

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001020	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/24/2015
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NAME OF PROVIDER OR SUPPLIER  NOVAMED EYE SURGERY CENTER OF NEW ALBANY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W FIRST ST NEW ALBANY, IN 47150
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S 0000  Bldg. 00	This visit was for State licensure survey.  Facility number: 005401  Dates: 6/23/15 & 6/24/15  QA: cjl 07/01/15	S 0000		
S 0106  Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)  The governing body shall do the following:  (3) Review the bylaws at least triennially. Based on document review and interview, the governing body failed to review their bylaws at least triennially.  Findings:  1. Review of the document titled Governing Body By-Laws, indicated the By-Laws were adopted on April 30, 2001.  2. Review of governing body meeting minutes dated 5/14/15, 7/1/14, 10/29/14, & 2/11/15 lacked documentation of	S 0106	Governing Board reviewed and approved Governing Board Bylaws 7/9/15. The facility administrator will add the medical staff by-laws to the list of items taken before the governing board for annual approval. Responsible Party: Facility Administrator/Quality Assurance Coordinator	07/09/2015

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

TITLE

(X6) DATE

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

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S 0110 Bldg. 00	<p>governing body by-law review.</p> <p>3. On 6/24/15 at 12:30pm, A2, Medical Records Coordinator, indicated the Governing Body had not reviewed their by-laws since adoption in 2001. No further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the governing body (GB) failed to review, at least quarterly, reports of the quality assessment and improvement program (QAPI) within the past 4 quarters.</p> <p>Findings:</p> <p>1. Review of GB meeting minutes dated 5/14/15, 2/11/15, 10/29/14 &amp; 7/1/14</p>	S 0110	The QAPI reports will be specifically identified in the governing board meeting minutes. The QAPI reports are presented to the Medical Advisory Committee prior to the Governing Board and will now be presented in their entirety to the Governing Board by the facility administrator. Responsible Party: Facility Administrator/Quality Assurance Coordinator	07/15/2015

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S 0172  Bldg. 00	<p>lacked evidence of review of QAPI reports or activity.</p> <p>2. Review of the document titled PERFORMANCE IMPROVEMENT PLAN indicated The Governing Body has the overall responsibility for developing, maintaining and supporting the ongoing, comprehensive program. The document further indicated: The committee is charged with the following QAPI activities...Reports at least quarterly to the Governing Body. The Policy/Procedure/Plan was approved 2/11/15.</p> <p>3. On 6/24/15 at 10:50am, A1, Administrator/Quality Assurance Coordinator, verified GB meeting minutes lacked documentation of QAPI activity review and indicated QAPI reports were not sent to the GB.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and</p>						

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	<p>experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review and interview, the facility failed to maintain personnel records per facility policy for six of eighteen employees of the center, which included immunization records and post offer physicals.</p> <p>Findings include:</p> <p>1. Review of the facility's policy 130.1 Influenza Vaccination Program, approved 02/11/2015, indicated the following:</p> <p style="padding-left: 20px;">a. Based on the recommendations of CMS and CDC, all employees will be offered annually the current flu vaccine. Procedure: Employees will be notified of the availability of the vaccine. The employee will sign to accept the vaccination or decline it. If declined the employee must indicate the reason for declination. The Influenza Vaccine Program will be completed and placed in the employee's health record.</p> <p>2. Review of the following personnel files indicated:</p> <p style="padding-left: 20px;">a. Employee #N3 lacked a post offer physical and proof of immunization for</p>	S 0172	<p>1. The facility administrator has assumed the role of infection control officer and will be administering the flu vaccine to the employees and medical staff of the facility. The influenz vaccine was ordered on 6/29/15. All employees/medical staff members will either receive the vaccine or sign a declination with reason. Vaccinations will be administered starting 10/1/15 in order to coincide with the beginning of flu season. Responsibility Party: Facility Administrator/Infection Control Officer</p> <p>2. The facility administrator/infection control officer will review all employee health files for the appropriate proof of immunizations. Any missing documenttion will be requested from the employee. Responsible Party: Facility Administrator/Infection control officer Completion date: 7/20/15</p> <p>3. Going forward all new hires will be sent for post-offer physicals prior to their first day of employment.</p>	10/01/2015

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S 0230 Bldg. 00	<p>Rubella, Rubeola and varicella. Employee #N9 lacked evidence of a post offer physical examination. Employees #N3, N7, N9 and N11 lacked evidence of receiving a flu vaccination for the current flu season. Employees #P1 and P2 lacked evidence of having received a PPD or having done a TB questionnaire for the last year.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the governing body failed to provide for periodic review of the center and its operation by a utilization review (UR) or other committee of 3 or more duly licensed physicians having no financial interest in the facility.</p>	S 0230	The Governing Board and Medical Advisory Committee established a utilization committee comprised of members of the medical staff who do not have financial interest in the facility. The utilization committee will meet at least annually and report to the Governing Board via the Medical	07/09/2015

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S 0310 Bldg. 00	<p><b>Findings:</b></p> <p>1. Review of facility documents lacked documentation of periodic review of the center and its operation by a utilization review or any other committee of 3 or more duly licensed physicians having no financial interest in the facility.</p> <p>2. On 6/24/15 at 3:00pm, A1, Administrator, indicated the center did not have a UR committee, or any other comprised of 3 or more physicians without financial interest in the center, utilized to provide periodic review of center operations. No further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the quality assessment and</p>	S 0310	<p>Director/Chief of Staff.Responsible Party: UR Committee Chair, Medical Director and Facility Administrator UR Committee formed on 7/9/15</p> <p>The QAPI reports will be specifically identified in the</p>	07/15/2015			

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S 0320  Bldg. 00	<p>performance improvement program (QAPI) failed to evaluate 2 directly provided services (waived laboratory &amp; nursing).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of quality evaluation reports 6/2014 to 6/2015 and QAPI meeting minutes dated 5/13/15, 2/11/15, &amp; 7/1/14 lacked documentation of a QAPI meeting 4th quarter 2014 and lacked documentation of QAPI evaluation of the following directly provided services: Waived laboratory and Nursing services.</li> <li>On 6/24/15 at 10:50am, A1, Administrator/Quality Assurance Coordinator, confirmed laboratory and nursing services were not included in QAPI evaluations.</li> </ol> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer.</p>		<p>Governing Board meeting minutes. The QAPI reports are presented to the Medical Advisory Committee prior to the Governing Board and will now be presented in their entirety to the Governing Board by the facility administrator. The QAPI report will be modified to include additional elements including evaluation of "waived laboratory" and "nursing" services. Responsible Party: Facility administrator/Quality Assurance Coordinator Completion Date: QAPI report to be updated by 7/15/15.</p>		

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S 0526  Bldg. 00	<p>(B) Infection control. (C) Medication errors. (D) Response to patient emergencies. Based on document review and interview, the quality assessment and improvement program (QAPI) failed to evaluate 4 functions (discharge, transfer, medication errors, &amp; response to patient emergencies).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of quality evaluation reports 6/2014 to 6/2015 and QAPI meeting minutes dated 5/13/15, 2/11/15, &amp; 7/1/14 lacked documentation of a QAPI meeting 4th quarter 2014 and lacked documentation of QAPI evaluation of the following functions: discharge, transfer, medication errors, &amp; response to patient emergencies.</li> <li>On 6/24/15 at 10:50am, A1, Administrator/Quality Assurance Coordinator, confirmed the functions of discharge, transfer, medication errors, &amp; response to patient emergencies were not included in QAPI evaluations.</li> </ol> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)  (h) All nursing and other center</p>			S 0320	<p>The QAPI reports will be specifically identified in the governing board meeting minutes. The QAPI reports are presented to the Medical Advisory Committee prior to the Governing Board and will now be presented in their entirety to the Governing Board by the facility administrator. The QAPI report will be modified to include the additional elements including evaluation of "waived laboratory", "nursing" services, discharge and transfer, infection control, medication errors, response to patient emergencies and other aspects of providing quality patient care. Responsible Party: Facility Administrator/Quality Assurance Coordinator Completion Date: QAPI report to be updated by 7/15/15</p>		07/15/2015

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	<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 annual point of care competencies for glucometer testing and pregnancy testing for eleven (N1-N11) of eleven nursing personnel.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of facility policy 100, Competency Assessment System, approved 02/11/2015, indicates the following: It is the responsibility of the Governing Board, Administration and Center leadership to ensure that each Center employee is competent in knowledge/skills required and safe/effective use of equipment as appropriate to his/her responsibilities. Yearly competency assessment includes core competencies and work area competencies which address, but are not limited to age specific skills, use of equipment, and acceptable performance of new procedures.</li> <li>Review of eleven nursing staff personnel files indicated that, for eleven (N1-N11) of eleven, competencies for glucometer blood sugar testing and urine</li> </ol>	S 0526	<p>All active nursing staff (all registerd and licensed practical nurses) have completed competencies in point of care testing for the glucometer and urine pregnancy testing. Those staff members who are not currently scheduled to work will complete their competencies prior to providing patient care. The charge nurse and clinical director will monitor and add to the annual competency lists. Responsible Pary: Charge Nurse and Clinical Director Completion Date: All actively scheduled employees have completed competencies on or before 7/13/15.</p>	07/13/2015

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S 0732 Bldg. 00	<p>pregnancy tests had not been done for over one year.</p> <p>3. In interview, on 6/24/2015 at 1400 hours, staff member #1, Clinical Director and Administrator, confirmed the above, and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based on document review and interview, the medical staff (MS) failed to review bylaws and rules at least triennially (2011 to 2014).</p> <p>Findings:</p> <p>1. Review of documentation titled BYLAWS OF THE MEDICAL STAFF indicated These bylaws, together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active Medical Staff and become effective upon their adoption by the Governing Body. The document lacked</p>	S 0732	The medical staff have reviewed and approved the Medical Staff By-laws. The facility Administrator and Medical Director/Chief of Staff will take the by-laws to the medical staff for review and approval on an annual basis. Responsible Party: Facility Administrator and Medical Director	07/09/2015

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S 1146 Bldg. 00	<p>documentation of an adoption or review date.</p> <p>2. Review of MS meeting minutes dated 5/13/15, 2/11/15, &amp; 7/1/14 lacked documentation of MS review and/or approval of MS bylaws or rules. The facility lacked documentation of 4th quarter 2014 MS meeting minutes.</p> <p>3. Review of Governing Body (GB) meeting minutes indicated MS bylaws were approved 2/11/15.</p> <p>4. On 6/24/15 at 12:30pm, A2, Medical Records Coordinator, indicated documentation of MS approval date of their bylaws could not be found and verified that MS meeting minutes 2014 through 6/2015 lacked documentation of MS review or approval of the bylaws and/or rules.</p> <p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or</p>				

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	<p>maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and document review, the facility failed to maintain the blanket warmer at a safe temperature of not over 130 degrees Fahrenheit (F).</p> <p>Findings:</p> <p>1. On 6/23/2015, at 1230 hours, the blanket warmer which was located in the pre-operative area was observed. A thermometer located inside the warming device registered 152 degrees F. Temperatures were noted to have been logged on a daily basis for all of 2015, (with three as high as 170 degrees F). For the month of June, 2015, the temperature was 140 degrees F or more on 6/2, 3, 4, 8, 9, 10, 15, 16, 22 and 23/2015. The temperature log and a sign on the front of the warmer both indicated that the temperature is not to exceed 130 degrees F.</p> <p>2. Policy 180.1 Blanket and Fluid Warmers, approved 02/11/2015, indicated each warming cabinet chamber is monitored daily and the temperature is recorded on a daily log sheet. Deviation from acceptable range is reported immediately for maintenance.</p> <p>a. The temperature for warming</p>	S 1146	<p>The charge nurse contacted the bio-mechanical contractor regarding the blanker warmer exceeding the recommended temperature. The contractor is scheduled to be on site and will evaluate the blanket warmer at that time. The temperature control has been turned down in an effort to reduce the temperature and will be monitored for change. If no change is identified, we will stop using the warmer until it can be repaired or replaced.</p> <p>Responsible Party: Charge Nurse, Facility Administrator and Bio-Mechanical Contractor Completion Date: To be evaluated for repair or replacement by 7/24/15.</p>	07/24/2015

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S 1166 Bldg. 00	<p>blankets cannot exceed 130 degrees F. Higher temperatures have been known to cause skin burns.</p> <p>3. No documentation was provided prior to exit that the high temperatures had been reported to maintenance for repair.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on observation, document review and interview, the center failed to provide evidence of preventive maintenance (PM) on 3 patient care equipment items (wheelchair, nurse call system, and a</p>	S 1166	The charge nurse contacted the bio-mechanical contractor to perform preventative maintenance evaluation on the facility wheelchairs and nurse call system. The contractor is	07/24/2015

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NAME OF PROVIDER OR SUPPLIER  NOVAMED EYE SURGERY CENTER OF NEW ALBANY LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 520 W FIRST ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>microscope device).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the policy &amp; procedure (P&amp;P) titled EQUIPMENT REPAIR AND MAINTENANCE indicated: Equipment used on or for patients will be checked by a qualified biomedical person at least twice a year.</li> <li>On 6/23/15 between 2:30pm and 3:30pm during tour of the physical plant, in a storage room with the door labeled Pre-op 3, was packaged patient supplies, wheel chairs, and medical equipment. In a cabinet in the room was a microscope type device labeled as Wild M650 Scope.</li> <li>Review of PM documentation between 1/2014 and 6/2015 lacked documentation of PM for the following: wheel chair(s), Wild M650 Scope, or Nurse Call System.</li> <li>On 6/24/15 at 12:37pm, A2, Medical Records Coordinator, indicated the center did not have evidence of PM for any wheelchair or the Nurse Call System. He/she also indicated that the Wild M650 Scope was not in use, therefore did not have PM and acknowledged that the scope was in an area with usable patient supplies/equipment, and did not have an</li> </ol>		<p>scheduled to be on site and will perform these evaluations at that time. The Wild M650 microscope head is unusable without a working base and has been tagged as Out of Service. Responsible Party: Charge Nurse, Facility Administrator and Bio-Mechanical Contractor Completion Date: to be completed by 7/24/15</p>				

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	out of use/service notice.				