

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001174	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/01/2012
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NAME OF PROVIDER OR SUPPLIER METRO SPECIALTY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MISSOURI AVE, BLDG 18 JEFFERSONVILLE, IN 47130
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 012244</p> <p>Survey Date: 7/31/2012 through 8/1/2012</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: cloughlin 08/06/12</p>	S0000	<p>There is no deficiency list here. Lee Ann Massey, Administrator, Metro Specialty</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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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 employee file review and interview, the facility failed to ensure 7 of 7 direct care providers had documentation of annual evaluations (#P1, P2, P4, P5, P6, P8, and P9).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The employee file for staff member #P1, hire date 01/18/10, indicated an annual evaluation dated 11/29/10. The employee files for staff members #P2, P4, P5, and P6, all hired in 2010, indicated evaluations, but no signatures or dates to indicate when they were completed and by whom. The employee files for 2 agency 	S0156	<p>Signature lines were added on employee evaluations and retro-actively signed. Date of completion 8-22-2012. Future evaluations will include both reviewers signature and employees signature and date. We will include future reviews on agency personnel with consistent employment at Metro Specialty Surgery Center. Employees are evaluated once per year and the administrator will audit the files to make sure evaluations are signed and dated at time they are completed. The facility administrator is the responsible person to implement and monitor this plan of correction.</p>	08/22/2012			

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	<p>nurses, #P8 and P9, lacked documentation of any evaluations. The files also lacked documentation of hire dates.</p> <p>4. At 3:45 PM on 08/01/12, staff member #P1 confirmed the employee file findings. He/she indicated the evaluation forms were revised and apparently the spaces for dates and signatures were omitted. He/she also indicated his/her evaluation was completed in January, but confirmed it was not in the file. He/she indicated he/she was not aware complete files needed to be kept for the agency staff and no evaluations were completed on them.</p>				

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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 documentation review and staff interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competency for 6 of 6 medical staff members (#9, 10, 11, 12, 13, and 14).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The medical staff members (#9, 10, 11, 12, 13, and 14) credential files were reviewed at 12:30 PM on 7/31/2012. The files lacked evidence of CPR competency. At 1:45 PM on 7/31/2012, staff member #1 indicated the credential files do not have evidence within 	S0162	<p>Per the Indiana State Health Department surveyor's suggestions, Metro Specialty created a new policy which is as follows: Medical Staff CPR requirement Policy: In our facility, the anesthesiaphysicians are not required to be ACLS certified, although it is highly recommended. All other physicians are not required to be certified. Documentation of state licensure and/or board certification constitutes CPR competency as determined by the Board of Managers. We created this new policy and had policy approved by Board of Managers at the August 22 meeting regarding CPR competency. The facility administrator is the responsible person to implement and monitor this plan of correction by quarterly review of credentialing files and Board certification in physician files.</p>	08/22/2012			

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	<p>them of having CPR competency. The staff member confirmed the only written procedure for whom was to have CPR competency was either in the Medical Staff Bylaws and the employees job descriptions. The Medical staff Bylaws noted that the CRNA are to have current ACLS certification. The staff member confirmed the Medical Staff Bylaws did not mention anything about the medical staff CPR competency requirements and nothing was documented that the medical staff are not to have CPR competency.</p>		<p>The facility administrator is the responsible person to implement and monitor this plan of correction.</p>		

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S0166	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on documentation review and staff interview, the facility failed to initially review Administrative policies and procedures for Metro Specialty Surgery Center.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of Administrative policy and procedures indicated Anesthesia, Surgery, Aseptic Techniques, Infection Control and Employee Health policies and procedures had not been reviewed. Metro Specialty Surgery Center Governing Body minutes were reviewed since January 28, 2012 which included 9 meetings of the 	S0166	<p>Policies and procedures had been approved on April 19, 2010 prior to commencement of first surgeries on May 1, 2010 on behalf of approval of Board of Managers (documentation available in "Governance" Folder; however, Administrator was on vacation during unannounced survey making some documents unavailable to Nurse Manager. Policies and Procedures were again approved at the August 22, 2012 Board meeting which is documented in the meeting minutes. Upon Administrator's return from vacation, she educated Nurse Manager on location of Governance documents so she would know where documents could be found in lieu of Administrator's absence if future situation should occur. The facility administrator is the responsible person to implement and monitor this plan of correction.</p>	08/22/2012			

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	<p>Medical Staff and Administration.</p> <p>The minutes had no documented evidence that the surgery center's policies and procedures were reviewed by the Governing Body.</p> <p>3. At 10:15 AM on 8/1/2012, staff member #1 indicated he/she could not locate when the Administrative Policy and Procedures were reviewed and approved by the Governing Body. The staff member indicated all the policies are presently under review so they can be approved by the Governing Body; however, he/she confirmed there was no evidence that the surgery center's policies and procedures were ever reviewed and approved by the Governing Body since January 28, 2010. The staff member indicated the facility received their first patient on April 1st, 2012.</p>				

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S0300	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and staff interview, the facility failed to ensure there was a organized, center-wide, comprehensive quality assessment and improvement (QAPI) program where all areas of the center participate.</p> <p>Findings Included:</p> <p>1. Metro Specialty Surgery Center Medical Staff Bylaws approved January 28, 2010 Article V section II states, "Committees shall be standing and special. All committees shall maintain a record of attendance and of their proceedings. The committees of the staff shall be: Medical Executive Committee, Credentials and Peer Review Committee, and Quality Review Committee." The Quality Assurance Committee was defined in the Medical staff Bylaws. The committee responsibilities were written procedures for how the surgery center was</p>	S0300	<p>20 services are now a part of our new QAPI plan. These are listed in the attached supporting documents. Will provide separate Quality Assurance Meeting Minutes from Board Meeting Minutes going forward to address our ongoing quality measures and improvements. We will ensure this happens following our upcoming board meetings of the QA committee starting with the next meeting 1/8/2013 with our newly adopted QA plan that the State Recommended new criteria for in August and the Metro Board of Managers subsequently approved in August. AUGUST: In the first 30 days from our State Survey, we developed the new QAPI plan. SEPTEMBER-DECEMBER: In the next 90 days we plan to gather and trend data we collected in the plan and seek corrective measures if needed by changing services or processes. JANUARY: In January we plan to</p>	08/22/2012			

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	<p>to maintain an ongoing plan how to evaluate all services that are provided. The Medical Staff Bylaws structure for the Quality Committee was to meet quarterly. Article V section II subsection F-13 states, "The function of the committee will address appropriate continuous Quality Assurance studies with emphasis on the following areas: Identification of the process; Assessment of the process; Development of Recommendations; and Reassessment of the study at a future date."</p> <p>2. Staff member #1 only provided 2 Quality Assurance Committee meetings since January 28th, 2010: 11/9/10 and 1/04/11. Therefore, the surgery center only provided 2 of 13 Quality Assurance Committee meeting minutes since the opening of the facility on April 1st, 2012.</p> <p>3. Staff member #1 provided the Quality Assurance Plan. The plan consisted of 18 indicators/services. Each indicator had a criteria and a standard each indicator was to achieve. However, the facility could not provide the reports for any of the indicators the Quality Assurance plan indicated.</p> <p>4. At 2:20 PM on 8/1/2012, staff member #1 indicated he/she was on the committee and each indicator was discussed.</p>		<p>present the data to the QA committee at the next meeting on January 8, 2013. The facility administrator is the responsible person to implement and monitor this plan of correction.</p>				

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	However, the staff member indicated reports were not maintained on each indicator if selected QA Plan Indicators were meeting their goals. The staff member confirmed the Quality Assurance plan does not have all the services the surgery center provides. The staff member indicated the facility had their first patient on April 1st, 2012.			

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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.</p> <p>Based on document review and staff interview, the facility failed to ensure 14 services provided are included in its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Metro Specialty Surgery Center Medical Staff Bylaws approved January 28, 2010 Article V section II describes that all services provided by the surgery center shall be evaluated for effectiveness. The Medical Staff Bylaws requires the Quality Assurance Committee to maintain documented and appropriate continuous Quality Assurance Studies of each service provided by the surgery center.</p>	S0310	<p>20 services are now a part of our new QAPI plan. These are listed in the attached supporting documents. The criteria of met/unmet is an additional criteria recommended by the State surveyor that we have added to our plan. We will use this criteria to evaluate services monthly as defined for each service individually in the QAPI plan. The facility administrator is the responsible person to implement and monitor this plan of correction.</p>	08/22/2012			

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	<p>2, The facility was asked at 2:00 PM on 7/31/2012 and 2:40 PM on 8/1/2012 studies that were done on the following Indicators: Biohazard, Biomedical, Housekeeping, Laboratory, Laundry/Linen, Maintenance, Medical Record, Nursing, Pharmacy, Radiology, Security, Tissue Transplant, Transcription, and Pest Control. The facility could not provide documentation on indicators showing the results of evaluations of each of the selected indicators.</p> <p>3. At 2:40 PM on 8/1/2012, staff member #1 indicated he/she could not provide documentation that any of the indicators in the QA Plan are evaluated. The staff member could not locate any studies as described in the Medical Staff Bylaws.</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 observation and staff interview, the facility could not ensure the following services: Discharge and Transfer; Infection Control, Medical Errors, and Response to Patient Emergencies, are being evaluated effectively by the Quality Assurance Committee.</p> <p>Findings included:</p> <p>1. Metro Specialty Surgery Center Medical Staff Bylaws approved January 28, 2010 Article V section II describes that all services provided by the surgery center shall be evaluated for effectiveness. The</p>	S0320	<p>20 services are now a part of our new QAPI plan. These are listed in the attached supporting documents. The criteria of met/unmet is an additional criteria recommended by the State surveyor that we have added to our plan. We will use this criteria to evaluate services monthly as defined for each service individually in the QAPI plan. This plan was approved by the Board at the August 22, 2012 meeting. The facility administrator is the responsible person to implement and monitor this plan of correction.</p>	08/22/2012			

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	<p>Medical Staff Bylaws requires the Quality Assurance Committee to maintain documented and appropriate continuous Quality Assurance Studies of each service provided by the surgery center.</p> <p>2. The facility was asked at 2:00 PM on 7/31/2012 and 2:40 PM on 8/1/2012 studies that were done on the following Indicators: Discharge and Transfer; Infection Control, Medical Errors, and Response to Patient Emergencies. The facility could not provide documentation on the above services showing the results of evaluations.</p> <p>3. At 2:40 PM on 8/1/2012, staff member #1 indicated he/she could not provide documentation that any of the services listed in the QA Plan are evaluated. The staff member could not locate any studies as described in the Medical Staff Bylaws.</p>				

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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 documentation review and staff interview, the facility failed to ensure there were documented action and documented outcome by the Quality Assurance Committee on the effectiveness of the criteria used to ensure all 18 services the surgery center provided standards/goals were met.</p> <p>Findings included:</p> <p>1. Metro Specialty Surgery Center Medical Staff Bylaws approved January 28, 2010 Article V section II subsection F-13 states, "The function of the committee will address appropriate continuous</p>	S0328	<p>We examined the services critical to providing effecient and safe care with particular attention to infection control looking at our key constituents: patients, staff, guests and doctors at Metro Specialty and created a list of services in our new evaluation form based on the criteria of MET or UNMET. The MET/UNMET criteria was recommended to us by our inspector as a simple but effective way of looking at these services. Our Board approved the system, which is essentially a new form with additonal criteria and services, on August 22, 2012 at our quarterly meeting. This plan is attached at supporting documents: QA. The facility administrator is the responsible person toimplement and monitor this plan of correction.</p>	08/22/2012			

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	<p>Quality Assurance studies with emphasis on the following areas: Identification of the process; Assessment of the process; Development of Recommendations; and Reassessment of the study at a future date." The Medical Staff Bylaws requires the Quality Assurance Committee to maintain documented and appropriate continuous Quality Assurance Studies of each service provided by the surgery center.</p> <p>2. The facility was asked at 2:00 PM on 7/31/2012 and 2:40 PM on 8/1/2012 studies that were done on the services listed on the QA plan. The facility never provided the documented evidence of the studies that was need for the Quality Assurance Committee to make quality recommendations needed for the Medical Staff.</p> <p>3. At 2:40 PM on 8/1/2012, staff member #1 indicated he/she was on the Quality Assurance Committee. The committee has not maintained</p>				

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	documentation on the evaluation and recommendations on each service the surgery center provided.				

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S0422	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk. Based on review of product information, employee files review, policy review, and interview, the facility failed to ensure TB testing was performed per policy, manufacturer's recommendations and CDC guidelines for 9 of 9 staff member files reviewed (#P1- P9).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The manufacturer's product information for Tubersol, the solution used for TB testing, indicated the tests should be placed and read within 48 to 72 hours for accuracy. 2. Review of the employee file for staff member #P1 indicated a TB test placed on 06/05/12 and read on 06/08/12, but lacked documentation of a time for the reading, making it unable to determine the reading between 48 and 72 hours after placement. 3. Review of the employee file for staff member #P2 indicated a TB test placed on 	S0422	<p>We revised our forms to include date and time. The Nurse Manager reviewed the State findings with our Health Nurse so she can be aware of the deficiencies with our TB timing documentation. During the weeks prior to the State Survey, Metro appointed a new Health Nurse to handle the upkeep on the Employee Files. We see this step as progressive in maintaining our files and as an important part of our infection control program. In response to the lack of timing our TB testing, a time line was added to the facility's TB test forms and each test going forward will be time stamped on the date that it is given and the date that it is read. The Nurse Manager will be responsible to implement and monitor this plan of correction and protocols per manufacturer and CDC guidelines.</p>	08/22/2012			

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	<p>05/21/12 and read on 05/24/12, but lacked documentation of a time for the reading, making it unable to determine the reading between 48 and 72 hours after placement.</p> <p>4. Review of the employee file for staff member #P3 indicated a TB test placed on 11/02/11 and read on 11/3/11 and again on 11/04/11, but lacked documentation of a time for the reading, making it unable to determine the reading between 48 and 72 hours after placement.</p> <p>5. Review of the employee file for staff member #P4 indicated a TB test placed on 06/25/12 and read on 06/27/12, but lacked documentation of a time for the reading, making it unable to determine the reading between 48 and 72 hours after placement.</p> <p>6. Review of the employee file for staff member #P5 indicated a TB test placed on 05/18/12 and read on 05/21/12, but lacked documentation of a time for the reading, making it unable to determine the reading between 48 and 72 hours after placement.</p> <p>7. Review of the employee file for staff member #P6 indicated a TB test placed on 06/25/12 and read on 06/27/12, but lacked documentation of a time for the reading, making it unable to determine the reading between 48 and 72 hours after placement.</p>			

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	<p>8. Review of the employee file for staff member #P7 indicated a TB test placed on 05/22/12 and read on 05/25/12, but lacked documentation of a time for the reading, making it unable to determine the reading between 48 and 72 hours after placement.</p> <p>9. The file for the agency staff nurse, #P8, lacked documentation of any TB testing.</p> <p>10. Review of the employee file for agency staff member #P9 indicated a TB test placed on 03/14/12 and read on 03/16/12, but lacked documentation of a time for the reading, making it unable to determine the reading between 48 and 72 hours after placement.</p> <p>11. The facility policy "Infection Control for Employee Health", effective 01/28/10, indicated, "...b. Baseline PPD (Purified Protein Derivative- TB testing) is mandatory for all employees. A baseline two-step PPD will be performed on new employees that do not have a documented negative PPD during the preceding 12 months."</p> <p>12. At 3:30 PM on 08/01/12, staff member #P1 confirmed the lack of times for the TB testing and also confirmed the Infection Control Program followed CDC guidelines, which specified TB tests were</p>						

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	to be read between 48 and 72 hours after placement.			

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S0630	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure the medical records were accurate and complete for 9 of 25 patient records reviewed (#N1, N2, N5, N6, N9, N11, N15, N21, and N22).</p> <p>Findings included:</p> <p>1. The facility policy "Medical Records", effective January 28, 2010, indicated, "A. All clinical entries in the patient's medical record shall be accurately dated and authenticated. ...C. All entries on the medical record shall be legible, factual and in chronological order."</p> <p>2. The "Transportation of Patient" transfer form for patient #N1 from 05/30/12 lacked documentation of vital signs and patient status when transferred in the spaces for this information.</p>	S0630	<p>We will continue to educate and reinforce complete and accurate documentation from staff and physicians. We will continue monthly internal chart audits and quarterly external auditor chart audits and determine trends in charting deficiencies. Upcoming chart audits will be employee focused so we can target errors and take corrective action based on individual employee mistakes rather than at-large group audits. These focused chart audits will be more effective in targeting education needs on a person -by-person basis. The Nurse Manager is the responsible person to implement and monitor this planof correction.</p>	08/22/2012			

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	<p>3. The "Post Anesthesia Care Record" from 01/16/12 for patient #N2 lacked documentation of time of arrival and procedure in the spaces for this information.</p> <p>4. The "Post Anesthesia Care Record" from 03/22/12 for patient #N5 lacked documentation of procedure, discharge time, and discharge scoring in the spaces for this information.</p> <p>5. The "Consent for Anesthesia Services" form from 05/07/12 for patient #N6 lacked a signature, date, and time from the anesthesiologist/CRNA.</p> <p>6. The "Transportation of Patient" transfer form for patient #N9 from 11/10/11 lacked documentation of vital signs and patient status when transferred in the spaces for this information.</p> <p>7. The "Post Anesthesia Care Record" from 01/25/12 for patient #N11 indicated vital signs were taken at 11:35 AM, 11:45 AM, 12:00 PM, and 12:15 PM, but the discharge time was documented as 11:22 AM.</p> <p>8. The "Informed Consent" form from 05/04/12 for patient #N15 lacked a signature, date, and time from the surgeon.</p>				

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	<p>9. The "Post Anesthesia Care Record" from 02/28/12 for patient #N21 lacked documentation of discharge time, discharged with a responsible person, and discharge scoring in the spaces for this information.</p> <p>10. The "Post Anesthesia Care Record" from 02/20/12 for patient #N22 lacked documentation of discharge scoring in the space for this information.</p> <p>11. At 3:45 PM on 08/01/12, staff member #P1 confirmed the medical record findings and indicated the blank spaces on the forms should have been completed.</p>				

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S0772	<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 policy review, medical record review, and interview, the facility failed to ensure a history and physical was completed according to policy and on the chart for 6 of 25 medical records reviewed (#N7, N8, N15, N21, N23, and N25).</p>	S0772	We will continue to educate and reinforce complete and accurate documentation from staff and physicians. We will continue monthly internal chart audits and quarterly external auditor chart audits and determine trends in charting deficiencies. Upcoming chart audits will be individual	08/22/2012			

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	<p>Findings included:</p> <ol style="list-style-type: none"> 1. The facility policy "Charting", effective January 28, 2010, indicated, "...Completion of the medical record shall be the responsibility of the admitting physician. Charts are to be completed within 30 days." 2. The facility policy "Required Documentation", effective January 28, 2010, indicated, " All patients require a history and physical which is documented and the documentation is placed in patient record prior to surgery. The history and physical must be performed within thirty days prior to surgery and reviewed and initialed by physician within seven days prior to surgery. The history and physical must be inclusive of the heart and lungs." 3. The "History and Physical" form for patient #N7 indicated dictation on 01/02/12, but lacked the signature of the physician. 4. The "History and Physical" form for patient #N8 from 01/03/12 indicated "Other" by every item in the physical exam instead of "WNL" (within normal limits). If "Other" was marked, there should have been documentation of what was meant by that. 		<p>focused so we can target errors and take corrective action based on individual employee or physician mistakes rather than at-large group audits. These focused chart audits will be more effective in targeting education needs on a person -by- person basis. The Nurse Manager will continue to follow up with physicians on H and P deficiencies and we will be communicative to our Medical Director if or when quarterly external chart audits continue to show problems with H and P's. The Nurse Manager is the responsible person to implement and monitor this planof correction.</p>				

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	<p>5. The "History and Physical" form for patient #N15 was signed by the physician, but had "5/ /12" written on the line for date.</p> <p>6. The "History and Physical" form for patient #N21 indicated an exam date of 02/09/12, but a physician signature date of 02/23/12. The patient had surgery on 02/28/12. The form was not checked or signed in the area "No changes in H&P assessment".</p> <p>7. The "History and Physical" form for patient #N23 indicated a date of 02/21/12 and a physician signature, but the form was not completed with a physical exam.</p> <p>8. The "History and Physical" form for patient #N25 indicated a printed History and Physical from 05/19/11 and a facility "Surgical History and Physical Examination" that was blank except for a check in "No changes in H&P assessment" and a physician signature dated 04/04/12, the date of the procedure.</p> <p>9. At 4:00 PM on 08/01/12, staff member #P1 confirmed the medical record findings.</p>			

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S0800	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)</p> <p>The anesthesia service is responsible for all anesthesia administered in the center as follows:</p> <p>(1) The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following: Based on documentation review and staff interview, the facility failed to ensure medical staff policies and procedures are approved by the Governing Body.</p> <p>Findings included:</p> <p>1. Review of Administrative policy and procedures indicated Anesthesia, Surgery, Aseptic Techniques, Infection Control and Employee Health policies and procedures were not reviewed. None of the policies and procedures that were reviewed on 7/31/2012 and 8/1/2012 had an approved date when the policy was approved by the Governing Body.</p>	S0800	<p>Policies and procedures had been approved on April 19, 2010 prior to commencement of first surgeries on May 1, 2010 on behalf of approval of Board of Managers (documentation available in "Governance" Folder; however, Administrator was on vacation during unannounced survey making some documents unavailable to Nurse Manager. Upon Administrator's return from vacation, she educated Nurse Manager on location of Governance documents so she would know where documents could be found in lieu of Administrator's absence if future situation should occur. The facility administrator is the responsible person to implement and monitor this plan of correction.</p>	08/22/2012			

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	<p>2. Metro Specialty Surgery Center Governing Body minutes were reviewed since January 28, 2012 which included 9 meetings of the Medical Staff and Administration. The minutes had no documented evidence that the surgery center's policies and procedures were evaluated and approved by the Medical Staff and/or Governing Body.</p> <p>3. At 10:15 AM on 8/1/2012, staff member #1 indicated he/she could not locate where the Administrative Policy and Procedures were reviewed and approved by the Medical Staff. The staff member indicated all the policies are being presently under review so they can be approved by the Governing Body; however, he/she confirmed there was no evidence that the surgery center's policies and procedures had been reviewed and approved by the Governing Body.</p>				

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S0882	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(D)</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>(D) A requirement for adequate provision of immediate postoperative care.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure the post-operative care was administered according to policy for 7 of 25 patients reviewed (#N3, N4, N5, N7, N12, N19, and N20).</p> <p>Findings included:</p> <p>1. The facility policy "Admission of Patient to PACU (post-anesthesia care unit)", effective January 28, 2010, indicated, "...3. The protocol for vital sign monitoring is, unless the physician requests differently, vital signs every 5 minutes times 3 and then every 15 minutes until discharge with continuous EKG(electrocardiogram) and pulse oximeter monitoring.)</p>	S0882	The Nurse Manager reviewed the protocol for proper vital signs documentation to ensure PACU nurses understood charting and State findings on deficiencies in charting. In the next 90 days, the Nurse Manager will develop and lead a QA study on vital signs monitoring with goal that the education from 8/24/2012 shows improvement from an August 2012 baseline. The Nurse Manager is responsible for monitoring and implementing this corrective plan of action.	08/24/2012			

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	<p>2. The "Post Anesthesia Care Record" from 01/30/12 for patient #N3 indicated vital signs at 0812 and 0817, but a discharge time of 0905. There were no physician orders requesting different criteria.</p> <p>3. The "Post Anesthesia Care Record" from 02/06/12 for patient #N4 indicated vital signs at 0852, 0857, and 0905, but there was no blood pressure at 0905. There were no physician orders requesting different criteria.</p> <p>4. The "Post Anesthesia Care Record" from 03/22/12 for patient #N5 indicated vital signs at 0813, 0815, 0820, 0837, 0858, and 0913, but there was no blood pressure for any of the times except 0813. There were no physician orders requesting different criteria.</p> <p>5. The "Post Anesthesia Care Record" from 01/05/12 for patient #N7 indicated vital signs according to protocol from 1012 until 1130, then every 30 minutes until 1330. There were no physician orders requesting different criteria.</p> <p>6. The "Post Anesthesia Care Record" from 02/03/12 for patient #N12 indicated vital signs at 0746, 0751, 0755 (written over/changed), and 0813, but a discharge</p>			

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	<p>time of 0850. There were no physician orders requesting different criteria.</p> <p>7. The "Post Anesthesia Care Record" from 01/10/12 for patient #N19 indicated vital signs at 1120, 1125, 1130, and 1145, but a discharge time of 1215. There were no physician orders requesting different criteria.</p> <p>8. The "Post Anesthesia Care Record" from 02/08/12 for patient #N20 indicated vital signs according to protocol, but the last one was at 1445 and the discharge time was 1535. There were no physician orders requesting different criteria.</p> <p>9. At 4:00 PM on 08/01/12, staff member #P1 confirmed the medical record findings</p>				

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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, policy review and staff interview, the facility failed to store health care supplies in a safe manner in the Employee Breakroom and failed to maintain a safe environment for patients and staff by discarding outdated supplies, securing gas tanks, and monitoring the warming cabinets.</p> <p>Findings included:</p> <p>1. At 11:30 AM on 7/31/2012, the Employee Breakroom was inspected. A storage shelf was located in the room along the wall opposite from the wall where the</p>	S1146	<p>Point of origin for facility supplies changed to storage area adjacent to the sterile corridor. No patient supplies will be kept or unloaded in the employee lounge from this point forward. Compliance will be monitored by Administrators daily facility rounding of employee lounge. Expired vacutainer sets and blood draw tubes discarded and new ones obtained from lab. Will include in monthly checks for expired goods. Compliance will be monitored by Nurse Managers monthly rounding of storage within clinical areas. Daily gas room check will include checking to ensure gas cylinders are secured to wall per facility policy. Compliance will be monitored by Nurse Managers daily rounding of clinical areas. Sign posted on warmer indicating no fluids to be placed inside. Findings reviewed with staff and facility policy reinforced.</p>	08/24/2012			

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	<p>employee refrigerator, microwave, coffee maker, counter and cabinets, sink, and employee break room table with a television. The storage shelf had 3 cans of gallon paint with evidence of paint drips on the outside of the cans. On the same shelves were fluid barrier bags, bedside bags, large prep trays, Luer slip 60 cc syringes, sponges, assorted IV solution bags, and other health care supplies. The room also had three carts containing sterile supplies that are for the surgery suites. Those supplies were not removed from the breakroom until 3:00 PM.</p> <p>2. The Floor Plan of the surgery center identifies the staff lounge being the breakroom and not a storage room.</p> <p>3. At 1:00 PM on 7/31/2012, staff member #1 indicated the surgery center must use the Employee Breakroom also as a storage room because there was no other room in the surgery center that can be the</p>		Compliance will be monitored by Nurse Managers daily facility rounding of clinical areas.		

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	<p>designated storage room for the supplies located in the breakroom. The staff member indicated most supplies are taken to areas where they should go; however, excess supplies and supplies/equipment that will be returned to the vendor must be stored in the breakroom.</p> <p>4. During the tour of the nurses' station at 1:10 PM on 07/31/12, accompanied by staff member #P1, the following items were observed in the lower cabinet:</p> <p>A. BD vacutainer sets, 32 of 32, with an expiration date of 02/2012. B. Blue top lab tubes, 4 of 4, with an expiration date of 01/2011. C. Red top lab tubes, 2 of 2, with an expiration date of 12/2011.</p> <p>5. During the tour of the gas storage closet at 1:20 PM on 07/31/12, accompanied by staff member #P1, the large oxygen tank nearest the door was observed unsecured with a chain clasped onto the chain of the tank next to it. Three medium size gas tanks were</p>						

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	<p>observed sitting on the floor of the closet, unsecured and not in any type of holder.</p> <p>6. During the tour of the surgical area at 1:30 PM on 07/31/12, accompanied by staff member #P1, two 500 milliliter bottles of 0.9% sodium chloride solution for irrigation were observed in the warming cabinet for blankets. The cabinet temperature registered 130 degrees Fahrenheit.</p> <p>7. The facility policy "Medical Gases", effective January 28 ,2010, indicated, "...B. All tanks shall be secured with chains or put into a storage cart to prevent tipping or falling."</p> <p>8. At 2:00 PM on 07/31/12, staff member #P1 indicated the supplies should be checked monthly for outdates and confirmed the gas tanks were not secured per policy. He/she also indicated the warming cabinets were only for blankets and the bottles of solution should not</p>			

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	have been in there since fluids had to be stored at a lower temperature.				