

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001088		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER GOSHEN AMBULATORY CARE CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1605 WINSTED DR GOSHEN, IN 46526			
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Q0000	<p>The visit was for a re-certification survey.</p> <p>Facility Number: 011074</p> <p>Survey Date: 12-03-12 to 12-05-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/07/12</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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Q0106	<p>416.44(d) EMERGENCY PERSONNEL Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC. Based on review of facility job descriptions, employee personnel file review, and staff interview, the governing board failed to ensure that CPR (cardiopulmonary resuscitation) competency was current for two of 5 staff files reviewed (staff members P1 and P2).</p> <p>Findings:</p> <p>1. at 3:55 PM on 12/3/12, review of staff job descriptions indicated:</p> <p>a. the "Surgical Technologist/Materials Specialist" job description states that "Qualifications" include: "...2. Must have current CPR certification..."</p> <p>b. the "Director of Nursing" job description states that "Qualifications" include: "...2. Must have current CPR certification,..."</p> <p>2. at 3:55 PM on 12/3/12 and 10:00 AM on 12/4/12, review of staff/employee files indicated:</p> <p>a. Staff member P1, the surgical technologist, had CPR documentation in the file that expired 7/12</p> <p>b. Staff member P2, the Director of Nursing, had CPR documentation in the file that expired 11/12</p>	00106	Q 106 Clinical staff performed & completed CPR/ACLS class. Executive Assistant will monitor staff & physician files first of each month for soon to expire credentials on an ongoing basis.	12/07/2012			

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	<p>3. interview with staff member #51, the Director of Nursing, at 4:35 PM on 12/3/12 indicated:</p> <p>a. this staff member (same as P2) has documentation that CPR expired 11/12, but is scheduled to take the CPR class on Friday, 12/7/12</p> <p>4. at 9:50 AM on 12/4/12, interview with staff member #51, the Director of Nursing, indicated:</p> <p>a. staff member P1 took an on line CPR "class" on 12/3/12 to have/maintain competency per the job description</p> <p>b. it was thought that staff member P1 had taken CPR last summer, but documentation cannot be found</p> <p>c. the only CPR documentation in the medical record on 12/3/12 was an expired document with a 7/12 expiration date</p>						

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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> <ol 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 policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure accurate documentation for 4 of 20 records reviewed (patients # 1, 3, 5, and 6) and failed to ensure the completeness of medical records for 2 patients (pts. # 14 and #16).</p> <p>Findings: 1. at 11:30 AM on 12/3/12, review of the policy and procedure manual indicated a policy titled: "J-20 Patient Medical record Protected Health Information",</p>	00162	Q 162 Policies J20 & J25 were modified on 12-19-12 to include, "Medical records will be accurate and complete". Policy will be sent to the Board of Directors for approval. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on allergy documentation to assure accuracy & consistency in the medical record including documentation completed by other offices. Consent form GACC002 was revised on 12-19-12 listing all anesthesia types with added sentence "anesthesia will be modified as condition warrants" and sent to printers. Draft back from printers	01/07/2013			

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	<p>with a most recent revised date of 01/12, indicated:</p> <p>a. the "Purpose" statement reads: "To Assure Complete Comprehensive and Accurate Documentation of Patient Treatment"</p> <p>2. at 11:30 AM on 12/3/12, review of the policy and procedure manual indicated a policy titled: "J-25 Entries in the Medical Record", with a most recent revised date of 01/12, indicated:</p> <p>a. the "Purpose" statement reads: "To Assure Accurate Record of Care and to Provide A Method for Verifying and Identifying the Authentication of All Entries in the Medical Record"</p> <p>3. review of patient medical records at 2:10 PM on 12/3/12, 11:40 AM, and 2:15 PM on 12/4/12 indicated:</p> <p>a. pt. record #1 had documentation on the "Short Stay History & Physical" form that indicated in the "Allergies" section: "NKDA" (no known drug allergies), but had documentation on other forms in the chart, such as the "Operation Room Record" form indicating the patient was allergic to "PCN (penicillin)" and "Dye"</p> <p>b. pt. #3 had "Monitored Anesthesia Care with or without sedation" checked as the anesthesia to be used for their 7/10/12 surgery on the consent form and the "Operation Room Record" form, but had</p>		<p>on 12-21-12. Send to printers for final print on 12-26-12. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on accurate anesthesia documentation. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on medical records for appropriate gender listed on dictated OP notes. A statement was added to Policies J20 & J25 on 12-19-12 to include "the physician's history & physical will be complete, including marking all boxes and filling in all spaces." Policies will be sent to the Board of Directors for approval. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on completeness of H&Ps. The Director of Nursing or Designee will be responsible for conducting the QA studies and forwarding results to QA Committee.</p>		

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	<p>both General and MAC checked on the "Anesthesia Record" form</p> <p>c. pt. #5 had "General Anesthesia" checked and then crossed out on the surgical consent form and "Monitored Anesthesia Care with or without sedation" marked on the consent form, had "MAC" marked on the "Operation Room Record" form and had "General" anesthesia marked on the "Anesthesia Record" form</p> <p>d. pt. #6 had an operative note that indicated the surgery was performed on a "...young girl...", when the surgery was on a 6 year old male patient</p> <p>4. interview with staff member #51, the Director of Nursing, at 1:15 PM on 12/5/12, indicated:</p> <p>a. the "NKDA" for pt. #1 was noted on the "office" portion of the short stay History and Physical form, but the surgery center is responsible for all documentation the patients' medical records</p> <p>b. the policies J-20 and J-25 don't specifically indicate that medical records will be "accurate" except in their purpose statements</p> <p>5. at 11:30 AM on 12/3/12, review of the policy and procedure manual indicated a policy titled: "J-20 Patient Medical Record Protected Health Information", with a most recently revised date of</p>						

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	<p>01/12, read on page 3 in section 7., "The Nursing Intra-Operative Room Record will document the pre-operative and post-operative diagnosis,...type of anesthesia and times of surgery and anesthesia..."</p> <p>6. review of patient medical records at 2:10 PM on 12/3/12, 11:40 AM, and 2:15 PM on 12/4/12 indicated:</p> <p>a. pt. #14 lacked documentation on the "Operation Room Record" form related to the "Method of Anesthesia" the patient received</p> <p>b. pt. #16 lacked documentation on the "Pre-Op/Phase II Record" form in the area of discharge related to how the patient exited the facility (whether "Ambulatory, W/C (wheel chair), cart, or carried")</p> <p>7. interview with staff member #51, the Director of Nursing, at 1:15 PM on 12/5/12, indicated:</p> <p>a. other than section 7. on page 3 of policy J-20, the policies related to medical record documentation (J-20 and J-25) are lacking the language that would require completion of the medical record in regard to marking or completing all boxes, spaces, and areas on forms</p>				

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Q0202	<p>416.49(b) RADIOLOGIC SERVICES</p> <p>(1) The ASC must have procedures for obtaining radiological services from a Medicare approved facility to meet the needs of patients.</p> <p>Based on document review and interview, the center failed to ensure that proper precautions were maintained against radiation hazards for all female patients of childbearing age.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure HCG Urine Testing (approved 10-11) indicated the following: " For the detection of pregnancy. " The policy/procedure failed to indicate the criteria to determine when the test must be performed. The policy/procedure Ionizing Radiation - Reducing Radiologic Exposure (approved 10-11) indicated the following: " Female patients of childbearing age should be questioned about the possibility of pregnancy. " The policy/procedure failed to ensure that a urine pregnancy test was performed prior to fluoroscopy for all potentially pregnant patients to avoid fetal exposure to ionizing radiation. During an interview on 12-05-12 at 1310 hours, staff A2 confirmed that the 	00202	<p>Q202 Policy O17 was revised on 12-19-12 to address required preoperative pregnancy testing on all females of childbearing age who have not signed a written refusal for a pregnancy test. Childbearing age is defined as menstruating females without prior hysterectomy or tubal ligation. Policy will be sent to the Board of Directors for approval. Policy P15 was revised on 12-19-12 to address personnel with known or suspected pregnancy should declare this condition to the safety officer and their immediate supervisor. Disclosure of the pregnancy, even if it is obvious, is not required. A written, voluntary, official declaration that includes the estimated date of conception is used to base the total dose limit to the pregnant person. The US Nuclear Regulatory Commission guidelines include the following: Occupational dose to the embryo or fetus of an occupationally exposed staff member who has declared her pregnancy must not exceed 0.5 rem during the entire gestational period. Dose should be uniform over time and not all at once. Policy will be sent to the Board of Directors for approval. The Director of Nursing will</p>	01/07/2013			

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	policy/procedures failed to indicate the center requirements to ensure that pregnancy testing was performed for all at-risk patients.		monitor this on an ongoing basis.		

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Q0242	<p>416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.</p> <p>Based on observation and interview, the infection control practitioner failed to ensure that nursing and medical staff followed AORN (Association of PeriOperative Nurses) standards and recommendations in relation to surgical masks dangling about the neck for one nurse and one physician observed (staff members #55 and #56).</p> <p>Findings:</p> <ol style="list-style-type: none"> at 9:21 AM on 12/5/12, it was observed in the nursing station of the pre/post op area that one RN had their surgical mask down about the neck (staff member #55) at 9:25 AM on 12/5/12, it was observed that the pediatric surgeon, staff member #56, was in the pre op hallway with their surgical mask in the right hip back pocket of their scrubs (with the mask ties dangling from the pocket) at 10:10 AM on 12/5/12, it was 	00242	Q242 Policy L100 was revised on 12-19-12 to address surgical masks should not be saved by hanging them around the neck or tucking them into a pocket for future use. They should be discarded immediately after each surgical procedure and not left down and dangling around the neck in hallways, pre/post op areas, etc. Policy will be sent to the Board of Directors for approval. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 monitoring surgical masks of staff and physicians. The Quality Assurance Coordinator will monitor this.	01/07/2013

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	<p>observed that nursing staff member #55 was transporting a patient by stretcher to the procedure room with their surgical mask down about the neck</p> <p>4. at 10:20 AM on 12/5/12, nursing staff #55 was transporting the patient by stretcher from the procedure room to the recovery area with their surgical mask down about the neck</p> <p>5. interview with staff member #51, the Director of Nursing, at 1:15 PM on 12/5/12 indicated:</p> <ul style="list-style-type: none"> a. the facility follows AORN recommendations b. the policy related to "Surgical Attire", policy number L-100, does not address the stipulation that surgical masks about the neck are forbidden c. it is a standard of practice that masks should be discarded after each surgical procedure and not left down and dangling about the neck in hallways, pre/post op areas, etc. 			

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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 011074</p> <p>Survey Date: 12-03-12 to 12-05-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/07/12</p>	S0000			

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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 review of facility job descriptions, employee personnel file review, and staff interview, the governing board failed to ensure that CPR (cardiopulmonary resuscitation) competency was current for two of 5 staff files reviewed (staff members P1 and P2) and failed to ensure that documentation of Cardiopulmonary Resuscitation (CPR) competency was maintained for 2 personnel (A4 and A5).</p> <p>Findings:</p> <p>1. at 3:55 PM on 12/3/12, review of staff job descriptions indicated:</p> <p>a. the "Surgical Technologist/Materials Specialist" job description states that "Qualifications" include: "...2. Must have current CPR certification..."</p> <p>b. the "Director of Nursing" job</p>	S0162	S162 Clinical staff performed & completed CPR/ACLS class. Executive Assistant will monitor staff & physician files first of each month for all soon to expire credentials on an ongoing basis.	12/07/2012			

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	<p>description states that "Qualifications" include: "...2. Must have current CPR certification,..."</p> <p>2. at 3:55 PM on 12/3/12 and 10:00 AM on 12/4/12, review of staff/employee files indicated:</p> <p>a. Staff member P1, the surgical technologist, had CPR documentation in the file that expired 7/12</p> <p>b. Staff member P2, the Director of Nursing, had CPR documentation in the file that expired 11/12</p> <p>3. interview with staff member #51, the Director of Nursing, at 4:35 PM on 12/3/12 indicated:</p> <p>a. this staff member (same as P2) has documentation that CPR expired 11/12, but is scheduled to take the CPR class on Friday, 12/7/12</p> <p>4. at 9:50 AM on 12/4/12, interview with staff member #51, the Director of Nursing, indicated:</p> <p>a. staff member P1 took an on line CPR "class" on 12/3/12 to have/maintain competency per the job description</p> <p>b. it was thought that staff member P1 had taken CPR last summer, but documentation cannot be found</p> <p>c. the only CPR documentation in the medical record on 12/3/12 was an expired document with a 7/12 expiration date</p>						

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	<p>5. Review of personnel files for A4 and A5 failed to indicate that the CPR training included skills performance to validate competency for CPR.</p> <p>6. During an interview on 12-04-12 at 0950 hours, staff A1 confirmed that the internet CPR training lacked skills validation for the 2 center staff.</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 policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that the transfer policy was implemented for 1 of 1 transfer patient. (pt. # 2)</p> <p>Findings:</p> <p>1. at 11:30 AM on 12/3/12, review of the policy and procedure manual indicated a policy titled: "K-185 Patient Transfer to Hospital" with an approved date of 10/99, that indicated:</p> <p>a. under "Procedure", in section 7., it reads: "A copy of the appropriate sections of the Medical Record will be sent with the patient. This is to include transfer form, H & P (history and physical), medication and anesthesia records, diagnostic test results, explanation of precipitating incident necessitating transfer..."</p> <p>2. at 2:10 PM on 12/3/12, review of</p>	S0166	S166 Transfer form was revised to reflect section 7 of Policy K185: what copies are sent with the transferred patient. The Director of Nursing will monitor and review the next transferred patient's chart for adherence to the policy.	12/19/2012	

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	<p>patient medical records indicated Patient #2 was transferred to an acute care hospital on 7/23/12 and had a "Transfer Record" form that noted: "History & Physical Attached...Yes", but lacked documentation that the medication, anesthesia, and diagnostic test results records were also sent with the patient for continuity of care</p> <p>3. interview with staff member #51, the Director of Nursing, at 3:30 PM on 12/4/12 indicated:</p> <ul style="list-style-type: none"> a. all other chart information is sent with a transfer patient, as per policy b. it is not clear that pertinent patient information is sent with a transfer patient due to the lack of documentation in the medical record related to this c. the Transfer Record form does not prompt nursing staff to document forms/information sent with a transfer patient except for the H & P 						

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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. Based on document review and interview, the center failed to establish quality standards for evaluating its contracted services through its quality assurance (QA) program for 33 contracted services.</p> <p>Findings:</p> <p>1. Documentation titled Contracted Services ISDH Monitors for the year 2012 failed to indicate the names of the contracted service providers for 23 of 33 services. The documentation lacked quality indicators including measureable and objective standards for evaluating each service through the QA program.</p> <p>2. During an interview on 12-05-12 at 1010 hours, staff A1 confirmed that the QA program failed to establish the indicators and standards for evaluating its contracted services.</p>	S0310	S310 New contracted services form will be updated to delineate name of service, and quality indicators including measurable and objective standards. The Director of Nursing will monitor annually and amend as necessary.	01/07/2013	

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S0444	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</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>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on observation and interview, the infection control practitioner failed to ensure that nursing and medical staff followed AORN (Association of PeriOperative Nurses) standards and recommendations in relation to surgical masks dangling about the neck for one nurse and one physician observed (staff members #55 and #56).</p> <p>Findings:</p> <p>1. at 9:21 AM on 12/5/12, it was observed in the nursing station of the pre/post op area that one RN had their surgical mask down about the neck (staff member #55)</p> <p>2. at 9:25 AM on 12/5/12, it was observed that the pediatric surgeon, staff member #56, was in the pre op hallway</p>	S0444	<p>S444 Policy L100 was revised on 12-19-12 to address surgical masks should not be saved by hanging them around the neck or tucking them into a pocket for future use. They should be discarded immediately after each surgical procedure and not left down and dangling around the neck in hallways, pre/post op areas, etc. Policy will be sent to the Board of Directors for approval. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 monitoring surgical masks of staff and physicians. The Quality Assurance Coordinator will monitor this.</p>	01/07/2013			

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	<p>with their surgical mask in the right hip back pocket of their scrubs (with the mask ties dangling from the pocket)</p> <p>3. at 10:10 AM on 12/5/12, it was observed that nursing staff member #55 was transporting a patient by stretcher to the procedure room with their surgical mask down about the neck</p> <p>4. at 10:20 AM on 12/5/12, nursing staff #55 was transporting the patient by stretcher from the procedure room to the recovery area with their surgical mask down about the neck</p> <p>5. interview with staff member #51, the Director of Nursing, at 1:15 PM on 12/5/12 indicated:</p> <ul style="list-style-type: none"> a. the facility follows AORN recommendations b. the policy related to "Surgical Attire", policy number L-100, does not address the stipulation that surgical masks about the neck are forbidden c. it is a standard of practice that masks should be discarded after each surgical procedure and not left down and dangling about the neck in hallways, pre/post op areas, etc. 				

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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 and procedure review, patient medical record review, and staff interview, the facility failed to ensure accurate documentation for 4 of 20 records reviewed (patients # 1, 3, 5, and 6).</p> <p>Findings:</p> <p>1. at 11:30 AM on 12/3/12, review of the policy and procedure manual indicated a policy titled: "J-20 Patient Medical record Protected Health Information", with a most recent revised date of 01/12, indicated:</p> <p>a. the "Purpose" statement reads: "To Assure Complete Comprehensive and Accurate Documentation of Patient Treatment"</p> <p>2. at 11:30 AM on 12/3/12, review of the policy and procedure manual indicated a policy titled: "J-25 Entries in the Medical Record", with a most recent revised date</p>	S0630	<p>S630 Policies J20 & J25 were modified on 12-19-12 to include, "Medical records will be accurate". Policies will be sent to the Board of Directors for approval. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on allergy documentation to assure accuracy & consistency in the medical record including documentation completed by other offices. Consent form GACC002 was revised listing all anesthesia types with added sentence "anesthesia will be modified as condition warrants" and sent to printers on 12-19-12. Draft back from printers on 12-21-12. Send to printers for final print on 12-26-12. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on accurate anesthesia documentation. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on medical records for appropriate</p>	01/07/2013			

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	<p>of 01/12, indicated:</p> <p>a. the "Purpose" statement reads: "To Assure Accurate Record of Care and to Provide A Method for Verifying and Identifying the Authentication of All Entries in the Medical Record"</p> <p>3. review of patient medical records at 2:10 PM on 12/3/12, 11:40 AM, and 2:15 PM on 12/4/12 indicated:</p> <p>a. pt. record #1 had documentation on the "Short Stay History & Physical" form that indicated in the "Allergies" section: "NKDA" (no known drug allergies), but had documentation on other forms in the chart, such as the "Operation Room Record" form indicating the patient was allergic to "PCN (penicillin)" and "Dye"</p> <p>b. pt. #3 had "Monitored Anesthesia Care with or without sedation" checked as the anesthesia to be used for their 7/10/12 surgery on the consent form and the "Operation Room Record" form, but had both General and MAC checked on the "Anesthesia Record" form</p> <p>c. pt. #5 had "General Anesthesia" checked and then crossed out on the surgical consent form and "Monitored Anesthesia Care with or without sedation" marked on the consent form, had "MAC" marked on the "Operation Room Record" form and had "General" anesthesia marked on the "Anesthesia Record" form</p> <p>d. pt. #6 had an operative note that</p>		gender listed on dictated OP notes.				

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	<p>indicated the surgery was performed on a "...young girl...", when the surgery was on a 6 year old male patient</p> <p>4. interview with staff member #51, the Director of Nursing, at 1:15 PM on 12/5/12, indicated:</p> <p>a. the "NKDA" for pt. #1 was noted on the "office" portion of the short stay History and Physical form, but the surgery center is responsible for all documentation the patients' medical records</p> <p>b. the policies J-20 and J-25 don't specifically indicate that medical records will be "accurate" except in their purpose statements</p>				

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S0640	<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>(1) Legible and complete. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the completeness of medical records for 2 patients (pts. # 14 and #16).</p> <p>Findings:</p> <p>1. at 11:30 AM on 12/3/12, review of the policy and procedure manual indicated a policy titled: "J-20 Patient Medical Record Protected Health Information", with a most recently revised date of 01/12, read on page 3 in section 7., "The Nursing Intra-Operative Room Record will document the pre-operative and post-operative diagnosis,...type of anesthesia and times of surgery and anesthesia..."</p> <p>2. review of patient medical records at 2:10 PM on 12/3/12, 11:40 AM, and 2:15 PM on 12/4/12 indicated:</p> <p>a. pt. #14 lacked documentation on the "Operation Room Record" form related to the "Method of Anesthesia" the patient received</p> <p>b. pt. #16 lacked documentation on the</p>	S0640	<p>S640 Policies J20 & J25 were modified on 12-19-12 to include, "Medical records will be accurate and complete". Policy will be sent to the Board of Directors for approval. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on allergy documentation to assure accuracy & consistency in the medical record including documentation completed by other offices.Consent form GACC002 was revised listing all anesthesia types with added sentence "anesthesia will be modified as condition warrants"and sent to printers on 12-19-12. Draft back from printers on 12-21-12. Send to printers for final print on 12-26-12. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on accurate anesthesia documentation.QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on medical records for appropriate gender listed on dictated OP notes.A statement was added to Policies J20 & J25 on 12-19-12 to include "the physician's history & physical</p>	01/07/2013			

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	<p>"Pre-Op/Phase II Record" form in the area of discharge related to how the patient exited the facility (whether "Ambulatory, W/C (wheel chair), cart, or carried")</p> <p>3. interview with staff member #51, the Director of Nursing, at 1:15 PM on 12/5/12, indicated:</p> <p>a. other than section 7. on page 3 of policy J-20, the policies related to medical record documentation (J-20 and J-25) are lacking the language that would require completion of the medical record in regard to marking or completing all boxes, spaces, and areas on forms</p>		<p>will be complete, including marking all boxes and filling in all spaces." Policies will be sent to the Board of Directors for approval on 1-7-13. QA study will be performed 4 th quarter 2012 & end of each quarter in 2013 on completeness of H&Ps. The Director of Nursing or Designee will be responsible for conducting the QA studies and forwarding results to QA Committee.</p>		

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S0888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on policy and procedure review, review of medical staff rules and regulations, patient medical record review, and staff interview, the medical staff failed to ensure that an operative report dictated by one podiatric physician was done immediately following the procedure for 1 patient (pt. #5).</p> <p>Findings:</p> <p>1. at 1:15 PM on 12/5/12, review of the medical staff rules and regulations with an approved date of 1/26/10, indicated:</p> <p>a. in section 3.6 "Basic Responsibilities of Medical Staff Membership", it reads:</p>	S0888	S888 Policy J20 was revised to include: dictation will occur on day of surgery. Policy will be sent to the Board of Directors for approval. The Administrative Assistant will audit medical records for physician #57 by the end of the 3rd quarter in 2013	01/07/2013	

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	<p>"Each Medical Staff member will:... (c) Abide by the Medical Staff policies and by all other lawful Surgery Center standards, policies and rules..."</p> <p>2. at 11:30 AM on 12/3/12, review of the policy and procedure manual indicated a policy titled: "J-20 Patient Medical Record", with a most recent revised date of 01/12, which reads on page 3 under section 11., "The surgeon must have on the chart an Operative Report describing the procedure performed..."</p> <p>3. review of patient medical records at 2:10 PM on 12/3/12 and 11:40 AM on 12/4/12 indicated:</p> <p>a. pt. #5 had a bunionectomy performed by physician # 57, a podiatric surgeon, on 6/5/12 and the operative record was not dictated until 6/6/12</p> <p>4. interview with staff member #51, the Director of Nursing, at 3:30 PM on 12/4/12 indicated:</p> <p>a. the standard of practice for this facility is that the operative note will be dictated on the day of surgery</p> <p>b. it is unclear why the operative note for patient #5 was not dictated until the day after surgery</p> <p>c. the medical staff rules and regulations do not address the time frame of expectation for the operative note, they</p>			

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	refer medical staff to facility policies d. the current policy (J-20) does not specify the expectation of dictation of the operative note either immediately following the procedure, or the same day as the procedure, making it unclear what facility and medical staff expectations are			

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S1182	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based upon document review and interview, the safety program failed to evaluate all safety hazards and safety practices by the committee for two safety functions.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Quality Assurance Plan (approved 10-11) indicated the following: " Review of monthly inspections ...[and] ...observations or concerns that may constitute a safety hazard ... " 2. Review of monthly safety committee meeting minutes for 2012 failed to indicate that the monthly safety rounding and radiation badge exposure monitoring was reviewed or discussed by the committee. 3. During an interview on 12-05-12 at 	S1182	S1182 Radiology Tech was added to Safety Committee and will report monthly radiation badge exposures. Safety check list will be reviewed monthly by Safety Committee. The Safety Officer will conduct monthly safety rounding. Dosimetry badge report will be reviewed monthly by the Safety Officer and reported to the Safety Committee.	12/19/2012	

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	1000 hours, staff A2 confirmed that the minutes lacked documentation that the two functions were reviewed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001088		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/05/2012	
NAME OF PROVIDER OR SUPPLIER GOSHEN AMBULATORY CARE CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1605 WINSTED DR GOSHEN, IN 46526			
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S1188	<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 authorities. (F) Fire drills.</p> <p>Based on document review and interview, the center failed to follow its policy/procedure and sound the alarm when conducting fire drills for 1 of 3 quarterly drills in 2012.</p> <p>Findings:</p> <p>1. The policy/procedure Fire Guidelines - Disaster Preparedness (approved 10-11) indicated the following: " All staff will participate in the following: quarterly fire drills, including testing the fire alarm system ... "</p> <p>2. Center documentation Fire/Evacuation Drill dated 3-21-12, 6-27-12 and 9-26-12 was reviewed and the 3-21-12 documentation failed to indicate that the</p>	S1188	S1188 Quarterly fire drills will include activating pull station to sound alarm from now on. The Safety Officer will review evaluation report monthly.	12/07/2012			

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	<p>training included sounding the fire alarm and the time of the drill.</p> <p>3. During an interview on 12-04-12 at 1210 hours, staff A2 and A5 confirmed that the Fire Drill documentation failed to indicate the fire alarm was sounded and that another drill would be performed in 2012.</p>			

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S1222	<p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(e)</p> <p>(e) Safeguards for patients, personnel, and public must be specified, including, but not limited to, the following:</p> <p>(1) Proper safety precautions must be maintained against radiation hazards in accordance with the center's radiation and safety program(s).</p> <p>(2) Hazards and faulty equipment identified must be promptly corrected in accordance with current standards of practice and applicable federal and state rules, including, but not limited to, collimation and filtration and evaluations of equipment performance.</p> <p>Based on document review and interview, the center failed to ensure that all female patients of childbearing age were screened to avoid fetal exposure to ionizing radiation.</p> <p>Findings:</p> <p>1. The policy/procedure HCG Urine Testing (approved 10-11) indicated the following: " For the detection of pregnancy. " The policy/procedure failed to indicate the criteria to determine when the test must be performed.</p> <p>2. The policy/procedure Ionizing</p>	S1222	<p>S1222 Policy O17 was revised on 12-19-12 to address required preoperative pregnancy testing on all females of childbearing age who have not signed a written refusal for a pregnancy test. Childbearing age is defined as menstruating females without prior hysterectomy or tubal ligation. Policy will be sent to the Board of Directors for approval. Policy P15 was revised on 12-19-12 to address Personnel with known or suspected pregnancy should declare this condition to the safety officer and their immediate supervisor. Disclosure of the pregnancy, even if it is obvious, is not required. A written, voluntary,</p>	01/07/2013			

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	<p>Radiation - Reducing Radiologic Exposure (approved 10-11) indicated the following: " Female patients of childbearing age should be questioned about the possibility of pregnancy. " The policy/procedure failed to ensure that a urine pregnancy test was performed prior to fluoroscopy for all potentially pregnant patients.</p> <p>3. During an interview on 12-05-12 at 1310 hours, staff A2 confirmed that the policy/procedures failed to indicate the center requirements to ensure that pregnancy testing was performed for all at-risk patients.</p>		<p>official declaration that includes the estimated date of conception is used to base the total dose limit to the pregnant person. The US Nuclear Regulatory Commission guidelines include the following: Occupational dose to the embryo or fetus of an occupationally exposed staff member who has declared her pregnancy must not exceed 0.5 rem during the entire gestational period. Dose should be uniform over time and not all at once. Policy will be sent to the Board of Directors for approval. The Director of Nursing will monitor this on an ongoing basis.</p>	