</p> <p>11. During a tour on 10-06-15 at 1035 hours, in the presence of staff A2, the director of nursing, and staff A5, the facilities manager, the following was observed in the minor procedure and exam room: a 24" square ceiling ventilation grille with a heavy accumulation of dust and particulate material that was located directly over a powered patient examination chair.</p>			

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S 1180 Bldg. 00	<p>12. During an interview on 10-06-15 at 1035 hours, staff A2, the director of nursing, and staff A5, the facilities manager, confirmed the presence of accumulated dust on the ventilation grille was unsanitary.</p> <p>13. During a tour on 10-06-15 at 1115 hours, in the presence of staff A2, the director of nursing, staff A3, the infection control nurse, and staff A5, the facilities manager, the following was observed in the instrument decontamination area located between OR rooms 1 &amp; 2: a 12" x 24" ceiling ventilation grille with a heavy accumulation of dust and particulate material.</p> <p>14. During an interview on 10-06-15 at 1115 hours, staff A2, the director of nursing, staff A3, the infection control nurse, and staff A5, the facilities manager, confirmed the presence of accumulated dust on the ventilation grille was unsanitary.</p> <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>			

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	<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 failed to develop and maintain its safety program and plan including a written description of the committee membership, meeting requirements, and safety functions to be reviewed by the committee.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 5-13-13 at 1030 hours, staff A1 was requested to provide a policy/procedure or documentation indicating a description of the safety management program including the program scope and functions, committee membership and meeting requirements and no documentation was provided prior to exit.</li> <li>During an interview on 10-7-15 at 1445 hours, staff A2, the director of nursing, confirmed no documentation of a safety program description or policy/procedure indicating the committee scope, functions, membership and meeting requirements was available.</li> </ol>	S 1180	<p>Center Director will be responsible for compiling all CenterSafety policies and procedures into a formalized written Safety Plan including a description of the committee membership, meeting requirements, and safety functions to be reviewed by the committee by the end of 1st quarter 2016.</p> <p>Responsible Person: Brandy Miller, MHA, MSN, RN, CNOR</p>	03/31/2016