

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/07/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001123		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 03/21/2017	
NAME OF PROVIDER OR SUPPLIER CLI SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 7747 W JEFFERSON BLVD STE B FORT WAYNE, IN 46804			
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S 0000 Bldg. 00	The visit was for a Licensure survey. Facility Number: 003375 Survey Date: 3/20-21/17 QA: 5/25/17 jlh		S 0000				
S 0148 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c) (4) (c) The governing body shall do the following: (4) Require that the chief executive officer designate in writing an administrative officer to serve during his or her absence. Based on document review and interview, the Governing Body failed to designate in writing an administrative officer to serve during his/her absence in 1 instance. Findings include: 1. Review of the Governing Body Bylaws (approved 4-16) indicated the following: "The Governing Body shall be the supreme authority responsible for		S 0148	Per the Governing Body Bylaws, they shall be the supreme authority responsible for the legal and ethical conduct of the center. The Governing Body shall appoint officers, committee chairman, or employ personnel to direct the clinic and administrative activities of the center. On June 2, 2017, a revision to the Organizational Chart was updated and approved to reflect the delineation of positions and responsibilities set forth by the Governing body for the day to day operations of the Center. On June 2, 2017 a revision to policy, Chain of Command was completed to		06/02/2017	

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

TITLE

(X6) DATE

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

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S 0153 Bldg. 00	the legal and ethical conduct of the Center (See exhibit B - Organizational Chart)... The Governing Body shall appoint officers, committee chairmen and/or employ personnel to direct the clinical and administrative activities of the Center..." 2. On 3-21-17 at 1400 hours, the physician and Governing Board member, staff MD14 confirmed they were the CEO for the center and attended the Board of Directors and Medical Staff meetings and confirmed the Governing Body Bylaws had not been maintained. 410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review and interview, the facility failed to develop a policy related to orientation of contracted employees to fire and safety plan and failed to ensure contracted housekeeping were oriented to the facility's fire and safety plan in 2 out of 2 (P #6 and P #7)		S 0153	bring clarity to positions within the Organizational Chart responsible for the day to day operations and decision making on behalf the Governing Body. See Attachment E-Chain of Command See Attachment "Organizational Chart" Completed 06/02/07 The policy, Infection Control Plan, was reviewed by the Governing Body on Friday, June 2,2017. Revisions included the addition of criteria concerning the cleaning personnel employed by our contracted environmental cleaning company, Office One. A detailed checklist was created for the contracted environmental		06/05/2017	

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S 0310 Bldg. 00	personnel records. Findings include; 1. There was no policy regarding the training of contract employees. 2. Employee #P6 and P7 personnel files lacked orientation to the facility fire and safety plan. 3. Interview with P#1, Director of Nursing on 03/21/17 at 3:15 pm confirmed that facility does not orient contract workers to fire and safety. 410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the Quality Assessment and Improvement (QA) program failed ensure all contracted services at the center were evaluated and reviewed through the program.		S 0310	cleaning company, Office One, to include documentation of but not limited to, facility fire and safety plan. This checklist was presented to Angie Soto, of Office One Cleaning on Monday, June 5, 2017. The facility Infection Control Officer will work closely with Office One Cleaning to ensure all requirements of the facility orientation checklist are completed for all cleaning personnel. See Attachment A – Infection Control Plan See Attachment B – Detailed orientation checklist Completed on June 5, 2017. The policy, Quality Assurance and Improvement Program was reviewed by the Governing Body on Friday, June 2, 2017. Revisions included additions to the program for monitoring the quality and appropriateness of indirect patient care vendors. A detailed checklist was created for		06/02/2017	

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S 0442 Bldg. 00	Findings include: 1. Review of the policy/procedure Quality Assurance and Improvement Program (approved 4-16) failed to indicate a requirement for evaluating all contracted services through the program. 2. Review of the 2016 and 2017 Quality Assurance and Improvement meeting minutes lacked documentation indicating a review of the contracted services identified on the 2017 Master List of Agreements was performed. 3. On 3-21-17 at 1535 hours, Director of Nursing, staff A2, confirmed the center lacked documentation indicating its contracted services were evaluated and reviewed through the Quality Assurance and Improvement program. 410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii) The infection control committee responsibilities must include, but are not limited to: (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:			the indirect patient care vendors to ensure the quality standards threshold for review are met. The results of the quarterly review will be reported in the QAPI meeting minutes and reviewed by the Governing Body. See Attachment C – Quality Assurance and Improvement Program See Attachment D – Master List of Indirect Patient Care Vendors Completed: 6/2/17			

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	(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. Based on document review and interview, the facility failed to follow its policy on annual tuberculosis test for 1 of 5 (N #1) and proof of immunity for 1 out of 5 (N #5) personnel records reviewed. Findings include; 1. Review of policy Physical Examination, Tuberculosis Screening and Verification Immunity, Procedure (reviewed/revised 3/16): (page 4) 3. A. stated "All facility employees/volunteers shall have an annual PPD (TB test) ...". 2. Personnel record (N #1) lacked documentation of a TB test completed in 2016. 3. Review of policy Physical Examination, Tuberculosis Screening and Verification Immunity, Procedure: (page 5) stated "All employees and volunteers shall provide proof of immunity before beginning employment". 4. Personnel record (N #5) lacked documentation of immunity of rubeola		S 0442	Personnel record lacked documentation (N#1) annual TB testing and (N#5) lacked proof of immunity. (N#1) Received her annual TB test on 03/21/17 and (N#5) received booster immunization on 03/30/17 for Rubeola. (N#5) received confirmation via titer draw confirming immunity for Rubeola on 05/31/17. The CLI Surgery Center checklist was reviewed to ensure that employee immunity and TB testing was up to date. It was discovered that (N#1) was not present during annual TB testing in October of 2016. Moving forward the Director of Nursing will create a list of any absent employee to ensure a makeup test date is secured. Completed: 5/31/17		05/31/2017	

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S 0732 Bldg. 00	completed at time of hire or since then. 5. Interview with P #1, Director of Nursing on 03/20/17 at 3:15 pm confirmed the lack of documentation for TB test (N #1) and rubeola immunity (N #5) in personnel records. 410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2) These bylaws and rules must be as follows: (2) Be reviewed at least triennially. Based upon document review and interview, the Medical Staff failed to follow its Bylaws and ensure its Bylaws, Rules and Regulations were reviewed at least triennially. Findings include: 1. Review of the Medical Staff Bylaws, Rules and Regulations (revised 1-17-14) indicated the following: "These Bylaws will be reviewed triennially by the medical staff and governing body." 3. Review of the 2016 and 2017 Medical Staff meeting minutes lacked		S 0732	On April 20, 2017, the Medical Staff reviewed and approved without revision the Medical Staff Bylaws, Rules and Regulations. Moving forward the Medical Staff will review the Medical Staff Bylaws, Rules, and Regulations triennially to make recommendation to the Governing Body prior to their triennial review of the Policy and Procedure Manual. Completed 04/20/17		04/20/2017	

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	documentation indicating the Medical Staff Bylaws, Rules and Regulations had been reviewed and approved by the Medical Staff. 4. On 3-20-17 at 1425 and at 1530 hours, the Administrator, staff A1, and the Director of Nursing, staff A2 confirmed the center lacked documentation indicating the Medical Staff Bylaws, Rules and Regulations had not been reviewed by the Medical Staff within the past 3 years and no other documentation was available.						