

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001053	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/31/2012
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NAME OF PROVIDER OR SUPPLIER VALLEY SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 220 E VIRGINIA ST EVANSVILLE, IN 47711
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Q0000	<p>This visit was for a Federal recertification survey.</p> <p>Facility #: 007651</p> <p>Survey Dates: 7-30/31-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>QA: claughlin 08/03/12</p>	O0000		

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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Q0162	<p>416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ul style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on document review and interviews, the facility failed to ensure the correct date was placed on the history and physical exam forms for 4 of 4 medical records (N12, N16, N17, and N18).</p> <p>Findings include:</p> <p>1. Review of patient #N12 medical record prior to procedure indicated the following: (A) Document titled "HISTORY AND PHYSICAL" had exam date listed as 7/31/12. (The document was copied prior to the patients procedure)</p>	Q0162	The medical office administrator and scheduling staff responsible for typing H&P's were informed of deficiency and correct standard. Due to their computer system, the date of the procedure must be on the top of the form to generate the correct date on the op-note. To fix the problem, instead of saying date of exam on the top of the form, it will say date of surgery. The date of the patients last office visit will be correctly documented under date of last physical. If greater than 30 days H&P will be completed day of surgery. The center manager will be responsible for making sure this is corrected. To prevent in the future, will be added to	08/21/2012	

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	<p>2. Review of the history and physical exam form for patient #N16 prior to his/her procedure indicated the following: (A) Document titled "HISTORY AND PHYSICAL" had exam date listed as 7/31/12. (The document was copied by staff member #A1 prior to the patient entering the surgery area.)</p> <p>3. Review of history and physical exam form for patient #N17 prior to his/her procedure indicated the following: (A) Document titled "HISTORY AND PHYSICAL" had exam date listed as 7/31/12. (The document was copied by staff member #A1 prior to the patient entering the surgery area.)</p> <p>4. Review of history and physical exam form for patient #N18 prior to his/her procedure indicated the following: (A) Document titled "HISTORY AND PHYSICAL" had exam date listed as as 7/31/12. (The document was copied by staff member #A1 prior to the patient entering the surgery area.)</p> <p>5. Patient #N12 indicated in interview at 10:15 a.m. on 7/31/12 that he/she saw M.D. #1 for exam on 6/7/12.</p> <p>6. Staff member #A1 verified at 2:20 p.m. on 7/31/12 that patient #N16 was</p>		ongoing chart review done monthly by CQI. Staff was inserviced on 8-7-12 on H&P date requirements.				

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	<p>last seen by M.D. #1 on 6/8/12.</p> <p>7. Staff member #A1 verified at 2:40 p.m. on 7/31/12 that patient #N17 was last seen by M.D. #1 on 6/11/12.</p> <p>8. Staff member #A1 verified at 3:00 p.m. on 7/31/12 that patient #N18 was last seen by M.D. #1 on 6/8/12.</p>			

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Q0181	<p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice.</p> <p>Based on observation, staff interview, and document review, the facility failed to ensure single dose vials of medications were used for only 1 patient for 1 operating room (OR) observed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During observation in OR #1 beginning at 11:40 a.m. on 7/31/12, the following was observed: (A) A 20 ml vial of sodium chloride with half of the contents gone and labeled as single dose vial was observed on the anesthesia cart when patient #N12 was brought into the room. (B) Anesthesia provider #1 used the vial of sodium chloride for patient #N12. 2. Anesthesia provider #1 indicated in interview at 12:10 p.m. on 7/31/12 that alcohol is used to wipe the top of the vial between patients. 3. RN #1 indicated in interview at 12:27 p.m. on 7/31/12 that the Sodium Chloride vial observed above is used for multiple patients and if any is left at the end of the day, it is discarded. 	00181	<p>To correct problem all remaining single dose vials will be used up on only one patient as per policy. Replacement of multidose vials were ordered for use when single dose vials are gone. Center Manager will be responsible for this. To prevent reoccurrence, staff inserviced on policy for use of single dose vials. Also stressed importance of always checking vial before use and not assuming substitutions are multidose. Will also be monitored quarterly by Infection Control Safe Injection Practices surveillance.</p>	08/02/2012			

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	<p>4. Staff member #1 indicated in interview at 1:00 p.m. on 7/31/12 that the manufacturer began sending 20 ml vials of Sodium Chloride instead of the usual 30 ml vials. Staff assumed the 20 ml were also multidose vials as previously ordered.</p> <p>5. Facility policy titled "Medication Administration" last reviewed/revised 11/22/11 states under procedure: "All medications, including eye drops, must be prepared and administered according to established policies and accepted standards of practice.</p>			

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Q0222	<p>4166.50(a)(1)(i) NOTICE - POSTING In addition, the ASC must - Post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.</p> <p>Based on observation and interview, the facility failed to include the name, address, and telephone number of a representative in the Indiana State Department of Health (ISDH) and the Web site for the Office of the Medicare Beneficiary Ombudsman with the Patient's Rights posted on the wall in the facility lobby.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the facility on 7-31-12 at 1340 hours with B#1 present, it was observed that the Patient's Rights posted on the wall in the lobby of the facility failed to include the name, address, and telephone number of a representative in the ISDH and the Web site for the Office of the Medicare Beneficiary Ombudsman. 2. Interview with B#1 on 7-31-12 at 1425 hours confirmed that the Patient's Rights posted on the wall in the lobby of the 	00222	<p>To correct problem the following contact information will be added to Patient Rights and Responsibilities in lobby as on our patient handout Department of State Health Services Phone # 317-233-1325 Address 2 North Meridian Street, Indianapolis, IN 46204-3006 Medicare 1-800-MEDICARE website www.medicare.gov/ombudsman/activities.asp Center Manager will be responsible for this Will be prevented from happening in the future by adding to original form from printers.</p>	08/20/2012

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	facility failed to include the name, address, and telephone number of a representative in the ISDH and the Web site for the Office of the Medicare Beneficiary Ombudsman.			

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S0612	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on document review and interviews, the facility failed to ensure the correct date was placed on the history and physical exam forms for 4 of 4 medical records (N12, N16, N17, and N18).</p> <p>Findings include:</p> <p>1. Review of patient #N12 medical record prior to procedure indicated the following: (A) Document titled "HISTORY AND PHYSICAL" had exam date listed as 7/31/12. (The document was copied prior to the patients procedure)</p> <p>2. Review of the history and physical exam form for patient #N16 prior to his/her procedure indicated the following: (A) Document titled "HISTORY AND PHYSICAL" had exam date listed as</p>	S0612	<p>The medical office administrator and scheduling staff responsible for typing H&P's were informed of deficiency and correct standard. Do to their computer system, the date of the procedure must be on the top of the form to generate the correct date on the op-note. To fix the problem, instead of saying date of exam on the top of the form, it will say date of surgery. The date of the patients last office visit will be correctly documented under date of last physical. If greater than 30 days H&P will be completed day of surgery. The center manager will be responsible for making sure this is corrected. To prevent in the future, will be added to ongoing chart review done monthly by CQI. Staff was in-serviced on 8-7-12 on H&P date requirements.</p>	08/21/2012			

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	<p>7/31/12. (The document was copied by staff member #A1 prior to the patient entering the surgery area.)</p> <p>3. Review of history and physical exam form for patient #N17 prior to his/her procedure indicated the following: (A) Document titled "HISTORY AND PHYSICAL" had exam date listed as 7/31/12. (The document was copied by staff member #A1 prior to the patient entering the surgery area.)</p> <p>4. Review of history and physical exam form for patient #N18 prior to his/her procedure indicated the following: (A) Document titled "HISTORY AND PHYSICAL" had exam date listed as as 7/31/12. (The document was copied by staff member #A1 prior to the patient entering the surgery area.)</p> <p>5. Patient #N12 indicated in interview at 10:15 a.m. on 7/31/12 that he/she saw M.D. #1 for exam on 6/7/12.</p> <p>6. Staff member #A1 verified at 2:20 p.m. on 7/31/12 that patient #N16 was last seen by M.D. #1 on 6/8/12.</p> <p>7. Staff member #A1 verified at 2:40 p.m. on 7/31/12 that patient #N17 was last seen by M.D. #1 on 6/11/12.</p>						

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	8. Staff member #A1 verified at 3:00 p.m. on 7/31/12 that patient #N18 was last seen by M.D. #1 on 6/8/12.			

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S1012	<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.</p> <p>Based on observation, staff interview, and document review, the facility failed to ensure single dose vials of medications were used for only 1 patient for 1 operating room (OR) observed.</p> <p>Findings include:</p> <p>1. During observation in OR #1 beginning at 11:40 a.m. on 7/31/12, the following was observed: (A) A 20 ml vial of sodium chloride with half of the contents gone and labeled as single dose vial was observed on the anesthesia cart when patient #N12 was brought into the room. (B) Anesthesia provider #1 used the vial of sodium chloride for patient #N12.</p> <p>2. Anesthesia provider #1 indicated in interview at 12:10 p.m. on 7/31/12 that</p>	S1012	<p>To correct problem all remaining single dose vials will be used up on only one patient as per policy. Replacement of multidose vials were ordered for use when single dose vials are gone. Center Manager will be responsible for this. To prevent reoccurrence, staff inserviced on policy for use of single dose vials. Also stressed importance of always checking vial before use and not assuming substitutions are multidose. Will also be monitored quarterly by Infection Control Safe Injection Practices surveillance.</p>	08/02/2012	

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	<p>alcohol is used to wipe the top of the vial between patients.</p> <p>3. RN #1 indicated in interview at 12:27 p.m. on 7/31/12 that the Sodium Chloride vial observed above is used for multiple patients and if any is left at the end of the day, it is discarded.</p> <p>4. Staff member #1 indicated in interview at 1:00 p.m. on 7/31/12 that the manufacturer began sending 20 ml vials of Sodium Chloride instead of the usual 30 ml vials. Staff assumed the 20 ml were also multidose vials as previously ordered.</p> <p>5. Facility policy titled "Medication Administration" last reviewed/revised 11/22/11 states under procedure: "All medications, including eye drops, must be prepared and administered according to established policies and accepted standards of practice.</p>						