

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001003	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/01/2011
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NAME OF PROVIDER OR SUPPLIER PREMIER SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11141 PARKVIEW PLAZA DRIVE, SUITE 200 FORT WAYNE, IN 46845
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S000000	The visit was for a licensure survey. Facility Number: 005385 Survey Date: 08-30-11 to 09-01-11 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Karilyn Tretter, RN Public Health Nurse Surveyor QA: claughlin 10/12/11	S000000		
S000028	410 IAC 15-2.2-2 SURVEY PROCEDURES 410 IAC 15-2.2-2 (c)(1) (c) All documents in legally reproducible form must be maintained within the center for the period required by statutes of limitations and must be made available upon request for inspection, including copying by representatives of the			

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>department as follows:</p> <p>(1) Items to include, but not limited to, the following:</p> <p>(A) Documents showing ownership, certified copy of articles of incorporation (if incorporated).</p> <p>(B) Constitution and bylaws of governing body.</p> <p>(C) Minutes of meetings of the governing body and committees thereof.</p> <p>(D) Minutes of meetings of the medical staff and committees thereof.</p> <p>(E) All documents pertaining to quality assurance and improvement of patient care and medical care.</p> <p>(F) A current roster of members of the medical staff with designated privileges.</p> <p>(G) Personnel records.</p> <p>(H) Medical records.</p> <p>(I) Reports pursuant to IC 16-21-2-6.</p> <p>Based on document review and interview, the facility failed to maintain medical records at the center for the period required by state law or otherwise obtain a waiver for medical record storage outside of the facility.</p> <p>Findings:</p> <p>1. On 08-30-11 at 1005, employee #A2 was requested to provide a waiver from the Indiana Department of Health indicating approval for offsite storage of medical records less than seven (7) years</p>	S000028	To correct the deficiency, on September 9, 2011 Rebecca Trimbur, Executive Director, submitted a request for a waiver to be provided for the off-site storage of medical records. On September 15, 2011 an order was issued to grant a waiver to Premier Surgery Center for off-site storage of medical records. The waiver went into effect 18 days after the order was issued.	10/03/2011

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S000100	<p>old and none was provided prior to exit.</p> <p>2. The policy/procedure Retrieval of Medical Records (revised 02-11) indicated the following: Medical Records for patients having been seen in excess of 1 year prior will be stored at an offsite facility that is clean, dry, and with controlled temperatures.</p> <p>3. During an interview on 08-30-11 at 1525, staff #A2 indicated that medical records prior to 2010 and less than seven (7) years old were being stored offsite at a document storage business.</p> <p>4. During an interview on 09-01-11 at 0930 hours, staff #A1 confirmed the facility lacked an offsite record storage waiver.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)</p> <p>Sec. 1.(a) The governing body shall function as the supreme authority of the center. The governing body shall assume full legal responsibility for determining, implementing, and monitoring policies governing the center's total operation and for ensuring that these policies are followed so as to provide quality health care in a safe environment. The governing body is legally</p>			

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	<p>responsible for the conduct of the center as an institution. The governing body shall do the following: Based on observation, policy/procedure review, interview, and facility documentation review, the governing body failed to ensure that ASC policies regarding outdated/expired items were implemented and monitored.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. During a tour of the ASC with E#11 on 8/31/2011, the following items were found: in the Clean Supply area - 4 packages of 4-0 Vicryl sutures with an expiration date of Jan. 2010, and, in the adult crash cart in the hallway off PACU - 1 Cardinal Health Medi-Vac Y-tubing connector with an expiration date of 2010/09 and one 1000cc IV bag of D51/2NS with an expiration date of 4/2011. 2. Premier Surgery Center Policy & Procedure "Inventory Supplies/Ordering", ADM 28, Developed: 1/1992, Last Review/Revision: 3/2011 includes "D. Expired items are removed from storage areas. Items that have expired may be..." 3. E#11 verified the expired items during the tour on 8/31/2011. 4. E#11 stated there is no checklist for the items in the Clean Supply area, although someone is assigned to check for outdated items in that area. The Adult Emergency Crash Cart Checklists for June, July, and August of 2011 were provided. That checklist includes, at the bottom of the page, things that are to be done monthly. This 	S000100	<ol style="list-style-type: none"> 1. To correct the deficiency, upon the 9/1/2011 exit interview, the facility removed identified items from patient care areas/the facility. 2. Following the identification of expired items in the facility, the Director (Brandy Miller) followed up with specific staff members responsible for monthly out date/expired supply checks within the areas which deficiencies were identified. All areas within the Center were then re-checked for expired items the week of September 5th, 2011. 3. September 9, 2011 staff meeting provided communication and open discussion of surveyor comments during survey and with closing meeting on the final day of the survey. Reiteration and review of Center's responsibility to provide quality health care in a safe environment through a systematic and consistent method of checking supply outdates to staff members. Center policy ADM 28- Supplies, Inventory, Ordering and Monitoring reviewed with staff. 4. The corrective action is being monitored through monthly review of Center supplies by assigned/designated persons. Any variances are reported to the Infection Control Meeting, the Medical Executive Committee, then to Governing Body. This plan of correction will be 	09/02/2011			

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S000130	<p>includes "2. Drugs present and not expired, verified with checklist." Each item was checked that it had been done.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(7)</p> <p>The governing body shall do the following:</p> <p>(7) Ensure all patients are admitted to the center only upon the recommendation of a practitioner with admitting privileges for the purpose of performing surgical procedures and services.</p> <p>Based on document review and interview, the governing body failed to ensure that patients were admitted and treated at the facility by a privileged medical staff member for one medical staff.</p> <p>Findings:</p> <p>1. The Governing Body Bylaws (approved 08-17-09) indicated the following: "In all cases, the Governing Body shall require that only a member of the Medical Staff with admitting privileges may admit a patient to the</p>	S000130	<p>monitored as written by the Director of the Center, Brandy Miller, MSN, RN, CNOR.</p> <p>1, 2, 3, & 4. To correct this deficiency, the facility Director, Brandy Miller, communicated with all members of MEC MD11's recredentialing information and requested admitting privileges for MD11. After approval was obtained from members of MEC, the Executive Director, Rebecca Trimbur, communicated with members of Governing Body MD11's recredentialing information and requested admitting privileges for MD11.a) The Credentialing Coordinator (Tricia Bair) and the Business Office Manager (Deborah Tempel) are attending courses to become certified through the National Association of Medical Staff Services (NAMSS).</p>	09/30/2011

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S000148	<p>Facility... " .</p> <p>2. The Medical Staff Rules and Regulations (approved 11-11-08) indicated the following; " Patients may be treated by physicians and podiatrists who have submitted proper credentials and have been duly appointed to the Medical Staff of the surgery center. "</p> <p>3. Review of an administrative medical staff roster indicated practice privileges expired 07-31-11 for one physician, MD11.</p> <p>4. Review of a monthly facility case log for MD11 for the period 08-01-11 to 08-30-11 indicated the physician had admitted 20 patients during the month.</p> <p>5. During an interview on 09-01-11 at 1030 hours, staff #A1 confirmed that MD11 was not privileged to admit patients and perform surgery until reapproved by the Governing Board.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES</p>		<p>Projected date to earn Certified Provider Credentialing Specialist (CPCS) is June 2012.b) The Credentialing Coordinator, Tricia Bair will document on the printed report actions taken to ensure all elements are in place for medical staff credentialing/re-credentialing.c) At the end of each month, the Business Office Manager, Deborah Tempel, will review an expiration report compiled by the Center's practice management (computer) system which will include licensure and credentialing expiration dates. d) The Business Office Manger, Deborah Tempel, will perform random audits throughout the month to ensure compliance. If during her audits, the Business Office Manager, Deborah Tempel identifies any variances, she will report them to Brandy Miller, Director so the information may be reported through the Center's Quality Committee, the Medical Executive Committee, and the Governing Body.e) The Business Office Manager, Deborah Tempel, will assume responsibility for the implementation of this corrective plan of action.</p>		

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S000172	<p>410 IAC 15-2.4-1 (c) (4)</p> <p>(c) The governing body shall do the following:</p> <p>(4) Require that the chief executive officer designate in writing an administrative officer to serve during his or her absence.</p> <p>Based on document review and interview, the chief executive officer failed to clearly indicate in writing who would be in charge when the chief executive officer was not present.</p> <p>Findings:</p> <p>1. The policy/procedure Chain of Command (revised 2-11) failed to indicate who would be in charge when the chief executive officer was unavailable.</p> <p>2. During an interview on 09-01-11 at 0900 hours, the Executive Director (staff #A1) confirmed the policy statement failed to indicate who would be in charge when the chief executive officer was unavailable.</p>	S000148	1, 2, 3 & 4. The deficiency was corrected by Brandy Miller, Director, through policy revision of ADM 06- Chain of Command on September 5, 2011. The policy now indicates that the Medical Director is in charge when the Executive Director is not available. The policy went through the Center's quarterly quality meeting on October 24th, will go through Medical Executive Committee Meeting to be held November 8th, and finally through Governing Body with the November Board meeting.	09/05/2011	
S000172	410 IAC 15-2.4-1				

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	<p>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 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 policy and procedure review, employee personnel file review, and interview, the facility failed to implement the facility policy related to new employee TB (tuberculosis) testing for 1 of 2 surgery tech files reviewed (P7), and facility standard of practice related to post offer physical examinations, for 1 of 4 Pre Op/PACU (post anesthesia care unit) RN (registered nurse) files reviewed (P13).</p> <p>Findings: 1. At 10:00 AM on 9/1/11, review of the policy and procedure "Employee Laboratory Screening", TM 02, indicated: a. under "Procedure", it read: "A. Each Surgery Center employee will receive initial laboratory screening as follows: 1.</p>	S000172	1, 2, 3, & 4. Brandy Miller, Director, updated Center policy TM 02-Employee Laboratory & Health Screening on September 5, 2011 to indicate a) if employee is able to provide documentation of prior two-step test with subsequent uninterrupted annual symptom screening, the two-step test required at time of hire may be waived. The deficiency will be prevented from occurring in the future through meticulous attention to medical personnel file with joint accountability by Deborah Tempel, Business Office Manager & Human Resource personnel and Brandy Miller, Director; as evidenced by the following:a) All new hires from November 1, 2011 on will have a checklist on the front of their medical file to help ensure all elements of the employee	11/30/2011	

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	<p>Hepatitis antigen screening 2. Mantoux test..."</p> <p>2. Review of personnel files on 8/30/11 indicated:</p> <p>a. staff member P7 was hired 2/14/11 and was not given a TB (Mantoux) test until May</p> <p>b. staff member P13 was hired 11/26/08 and was lacking documentation of a post offer physical examination</p> <p>3. Interview with staff member ND at 11:45 AM and 3:15 PM on 8/31/11 indicated:</p> <p>a. after a phone call to the occupational health offices, it was determined that staff member P13 was lacking a post offer physical in the employee file, as per the employee handbook requirement and facility standard of practice</p> <p>b. the October 2010 TB test done at a previous place of employment had been accepted for staff member P7, so that a TB test was not done at the time of hire (May was the annual TB/Mantoux testing time frame for all facility employees)</p> <p>c. the facility policy in place at the time of hire for staff member P7 dictated that a TB test would be done at the time of hire, it did not address allowing documentation of history of a test from a previous employer</p>		<p>medical file are in place. b) All current employee medical files will be audited for any further deficiencies by November 30, 2011. c) Any deficient employee immunization status information will be immediately addressed to ensure all employee medical charts are complete and accurate. d) Any employee medical files that are found to be deficient will be reported to the Center Infection Control Committee, the Quality Committee, the Medical Executive Committee, and then through Governing Body. e) Deborah Tempel, Business Office Manager, will assume responsibility to ensure all employee medical files are complete, accurate, and that this plan of correction is implemented as written.</p>	

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S000176	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on document review and interview, the facility failed to document contracted housekeeping personnel competency for cleaning and disinfecting operating rooms and sterile processing areas at the surgery center for two contracted employees.</p> <p>Findings:</p> <p>1. The policy/procedure Environmental Cleaning (reviewed 03-11) indicated the following: Personnel receive initial education and training on proper environmental cleaning and disinfection methods, agent selection, and safety precautions. [and] Perform 7-step cleaning procedures in scrub areas.</p> <p>2. Review of the documentation 7 Step Cleaning dated 04-19-2011 failed to</p>	S000176	<p>1. The Center further demonstrated contracted staff competency in fulfilling assigned responsibilities through: Premier Surgery Center Director, Brandy Miller, collaborated with contracted housekeeping Operations Manager, Darton Shafer to further elucidate the already existing O. R. Cleaning Competency Validation Tool (which already requires housekeeping employees to view 7-step Cleaning video, employees to demonstrate cleaning processes and the verification of competency through validator/educator signatures). The newly revised and exceptionally specific document will be put into effect no later than November 4, 2011 for all current and future contracted staff. A form for the documentation of the monitoring of quality indicators for contracted</p>	11/04/2011

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S000216	<p>describe a process for cleaning and disinfecting an operating room and lacked documentation indicating a surgical center staff person had validated the subject performance by direct observation of specific cleaning objectives.</p> <p>3. During an interview on 08-30-11 at 1420 hours, employee #A2 confirmed the facility had not conducted a competency validation of operating room cleaning by the two housekeeping personnel and the facility lacked a competency/audit tool indicating specific, measurable cleaning objectives for documentation of cleaning competency and quality assurance in the operating room and sterile processing areas.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(d)(4)</p> <p>In accordance with center policy, the governing body shall do the following:</p> <p>(4) Ensure that there is a center-wide, quality assessment and improvement program that evaluates the provision of patient care and outcome.</p>		<p>services was developed by Lea Anne Myers, Quality Coordinator. Quartery documentation of identified quality indicators will be monitored by Brandy Miller, Director of the Center, being placed into effect 4th quarter of 2011.</p>	

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S000224	<p>Based on policy and procedure review and staff interview, the quality improvement program failed to implement its policy related to the reporting of critical test results.</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Pre-Admission Testing", PC 137, on 8/30/11, indicated on page 2 under "Monitoring the Reporting of Critical Test Results": "A. At least annually, a collection of data will take place to evaluate and ensure that the reporting of critical results and values is taking place within an acceptable amount of time. B. The data collected will then be presented to and evaluated by the Performance Improvement (PI) Committee..."</p> <p>2. Interview with staff member ND at 4:30 PM on 8/31/11 indicated:</p> <p>a. policy PC 137 has not been implemented</p> <p>b. there is no evaluation of critical test data/reporting and no reporting to the PI committee</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(2)</p>	S000216	1, 2, 3 & 4. This deficiency was corrected through: Due to low volumes of critical test values/results, the Center Director, Brandy Miller, updated policy, PC 137- Preadmission Testing. The update of this policy excludes this data from quarterly monitoring as other quality indicators for patient care supercede the need to report out on this specific data element.	10/27/2011			

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	<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>(2) Ensure that the services performed under a contract are provided in a safe and effective manner and are included in the center's quality assessment and improvement program. Based on document review and interview, the governing body failed to ensure that contracted services were performed in a safe and effective manner for one contracted housekeeping service.</p> <p>Findings:</p> <p>1. The Premier Surgery Center Governing Body Bylaws (approved 09-17-2009) indicated the following: All facility staff rendering services to patients, including the Facility's environmental services staff, shall participate in a planned systematic program review to monitor quality assessment and involved processes... [for the facility].</p> <p>2. During an interview on 08-30-11 at 1610 hours, building personnel #A6 indicated the contracted cleaning service had purchased and installed a washing machine specifically for microfiber mop</p>	S000224	1, 2, 3, & 4. This deficiency was corrected by changing the process for which mop heads being utilized in the Center are laundered. Effective November 1, 2011, mop heads utilized in the Center will be no longer be laundered by the contracted housekeeping services, but through the contracted laundry service, Hospital Laundry Service (HLS). HLS has documented quality indicators; providing the Center with monthly titration and standard variance reports. These reported quality indicators further ensure appropriate cleaning and disinfection of Center-utilized linens and linen-specific cleaning products, providing the contracted service in a safe and effective manner. Any deviations in the monthly titration and standard variance reports are reported by the Director, Brandy Miller, through the Center's Infection Control Committee, the Quality Committe, the Medical Executive Committee, and then through the Governing Body. The	11/01/2011

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S000310	<p>heads and no longer utilized the commercial hospital laundry service for laundering the mop heads used at the facility.</p> <p>3. During an interview on 08-31-11 at 1030 hours, personnel #A9 indicated that the housekeeping detergent being used to launder the mop heads had not been evaluated for effectiveness as a commercial hospital laundry detergent by the housekeeping service.</p> <p>4. During an interview on 08-31-11 at 1540 hours, staff #A3 indicated they were not aware of the change in mop head laundering by housekeeping services and the quality assessment program had not reviewed the change ensuring that the services provided were safe and effective.</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</p>	S000310	Director, Brandy Miller, MSN, RN, CNOR, will assume responsibility that this plan is implemented as described.	10/25/2011		1, 2, 3, & 4. The Center is committed to providing quality	

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	<p>interview, the facility failed to evaluate 2 direct services (internal laboratory and radiology) and 3 contracted services (housekeeping, laboratory and laundry) through the Quality Assessment and Performance Improvement (QAPI) program.</p> <p>Findings:</p> <p>1. The facility document Performance Improvement 2nd Quarter 2011 failed to include monitoring for Point of Care laboratory services and fluoroscopy services provided at the facility. The document failed to indicate specific, objective, and measureable standards used to evaluate the contracted housekeeping, laboratory, and laundry services provided at the facility. The document failed to identify a reference standard or quality indicator for what the values "100%" and "Threshold 100%" reflected for the majority of services listed and reported on.</p> <p>2. During an interview on 08-30-11 at 1500 hours, staff #A3 confirmed that the facility was not evaluating the Point of Care testing or fluoroscopy services and that the reference standards were not identified on the Performance</p>		<p>services through the implementation of quality improvement actions focused at providing evaluation of services with specific, objective and measureable standards. The deficiency was corrected through the following actions: a) The Center's QI Data collection report was enhanced by the Director, Brandy Miller and the Quality Coordinator, Lea Anne Myers on October, 25, 2011 to include specific, objective, meaningful, and measureable outcome standards. b) The Center also developed a 'Contracted QI Indicators' form which lists specific quality indicators for services listed in the deficiency as well as other services either contracted or provided through/at the Center. c) Quality Committee Meetings starting 4th quarter, 2011 will have documentation of review, discussion &/or approval of the Performance Improvement reports-responsible party for this element is Brandy Miller, Center Director.</p>	

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S000320	<p>Improvement report. Staff #A3 indicated that the Performance Improvement Plan was being revised to ensure that documentation effectively reported how the services were being evaluated for the facility.</p> <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 facility failed to evaluate 1 function (discharge) performed at the facility through the Quality Assessment and Performance Improvement (QAPI) program.</p> <p>Findings:</p> <p>1. The Performance Improvement Plan</p>	S000320	1, 2, 3, & 4. The deficiency was corrected by incorporating specific terminology into Center Facility Plan # 9- Performance Improvement. The Performance Improvement Plan was updated October 24, 2011 by the Director, Brandy Miller. The Center's QI Data collection report was enhanced by the Director, Brandy Miller and the Quality Coordinator, Lea Anne Myers on October, 25, 2011 to include specific, objective, meaningful,	10/24/2011

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	<p>(approved 02-08-11) failed to indicate the required functions of discharge and transfer, medication errors, and response to patient emergencies were an integral part of the program and would be continuously monitored and reviewed.</p> <p>2. Review of the facility document Performance Improvement 2nd Quarter 2011 failed to indicate any specific, objective, meaningful and measureable outcome standards for evaluating the Discharge function. The document failed to identify a reference standard or quality indicator for what the values "100%" and "Threshold 100% " reflected for the majority of functions listed and reported on.</p> <p>3. The Quality Committee 2nd Quarter Minutes dated July 19, 2011 failed to indicate a review, discussion or approval of the Performance Improvement 2nd Quarter 2011 report by the committee.</p> <p>4. During an interview on 08-30-11 at 1500 hours, staff #A3 confirmed that discharge outcome standards were not identified on the Performance Improvement report.</p>		<p>and measureable outcome standards under the Discharge Status element(s) of the report. Quality Committee Meetings starting 4th quarter, 2011 will have documentation of review, discussion &/or approval of the Performance Improvement reports-responsible party for this element is Brandy Miller, Center Director.</p>				

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S000328	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the facility failed to document a response to deficiencies identified by the quality assessment/performance improvement program following a fire/evacuation drill performed at the facility on June 14, 2011.</p> <p>Findings:</p> <p>1. The Fire Safety/Prevention Plan (revised 03-01-10) indicated the following; "Fire safety/prevention ... program data are collected and reviewed by the Performance Improvement committee quarterly. Data is collected based on ... internal and external monitoring of ... staff performance."</p> <p>2. Documentation of a fire drill at the facility on 06-14-2011 at 0902 hours</p>	S000328	1, 2, 3, & 4. This deficiency was corrected through discussion of reported elements at the 3rd quarter Safety and Quality Committee meetings. Minutes reflect discussion of 6-24-11 fire drill documentation including employee recommendations, identified effectiveness, follow-up and impact on patient care. The Director, Brandy Miller, is the responsible party for ensuring this deficiency does not occur again and for reporting out this information to the Safety, Quality and Medical Executive Committees.	10/24/2011

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	<p>indicated the following: One hundred sixty people including staff, visitors, and patients evacuated in approximately four minutes. The staff conducting the drill indicated the following recommendations on the Check Sheet for Quarterly Fire Drill dated 06-14-11:</p> <p>A. Would recommend that PSC staff have a designated meeting place outside.</p> <p>B. Would recommend the front office staff brings their copy of patient schedule (it shows what patients have checked in).</p> <p>C. Develop a staff roster check-in paper that could easily be grabbed to take out of the building.</p> <p>3. Safety Committee and Quality Committee meeting minutes dated July 19, 2011 failed to document any discussion or plan for follow-up in response to the identified opportunities for improvement. Documentation failed to indicate a person responsible for follow-up, the expected outcome(s) for determining success/effectiveness of the response plan, or the time period during which the response plan would be evaluated.</p> <p>4. During an interview on 08-30-11 at 1210 hours, staff #A3 confirmed the facility failed to document a committee response to the fire drill deficiencies identified on the Check Sheet for</p>			

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S000414	<p>Quarterly Fire Drill dated 06-14-11.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on facility documentation review and interview, the ASC failed to ensure that the Infection Control committee included all required members.</p> <p>Findings included: 1. During review of the ASC's Meeting Chart (listing names of members of the</p>	S000414	1, 2, 3, & 4. This deficiency was corrected when the Director, Brandy Miller, requested that Dr. Rhys Rudolph, MD, be the medical staff representative for the Center's Infection Control Committee. Dr. Rhys Rudolph, MD, accepted the responsibility on September 2, 2011. The Center's Meeting charts were	09/02/2011

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S000434	<p>Quality, Infection Control, and Safety Committees) and review of the Infection Control committee meetings and minutes on 8/30/2011, it was found that no physicians from the ASC were members of the Infection Control committee or attending the meetings.</p> <p>2. During interview with E#11 on 8/31/2011, he/she verified that none of the ASC physicians were members of the Infection Control committee.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iv)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on policy and procedure review, observation, and staff interview, the facility failed to ensure patient and staff safety, in regard to aseptic techniques, in three instances.</p> <p>Findings:</p> <p>1. At 1:30 PM on 9/1/11, review of the policy and procedure "PC 204", "Operating Room Attire", indicated:</p>	S000434	<p>updated to include Dr. Rhys Rudolph, MD, on the Infection Control Committee on September 2, 2011.</p> <p>1, 2, 3, & 4. Premier Surgery Center is committed to providing safe care to all patients through the review and updating of policies, procedures, and programs pertinent to infection control. To correct deficiencies and to prevent them from occurring again, the Center performed the following actions: a) The Director, Brandy Miller, and the Quality Coordinator, Lea Anne Myers</p>	10/14/2011

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	<p>a. on page 2 under "Procedure", it read: "M. Masks must be worn in OR (operating room) suites when clean surgical cases are being performed."</p> <p>2. While observing patients in the pre op area of the facility at 1:10 PM on 8/31/11, it was noted that there were three staff drinks at the nurses' station</p> <p>3. Observed at 1:44 PM on 8/31/11, while in the OR suite during patient observation, the surgeon and the circulating nurse were not wearing masks during this cystoscopy and transurethral resection procedure (at 1:57 PM, another surgeon entered the OR suite without a mask on)</p> <p>4. At 3:30 PM, it was observed that a staff member was in the staff lounge with a surgical mask around the neck</p> <p>5. Interview with staff member ND at 2:00 PM on 8/31/11 indicated:</p> <p>a. staff are only required to wear a mask in "clean surgical cases", when an incision is made</p> <p>b. the cystoscopy was considered a "clean contaminated" case</p> <p>c. it is employee choice whether or not to wear a mask during a clean contaminated case</p>		<p>revised and re-titled the Center's policy, PC 204- Operating Room Attire to : PC 204- Center Personnel Attire. The updated comprehensive policy further describes Center expectations related to employee attire in restricted, semi-restricted and un-restricted patient care areas.b) Employees were re-educated by Brandy Miller, Director, in the September 9th, 2011 staff meetings regarding Center policy that employees are required to wear appropriate personal protective equipment (PPE) when exposure to blood or potentially infectious materials is anticipated.c) All State Surveyor comments were shared with staff on September 9, 2011 staff meetings. A copy of the meeting minutes was provided in the doctor's lounge for open communication and disclosure with practicing physicians of identified areas of improvement.d) Employees were educated on September 9, 2011 of Center policy change involving the restriction of all personal communication devices, beverages or food from direct patient care areas by Brandy Miller, Director.e) The Director, Brandy Miller, posted Center policy, PC 204- Center Personnel Attire in the doctor's lounge for doctor review. f) The Director, Brandy Miller, communicated to the involved surgeon the findings of the State Surveyor on</p>	

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S000442	<p>6. Interview with staff member NC at 2:15 PM on 8/31/11 indicated:</p> <p>a. even though the patient observed in OR was not a "clean" surgical case, there was a chance of "splash" contamination to the surgeon and a mask should have been worn</p> <p>b. AORN (association of peri-operative registered nurses) recommendations should be checked regarding this</p> <p>7. Interview with staff members NC and ND at 4:15 PM on 8/31/11 indicated:</p> <p>a. staff are not to wear masks around the neck</p> <p>b. the facility does not allow staff drinks in patient care areas, but the nursing desk in pre and post op is not considered a patient care area (only the cubicles are considered patient care areas)</p> <p>c. AORN recommendations related to drinks in the patient care areas, and what is considered a patient care area, needs to be reviewed</p> <p>d. facility policy does not address: Masks around the neck (or other surgical mask etiquette) or protocol with regard to drinks in patient care areas</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p>		<p>September 2, 2011.g) All team members and physicians interfacing with the Center are responsible for following Center policies and procedures. The Director, Brandy Miller, in conjunction with Team Members, will visually monitor staff and physicians to ensure adherence to Center policies and procedures. Identified deviances from Center specific policies and procedures will be communicated to the Director, Brandy Miller. The Director, Brandy Miller, will be responsible for investigating and addressing any identified deviances one-on-one with the offender; continued non-compliance of Center policies or procedures will result in written documentation through an occurrence report. The data will be reported through the Center's Infection Control Committee, Quality Committee, the Medical Executive Committee and then the Governing Body.h) The Director, Brandy Miller, MSN, RN, CNOR, will assume responsibility that this plan of correction is implemented.</p>	

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	<p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on personnel file review and interview, the Infection Control committee at the facility failed to ensure documentation of the immune status for required communicable diseases for 2 of 14 (E#3, E#10) ASC employees.</p> <p>Findings included: 1. During personnel file review of ASC employees on 8/31/2011, it was found that E#3 had no documentation of immunity to Rubeola and E#10 had no documentation of immunity to Rubella. 2. E#11 verified that the personnel files lacked the required documentation of immunity.</p>	S000442	<p>1. The ensure compliance with the Center's employee health program and to correct the identified state deficiency, the Center performed the following:a) On September 2, 2011, the two identified employees were instructed of employee immunity status findings. Center Director, Brandy Miller, provided written orders to the employees for titers/vaccination/boosters to be completed at Parkview North Occupational Health. Employee E#3 had Rubeola titer drawn on 8-31-2011; immunity status confirmed. Employee E#11 had MMR booster performed on 9-9-2011. Titers were drawn on 10-28-2011. Subsequent documentation of boosters and immunization levels will be located in the employee's medical charts for future review. 2, 3, & 4. The deficiency will be prevented</p>	09/02/2011			

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S000612	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)		from occurring in the future through meticulous attention to medical personnel file through shared joint accountability by Deborah Tempel, Business Office Manager & Human Resource personnel and Brandy Miller, Director as evidenced by the following:a) All new hires from November 1, 2011 on will have a checklist on the front of their medical file to help ensure all elements of the employee medical file are in place. b) All employee medical files will be audited for any further deficiencies by November 30, 2011.c) Any deficient employee immunization status information will be immediately addressed to ensure all employee medical charts are complete and accurate.d) Any employee medical files that are found to be deficient will be reported to the Center Infection Control Committee, the Quality Committee, the Medical Executive Committee, and then through Governing Body.e) Deborah Tempel, Business Office Manager, will assume responsibility to ensure all employee medical files are complete, accurate, and that this plan of correction is implemented as written.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<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 patient medical record review and staff interview, the facility failed to ensure accurate documentation in 5 of 10 medical records (N1, N2, N4, N5 and N7).</p> <p>Findings:</p> <p>1. At 9:30 AM on 9/1/11, review of patient medical records indicated:</p> <p>a. pt. N1 had documentation by nursing staff on the "Pre-Op Record" form of having Kefzol 2 mg IVP (intravenous piggy back) at 1409 hours, but had documentation by the anesthesiologist on the "Anesthesia Record" form that the pre surgery antibiotic was at 1620 hours</p> <p>b. pt. N2 had an "Anesthesia Class" selected as a "II" by the physician on the "Physical History" form, but had a Class "III" documented by the anesthesiologist on the "Anesthesia Record" form</p> <p>c. pt. N4 had documentation by nursing staff of Kefzol 1 gm IVP at 0848 hours in pre op, but was lacking any documentation by the anesthesiologist that pre op antibiotic was given on the</p>	S000612	1, 2, & 4. The Center is committed to maintain medical records that are accurate, has timely entries, and readily accessible. To correct and prevent the identified deficiencies related to the medical records from occurring again, the Center performed the following:a) State surveyor(s) identified discrepancies in medical records were noted and communicated to staff at September 9, 2011 staff meeting. b) Findings were then posted in the medical staff lounge for communication and physician review of findings. c) The Center's anesthesia liaison, Dr. Edward Tompa, MD, was provided full disclosure to results of state survey. Dr. Edward Tompa, MD will report back to contracted anesthesia services; Dr. Edward Tompa, MD is also a member of the Center's Medical Executive Committee (MEC) and will participate in 3rd quarter MEC by above noted date.d) The next date scheduled for the Center's externally contracted medical record review auditor to visit to center is Wednesday, November	11/02/2011

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	<p>"Anesthesia Record" form in the designated area for pre op antibiotic</p> <p>d. pt. N5 had an "Anesthesia Class" selected as a "I" by the physician on the "Physical History" form, but had a Class "II" documented by the anesthesiologist on the "Anesthesia Record" form</p> <p>e. pt. N7 had documentation by nursing staff of Cefazolin 1 gm IVP at 1208 hours in pre op, but was lacking any documentation by the anesthesiologist that pre op antibiotic was given on the "Anesthesia Record" form in the designated area for pre op antibiotic</p> <p>2. Interview with staff member ND at 12:15 PM on 9/1/11 indicated:</p> <p>a. neither policy provided related to charting ("Documentation: Charting and Charts" nor "Guidelines for Maintaining the Medical Record as a Medical-legal Document") addresses accuracy in the medical record</p> <p>b. the patient records listed in 1. above had inaccuracies noted when reviewed with the surveyor</p>		<p>2, 2011. The auditor will be provided full disclosure of state survey results to heighten awareness of deficiencies and to increase surveillance of identified quality indicators. e)Any identified deficiencies through the medical record review by the contracted medical record review auditors are reported out in the Center's Quality Committee, the Medical Executive Committee, and the Governing Body. f) All identified deficiencies through the medical record review by the contracted medical record review auditors is provided for staff to review by being posted on the Clinical Communication Board located in the Education Room and communicated to physicians by being posted in the physician's lounge.g) Center policy, MR 04-Guidelines for Maintaining the Medical Record as a Medical-Legal Document was updated to include and communicate Center expectation on the following: i) practitioners and individuals documenting in the medical record provide accurate and legible documentation in a timely manner.3. Responsibility for the above lies in all practitioners and individuals that document in the patient's medical chart, the Business Office Manager, Deborah Tempel, and the Center Director, Brandy Miller. Deborah Tempel, Business Office Manager, will be responsible for</p>	

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S000624	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(7)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(7) The center shall ensure the confidentiality of patient records. The center must develop, implement, and maintain the following:</p> <p>(A) A procedure for releasing information or copies of records only to authorized individuals, in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records.</p> <p>Based upon document review, observation and interview, the facility failed to ensure that medical records (MR) were not accessible to unauthorized individuals.</p> <p>Findings:</p> <p>1. Review of the policy/procedure Confidentiality of the Medical Record (revised 02-11) failed to indicate how the</p>	S000624	<p>ensuring the above mentioned plan of correction is implemented.</p> <p>1, 2, 3, & 4. In its continued commitment to ensure confidentiality of medical/patient records and to correct identified state survey deficiencies, the Center performed the following:a) On October 14, 2011 the Director, Brandy Miller, updated policy ADM 12- Confidentiality of the Medical Record which further developed the already existing documentation of securing of the patient record to include specific wording addressing the physical barriers</p>	10/14/2011

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S000640	<p>facility provided physical barriers to limit access to MR by unauthorized individuals at the facility.</p> <p>2. During a facility tour on 09-01-2011 at 1045 hours, accompanied by employee #A2, large under-counter drawers containing current patient charts were observed in the doctors' lounge. The chart drawers lacked locks to prevent unauthorized access to protected health information.</p> <p>3. During an interview on 00-01-2011 at 1045 hours, employee #A2 indicated that the contracted housekeeping services cleaned the doctors' lounge areas where MR were stored in the evening when other facility staff were not present.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p>		<p>that the Center has in place to protect patient records.b) In addition to the locks provided on the physicians' lounge to help secure patient records, the Director of the Center, Brandy Miller, submitted a work order on September 2, 2011 to have locks install on four sliding cabinets which house patient records. The locks were installed on September 7, 2011.c) The lock security is to be checked each night by the front office staff members. This check was added to the evening check sheet that is completed by the front office staff.d) Any deviances in the security of the locks will be reported to Deborah Tempel, Business Office Manager. She will then report the information to the Director, Brandy Miller; the information will be then reported through the following Center committees: Quality Committee, Medical Executive Committee, and the Governing Body.e) The Business Office Manger, Deborah Tempel, is assuming responsibility for the implementation of the corrective plan of action as described.</p>	

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	<p>(1) Legible and complete.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that medical records were complete and/or legible for 10 of 10 patient records reviewed (Pts. N1 through N10).</p> <p>Findings:</p> <p>1. At 1:00 PM on 9/1/11, review of the policy and procedure MR 04, "Guidelines for Maintaining the Medical Record as a Medical-legal Document", indicated:</p> <p>a. under "Purpose", it read: "To assure consistency in maintaining the medical record..."</p> <p>b. under "Policy", it read: "Team members will follow the procedure below for maintaining the medical record."</p> <p>c. under "Procedure", it read: "A. All entries in the medical record must be authenticated (name and professional status) and dated...E. If a correction needs to be made in the medical record, one line should be neatly drawn through the error, leaving the incorrect material legible, and then it should be initialed and dated and 'error' written so it will be obvious that it was a corrected mistake...G. All blanks should be completed on special forms:..."</p> <p>2. At 1:30 PM on 9/1/11, review of the policy and procedure MR 02,</p>	S000640	<p>1, 2, & 4. The Center is committed to maintain medical records that are legible, accurate, has timely entries, and readily accesible. To correct and prevent the identified deficiencies related to the medical records from occurring again, the Center performed the following:a) State surveyor(s) identified discrepancies in medical records were noted and communicated to staff at September 9, 2011 staff meeting. b) Findings were then posted in the medical staff lounge for communication and physician review of findings. c) The Center's anesthesia liaison, Dr. Edward Tompa, MD, was provided fulll disclosure to results of state survey. Dr. Edward Tompa, MD will report back to contracted anesthesia services; Dr. Edward Tompa, MD is also a member of the Center's Medical Executive Committe by above noted date.d) The next date scheduled for the Center's externally contracted medical record review auditor to visit to center is Wednesday, November 2, 2011. The auditor will be provided full disclosure of state survey results to heighten awareness of deficiencies and to increase surveillance of identified quality indicators. All auditor reports are posted on the Clinical Communication Board located in the Education Room for staff review and also posted in the</p>	11/02/2011

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	<p>"Documentation: Charting and Charts", indicated:</p> <p>a. under "Purpose", it read: "To provide a written record of patient care received in the Center and to facilitate communications and insure continuity of care."</p> <p>b. under "Procedure", it read: "A...3. Fill in all spaces...4. If an error is made, draw one line through it and print 'error' above it and initial it. Fill in correct information..."</p> <p>3. Review of patient medical records during the 8/30/11 to 9/1/11 survey process indicated:</p> <p>a. pt. N1 had a general anesthetic and lacked documentation on the "Anesthesia Record" form in the area: "Extubated: [in] OR (operating room) [or in] PACU (post anesthesia care unit)" (neither box was checked)</p> <p>b. pt. N2 lacked documentation of the "Receiving Physician" on the "Transfer Form"</p> <p>c. pt. N3:</p> <p>A. lacked a time of physician authentication (top of the page) on the "Outpatient History & Physical Procedure Summary" form</p> <p>B. had illegible dating and timing by the physician with the authentication at the bottom of the page on the "Outpatient History & Physical Procedure Summary"</p>		<p>physician's lounge for physician review. All auditor reports and reported through the Quality Committee, the Medical Executive Committee, and the Governing Body.e) Center policy, MR 04-Guidelines for Maintaining the Medical Record as a Medical-Legal Document was updated to include and communicate Center expectation on the following:f) Deborah Tempel, Business Office Manager is responsible for ensuring the plan is implemented as written. i) practitioners and individuals documenting in the medical record provide accurate and legible documentation in a timely manner.ii) additional instructions regarding the documentation of errors under section 'E'.f) The Director, Brandy Miller, updated policies MR 02 and MR 04such they have identical and congruent information regarding the documentation of errors in the a medical record.3. Responsibility for the above lies in all practitioners and individuals that document in the patient's medical chart, the Business Office Manager, Deborah Tempel, and the Center Director, Brandy Miller.</p>	

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	<p>form</p> <p>C. lacked documentation of the pre medication and time of the medication on the "Anesthesia Record" form for the 2 mg of Versed given in pre op</p> <p>D. had corrections made in 3 areas of documentation by nursing staff on the "Intraoperative Record" form, that are not corrected as per facility policy</p> <p>E. was lacking a discharge "PAR" (post anesthetic recovery) scoring prior to transfer for a 23 hour admit at another facility</p> <p>d. pt. N4:</p> <p>A. had corrections made to the medical record on the "Pre-op Record" form in the vital signs area that were not corrected as per facility policy</p> <p>B. lacked documentation of the pre op antibiotic (and time) that was given (Kefzol 1 gm) on the "Anesthesia Record" form</p> <p>C. lacked documentation on the "Anesthesia Record" form in the area: "Extubated: [in] OR [or in] PACU" (neither box was checked)</p> <p>D. had illegible times written by the anesthesiologist in the "Gas On", "Gas Off", and "Anesthesia Start and End" times on the "Anesthesia Record" form</p> <p>e. pt. N5 had an illegible time written by the anesthesiologist in the "Anesthesia End" time on the "Anesthesia Record" form</p>			

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	<p>f. pt. N6:</p> <p>A. had illegible entry by the physician on the "Anesthesia Standing Orders" form for the maximum amount of Fentanyl that can be given for post op pain</p> <p>B. was lacking a time written by the anesthesiologist in the "Gas Off" section of the "Anesthesia Record" form</p> <p>C. lacked a total for the discharge PAR scoring on the "Recovery Room Record" form</p> <p>g. pt. N7:</p> <p>A. lacked documentation of the pre op antibiotic (and time) that was given (Cefazolin 1 gm) on the "Anesthesia Record" form</p> <p>B. lacked documentation on the "Anesthesia Record" form in the area: "Extubated: [in] OR [or in] PACU" (neither box was checked and the patient had a general anesthetic given)</p> <p>C. had an illegible time written by the anesthesiologist in the "Anesthesia End" time on the "Anesthesia Record" form</p> <p>D. lacked documentation of the times, to have been written by the anesthesiologist, in the "Gas On" and "Gas Off" areas of the "Anesthesia Record" form</p> <p>E. lacked completion on the "Anesthesia Record" form of "Anesthesia Complications: Yes (or) No" (neither</p>			

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	<p>box is checked)</p> <p>F. had corrections made to documentation on the "Intraoperative Record" form that were not corrected per facility policy</p> <p>G. had write overs made to documentation in the "Temperature" section on the "Recovery Room Record" form that were not corrected per facility policy</p> <p>h. pt. N8:</p> <p>A. had a general anesthetic and lacked completion on the "Anesthesia Record" form of "Anesthesia Complications: Yes (or) No" (neither box is checked)</p> <p>B. lacked documentation of the times, to have been written by the anesthesiologist, in the "Gas On" and "Gas Off" areas of the "Anesthesia Record" form</p> <p>i. pt. N9:</p> <p>A. had write overs on the "Pre-op Record" form that were not corrected per facility policy</p> <p>B. had illegible times written by the anesthesiologist, in the "Gas On", "Gas Off" area of the "Anesthesia Record" form and on the same form in the "Anesthesia End" time</p> <p>j. pt. N10:</p> <p>A. lacked documentation of the pre medication time of the Versed on the "Anesthesia Record" form</p>			

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S000780	<p>B. had corrections made to documentation on the "Intraoperative Record" form that were not made per facility policy</p> <p>4. Interview with staff member ND at 12:15 PM on 9/1/11 indicated:</p> <p>a. policy MR 02 and MR 04 do not have the same instructions regarding the correction of errors made in the medical record</p> <p>b. the corrections made to medical records, as listed in 3. above, were not made according to either policy MR 02 or MR 04</p> <p>c. illegibility has been a problem for some practitioners</p> <p>d. anesthesiologists have been reminded to fully complete their Anesthesia Record forms</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws</p>						

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	<p>and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on patient medical record review and staff interview, nursing staff failed to follow physician orders, related to the timing of pre op antibiotics, for 1 patient (N1).</p> <p>Findings:</p> <p>1. At 9:30 AM on 9/1/11, review of patient medical record N1 indicated:</p> <p>a. the physician ordered "Kefzol 2 mg IV (intravenous) within 1 hour of surgery"</p> <p>b. nursing staff documented that Kefzol 2 gm was given at 1409 hours</p> <p>c. the surgery start time, documented on the "Intraoperative Record" form was 1635 hours</p> <p>2. Interview with staff member ND at 12:15 PM on 9/1/11 indicated:</p> <p>a. antibiotics are to be started within an hour of the operative time</p> <p>b. it is unknown why there was a delay</p>	S000780	1, 2, & 4. The Center is committed to providing safe quality care and carrying out physician orders that support the Center's goal of safe quality care to patients. While the listed findings of this elements does not support a deficiency to the specific rules and bylaw cited here/submitted by the state survey, the Center does agree and understand where the findings listed does indicate an area to be addressed, providing an opportunity to improve the quality of care and ensure every opportunity for optimal and best patient outcomes occur in our Center. To ensure safe quality care and to correct and prevent the identified findings related to the safe administration of antibiotics and carrying out surgeon's orders, the Center performed the following:a) State surveyor(s) identified discrepancies in medical records were noted and communicated to staff at September 9, 2011 staff	11/02/2011	

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S001020	for pt. N1 when the antibiotic was given at 1409 and the surgery did not occur until 1635 c. the antibiotic for pt. N1 was not given as per physician orders 410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(D)		meeting. b) Findings were then posted in the medical staff lounge for communication and physician review of findings. c) Non-penalized communication to staff involved in incident in order to heighten awareness of state survey findings.d) The next date scheduled for the Center's externally contracted medical record review auditor to visit to center is Wednesday, November 2, 2011. The auditor will be provided full disclosure of state survey results to heighten awareness of deficiencies and to increase surveillance of identified quality indicators. All auditor reports are posted on the Clinical Communication Board located in the Education Room for staff review and in the physician's lounge for physician review. The auditor reports are reported through the Center's Quality Committee, the Medical Executive Committee, and the Governing Body.3. Responsibility for the above lies in all practitioners and individuals that document in the patient's medical chart, the Business Office Manger, Deborah Tempel, and the Center Director, Brandy Miller. The Director, Brandy Miller, will assume responsibility to ensure the correction plan is implemented as written.		

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	<p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(D) Reporting of adverse reactions and medication errors to the practitioner responsible for the patient and the appropriate committee, and documented in the patient's record.</p> <p>Based on document review and interview, the facility lacked the policy/procedure requirement for documenting all adverse reactions and medication errors in the patient record.</p> <p>Findings:</p> <p>1. The policy/procedures RM 34 Medication Error (reviewed 06-11), PC 170 Medications: PACU (reviewed 04-11), and PC 340 Medications, Administration of (reviewed 05-11) lacked the documentation requirement for recording adverse reactions and/or medication errors in the patient record when requiring the responsible physician be notified and an incident report be completed.</p>	S001020	<p>1, 2, 3, & 4. The Center is committed to accurate and complete reporting and documentation of adverse reactions &/or medication errors. To correct the deficiency identified in our recent State Survey, the Center performed the following:a) On August 31, 2011, the Director, Brandy Miller, revised policies RM 34- Medication Error; PC 170- Medications: PACU and PC 340- Medications, Administration of to include staff requirement to document in the patient's record any adverse reactions or medication errors.b) On September 9, 2011, staff were educated on the policy changes and Center expectations regarding documentation of adverse pharmaceutical reactions and medication errors by Brandy Miller, Director.c) The Director, Brandy Miller, will review any chart that has an adverse</p>	09/09/2011

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NAME OF PROVIDER OR SUPPLIER PREMIER SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11141 PARKVIEW PLAZA DRIVE, SUITE 200 FORT WAYNE, IN 46845
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S001188	<p>2. During an interview on 08-30-11 at 0840 hours, employee #A2 confirmed that the policy/procedures lacked the requirement for documenting the adverse reaction or medication error in the patient record.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting</p>		<p>reaction/medication error (this will be tracked through incident reports). Any patient chart that does not have documentation of the event in the patient care record will result in the following: i) Chart will be pulled for formalized chart review ii) non-punitive communication of event with involved staff member iii) Discussion of findings (omitting staff member's name) at next employee staff meeting to heighten awareness of event (should it occur) iv) All findings will be reported to the Center's Quality Committee, the Medical Executive Committee, and the Governing Body.d) The Director, Brandy Miller, will assume responsibility that the corrective plan is implemented as described.</p>	

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	<p>authorities. (F) Fire drills. Based on document review and interview, the facility failed to follow their policy/procedure for quarterly fire drills for 4 of 4 drills performed.</p> <p>Findings:</p> <p>1. The policy/procedure Fire Drill (reviewed 06-11) indicated the following: Once the evacuation is successfully completed, the safety officer or designee will complete the "Check Sheet for Quarterly Fire Drill" and associates in attendance must sign the [attendance] form.</p> <p>2. Fire drill documentation dated 06-14-11 at 0902 hours indicated 24 occupants from the facility were participants in the drill and the safety officer or designee failed to document attendance by staff signing an attendance record..</p> <p>3. Fire drill documentation dated 1st Quarter failed to indicate what month or day the drill was conducted in 2011. The Check Sheet for Quarterly Drill indicated 13 staff were present for the drill and the sign in sheet dated 1st Quarter 2011 listed 24 staff participants. 1st Quarter drill documentation failed to</p>	S001188	<p>1, 2, 3, & 4. The Center is committed to maintaining a safe environment to all individuals within the Center. The Center corrected the listed deficiency by:a) On September 9, 2011, the Director, Brandy Miller, communicated to the Center Safety Officer, Andy Straub, the state survey findings with attention to any deficiencies related to safety. b) On September 9, 2011, The Center Safety Officer, Andy Straub, verbalized understanding of following Center policies related to processes around safety drills. All subsequent fire drills will have a method of documenting attendance.c) The Safety Officer, Andy Straub, will be responsible for ensuring all fire drills have the full and accurate date when the drill is being conducted.d) The attendance sheet for fire drills was revised on October 28, 2011 to clearly indicate which employees of the Center participated in the fire drill and which employees were provided an alternative method of review/learning of Center fire safety procedures. e) All materials utilized to indicate an alternative learning method of individuals not present during fire drills will be included in the State Board of Health 3-ring binder located in the Director's (Brandy Miller) office in order to validate</p>	10/31/2011

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	<p>indicate why 13 staff were present for the drill and 24 staff signed an attendance record.</p> <p>4. During an interview on 08-30-11 at 1205 hours, staff #A2 indicated that an alternative learning experience was provided to staff not present during the 1st Quarter fire drill. Documentation of materials and information presented to staff as an alternative learning experience and a list of participants was requested from staff #A2 and not provided prior to exit.</p> <p>5. Fire drill documentation dated 11-11-2011 at 0930 hours indicated 16 occupants from the facility were participants in the drill and the safety officer or designee failed to document attendance by staff signing an attendance record.</p> <p>6. During an interview on 08-30-11 at 1205 hours, staff #A2 confirmed the (11-11-2011) Fire Drill documentation was dated in error.</p> <p>7. Documentation of the fire drill dated 08-09-10 at 1000 hours indicated 23 occupants from the facility were participants in the drill and the documentation included an attendance sheet indicating 23 staff were present</p>		content presented.				

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	<p>during the drill. A discrepancy was observed with three housekeeping staff listed on the attendance record who would not be present at the time the drill was performed. The facility failed to document staff attending the drill on 08-09-10 or when other staff participated in an alternative leaning experience.</p> <p>8. During an interview on 08-30-11 at 1205 hours, staff #A2 confirmed the documentation of fire drills was incomplete for 5 of 5 drills and the facility failed to document staff that attended the drills or when other staff participated in an alternative learning experience. Staff #A2 confirmed that materials used for the alternative learning experience were not available to validate the content presented or that the content was reviewed and approved by the safety committee as an appropriate alternative to a drill.</p>			