

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001021	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/05/2012
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NAME OF PROVIDER OR SUPPLIER SCP INDIANAPOLIS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7430 N SHADELAND AVE STE 100 INDIANAPOLIS, IN 46250
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Q000000	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 005402</p> <p>Survey Date: 10-3/5-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: clauglin 10/31/12</p> <p>02/06/13 revised due to IDR</p>	O000000		

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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Q000106	<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 document review and interview, the facility failed to ensure that cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and Advanced Cardiac Life Support (ACLS) for all health care workers who provide direct patient care for 8 of 12 direct patient care personnel files reviewed (Staff #2, 4, 5, 6, 8, 9, 10 and 11). Findings include:</p> <ol style="list-style-type: none"> Review of staff #2, 5, 6, 8, 10 and 11's personnel file indicated each had Institute of CPR training and lacked documentation of CPR competence that met current standards of practice that met American Heart Association or Red Cross standards. Review of staff #9's personnel file indicated that he/she was a certified surgical tech hired on 07-30-12 and lacked documentation of current CPR competency. On 10-04-12 at 1100 hours, staff #8 confirmed the Institute of CPR training is 	O000106	<p>Q0106 416.44(d) Emergency Personnel</p> <p><u>Plan of Correction:</u> 1. Employees #2,5,6,8,10, and 11 have been scheduled for CPR hands-on training that will supplement their current online training making their training American Heart Association compliant. The training is scheduled for November 12, 2012. In the event that any staff is unable to attend, certification must be completed independently no later than December 1, 2012. Any Employee who has not completed training by December 1, 2012 will be removed from the center schedule and will not be scheduled until certification in up to date. Employee #9 also has an expired CPR certification and is scheduled for the November 12 retraining class. The three nurses lacking ACLS certification were certified within 12 months of their hired date, as required by our policy, and all have recently expired. All three are PRN staff members who work, on average 2 shifts per month. However, these three nurses have all been registered for ACLS Refresher training to take place on November 27, 2012. Any nurse</p>	12/01/2012			

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	<p>completed online and lacked hands on training evaluation as done with American Heart Association or Red Cross standards.</p> <p>4. Review of the Position Description for Staff Nurse - Operating Room/Pre-Op/Recovery indicated the following: "Must be ACLS certified within 12 months of hire." This policy/procedure was last reviewed/revised on 08-15-12.</p> <p>5. Review of staff #4's personnel file indicated that he/she was hired on 04-08-10 as a recovery nurse and lacked current certification in ACLS.</p> <p>6. Review of staff #10's personnel file indicated that he/she was hired on 10-04 as a Operating Room/Pre-Op/Recovery nurse and lacked current certification in ACLS.</p> <p>7. Review of staff #11's personnel file indicated that he/she was hired on 07-10-00 as a Operating Room/Pre-Op/Recovery nurse and lacked current certification in ACLS.</p>		<p>unable to attend the company-provided retraining will be responsible for independently completing refresher training and will be removed from the schedule as of December 1, 2012 until such training is completed.</p> <p>2. A form has been created entitled Staff Credentialing/Expiration Dates, which will assist management in keeping track of staff certifications and licensure. This form was created November 5, 2012 and will be updated when staff completes refresher training and as needed. The form is stored securely online.</p> <p>3. The Director of Nursing will be responsible for assuring that staff maintains credentialing and licensure.</p> <p>4. The classes for CPR and ACLS retraining were scheduled as of Monday November 5, 2012. The classes will be completed by November 27, 2012. All staff not recertified by December 1, 2012 will be removed from the Center schedule until such a time as recertification is completed and proof of recertification is provided to the Director of Nursing.</p>		

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Q000184	<p>416.48(a)(3) VERBAL ORDERS Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician. Based on document review and interview, the facility failed to ensure that verbal orders were documented as required by the facility's policy & procedure for 4 of 30 patient medical records (MR) reviewed (Patient #3, 6, 12 and 24).</p> <p>Findings include:</p> <p>1. Review of policy/procedure Pharmaceutical Services indicated the following: "5. Issuing/Dispensing of Drugs. Physicians may prescribe drugs for patients during their stay in the Center as standing Orders, or by verbal order. The following protocol shall be followed: b. Verbal medication orders may be taken from a staff physician by a Registered Nurse. There medication orders shall be entered in the patient's medical record as a verbal order and signed by the ordering physician with the date and time of the order." This policy/procedure was last reviewed/revised on 08-15-12.</p> <p>2. Review of patient #3, 6, 12 and 24's MR indicated that a verbal order for Ofirmev, 1000 mg / 100 ml IVPB be</p>	O000184	<p>Q0184 416.48(a)(3) Verbal Orders</p> <p>1. <u>Plan of Correction:</u> 2. On November 5, 2012 Verbal Order Policy 12.5 (b) was re-written to include more specific requirements for the documentation of verbal orders. New policy specifically states that documentation is to include "date and time the order was taken", and documentation of the "date and time the order was carried out." This policy will be submitted for approval to the Quality Assurance Committee, which meets in February 2013. Until such a time as the new policy is approved, all registered nurses will be required to attend in-service training in proper documentation of verbal orders not later than December 1, 2012. Adherence to the new policy will be checked by Random Electronic Record Review conducted quarterly by the Director of Nursing. On-going education of nursing staff will also be undertaken to assure compliance. 3. The Director of Nursing is responsible for the changes to the policy, the education of the staff, and for the on-going support to assure compliance.</p>	12/01/2012	

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	<p>administered. Review of the order lacked the date and time the verbal order was given.</p> <p>3. On 10-04-12 at 1410 hours, staff #40 confirmed that the verbal orders for patient #3, 6, 12 and 24 lacked documentation of the date and time received.</p>		<p>4. Policy was re-written November 5, 2012 and will be submitted to the Quality Assurance Committee at its meeting in February 2013 for approval. Functional change will commence immediately and in-service education will be accomplished not later than December 1, 2012.</p>		

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Q000202	<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 facility did not have complete written radiological policies and procedures for its radiology services.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a document entitled Surgery Center Plus, Inc., Policy and Procedure has been reviewed, revised and approved effective August 15, 2012, Section 13.12, Fluoroscanner Usage, indicated physician operating mini fluroscan and scrub will wear badges to monitor amount of radiation exposure. No further documentation was provided. In interview, on 10-5-12 at 12:30 pm, employee #A2 indicated there could be more than just a scrub in the area where the mini fluroscan was being used. Thus, the policy did not apply to all employees in the area where the mini fluroscan was being used and no further documentation was provided. Review of a document entitled Surgery Center Plus, Inc., Policy and Procedure 	O000202	<p>1. Tag # : Q0202 2. 416.49(b) Radiologic Services</p> <p>3. Plan of correction: As of 12/31/2012, SCP was purchased by Covenant Surgical Partners. On February 7, 2013, a new Radiation Safety Policy was adopted by the Board of Managers requiring all staff in the room while the Mini-C-Arm is in operation to wear lead aprons. Additional radiation monitoring badges have been added, and all staff in the room when the mini-C-Arm is in use are required by policy to wear their own individual badge. As regards pregnant patients, policy now requires all women under the age of 49 who have not been surgically sterilized to take a urine pregnancy or sign a waiver. The new policy specifies that all patients with a positive pregnancy test will have their procedures cancelled. Pregnant staff members are not assigned to rooms where the mini-C-Arm will be in use. As of Feb. 1, 2013, new signage has been added to the waiting room warning of the use of radiation and requesting that all female patients advise the receptionist and nurse if there is any possibility of their being pregnant.</p>	12/01/2012			

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	<p>has been reviewed, revised and approved effective August 15, 2012, did not indicate a method for the facility to identify pregnant patients.</p> <p>5. In interview, on 10-5-12 at 12:30 pm, employee #A2 confirmed the radiological policies did not indicate a method for the facility to identify pregnant patients and no further documentation was provided prior to exit.</p>		In this way, SCP feels certain we are now in full compliance with the regulations cited in this tag.	

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Q000221	<p>416.50(a)(1) NOTICE OF RIGHTS</p> <p>The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands.</p> <p>Based on document review and interview, the facility failed to provide the patient or the patient's representative with verbal and written notice of several of the patient's rights prior to surgery.</p> <p>Findings:</p> <p>1. Review of the patient rights document posted in the facility indicated it did not contain the following: names of specific owners of the facility, information about the State advanced directive brochure, the exercise of patient rights without being subjected to discrimination or reprisal, grievances regarding treatment that is or fails to be furnished, patient incompetency whether adjudged by a court of law or not, a setting free of contaminated materials and unwanted visitors, and a setting free from all forms of staff abuse, neglect or harassment.</p> <p>2. In interview, on 10-4-12 at 2:15 pm, employee #A1 indicated the above issues were not included in the patient rights given verbally and in writing to the</p>	O000221	<p>Q0221 416.50(a)(1) Notice of Rights</p> <p><u>Plan of Correction:</u></p> <p>1. Our Patient Rights provided do include entries that address: physician ownership, advanced directives, grievances, patient incompetency, and harassment. (Attachment: W) We will; however, update our patient rights to include entries that address discrimination or reprisal, a setting free of contaminated materials and unwanted visitors and a setting free from all forms of staff abuse.</p> <p>2. To prevent this deficiency from recurring, we will review our Patient Rights annually with the ISDH requirements and update accordingly.</p> <p>3. The General Manager will be responsible for ensuring that these rights are reviewed and updated.</p> <p>4. Date of correction: 12/1/12</p>	12/01/2012	

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	patient or the patient's representative. No further documentation was provided prior to exit.			

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Q000222	<p>4166.50(a)(1)(i) NOTICE - POSTING In addition, the ASC must - Post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. Based on document review and interview, the facility failed to post several of the patient's rights.</p> <p>Findings:</p> <p>1. Review of the patient rights document posted in the facility indicated it did not contain the following: names of specific owners of the facility, information about the State advanced directive brochure, the exercise of patient rights without being subjected to discrimination or reprisal, grievances regarding treatment that is or fails to be furnished, patient incompetency whether adjudged by a court of law or not, a setting free of contaminated materials and unwanted visitors, and a setting free from all forms of staff abuse, neglect or harassment.</p> <p>2. In interview, on 10-4-12 at 2:15 pm, employee #A1 confirmed the above issues</p>	0000222	<p>Q0222 4166.50(a)(1)(i) Notice - Posting</p> <p><u>Plan of Correction:</u></p> <p>1. Our Patient Rights posted do include entries that address: physician ownership, advanced directives, grievances, patient incompetency, and harassment. (Attachment: W) We will; however, update our patient rights to include entries that address discrimination or reprisal, a setting free of contaminated materials and unwanted visitors and a setting free from all forms of staff abuse.</p> <p>2. To prevent this deficiency from recurring, we will review our Patient Rights annually with the ISDH requirements and update accordingly.</p> <p>3. The General Manager will be responsible for ensuring that these rights are reviewed and updated.</p> <p>4. Date of correction: 12/1/12</p>	12/01/2012

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	were not included in the patient rights posted in the facility. No further documentation was provided prior to exit.			

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Q000223	<p>416.50(a)(1)(ii) NOTICE - PHYSICIAN OWNERSHIP The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure. Based on document review and interview, the facility failed to have a policy and procedure indicating the specific names of all physicians who have financial interests or ownership in the facility</p> <p>Findings:</p> <p>1. Review of a document entitled Surgery Center Plus, Inc., Policy and Procedure has been reviewed, revised and approved effective August 15, 2012, indicated it did not include a policy and procedure indicating the specific names of all physicians who have financial interests or ownership in the facility.</p> <p>2. In interview, on 10-4-12 at 2:15 pm, employee #A1 confirmed the above-stated document did not include the names of specific physicians who have financial interests or ownership in the facility. No other documentation was provided prior to exit.</p>	Q000223	<p>Q0223 416.50(a)(1)(ii) Notice - Physician Ownership</p> <p><u>Plan of Correction:</u></p> <p>1. Our Policy and Procedures have been updated to include a policy that a list will be provided to the patient with specific names of all physicians who have financial interests or ownership in the facility.</p> <p>2. The list provided to the patient will be updated whenever there are changes in ownership.</p> <p>3. The General Manager will be responsible for ensuring that these rights are reviewed and updated.</p> <p>4. Date of correction: 12/1/12</p>	12/01/2012			

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Q000224	<p>416.50(a)(2) ADVANCE DIRECTIVES The ASC must comply with the following requirements:</p> <p>(i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms.</p> <p>(ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care.</p> <p>(iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>Based on document review, the facility failed to provide a policy of and description and availability of the applicable State health and safety laws, and the State advanced directive brochure.</p> <p>Findings:</p> <p>1. Review of a document entitled Surgery Center Plus, Inc., Policy and Procedure has been reviewed, revised and approved effective August 15, 2012, in a section entitled Rights of Patients, indicated it did not include a policy of and description and availability of the applicable State health and safety laws, and the State advanced directive brochure.</p>	0000224	<p>Q0224 416.50(a)(2) Advance Directives</p> <p><u>Plan of Correction:</u></p> <p>1. Our Policy and Procedures have been updated to include a policy that provides a description and indicates availability of the State health and safety laws and the State advanced directive brochure. .</p> <p>2. The policy will be reviewed and updated whenever there are ISDH changes to the policy on advance directives.</p> <p>3. The General Manager will be responsible for ensuring that these rights are reviewed and updated.</p> <p>4. Date of correction: 12/1/12</p>	12/01/2012			

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	2. In interview, on 10-4-12 at 2:15 pm, employee #A1 confirmed the above-stated document did not include a policy of and description and availability of the applicable State health and safety laws, and the State advanced directive brochure. No other documentation was provided prior to exit.				

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Q000225	<p>416.50(a)(3)(i), (v), (vi), (vii) SUBMISSION AND INVESTIGATION OF GRIEVANCES</p> <p>(i) The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC.</p> <p>(v) The grievance process must specify timeframes for review of the grievance and the provisions of a response.</p> <p>(vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished.</p> <p>(vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.</p> <p>Based on document review, the facility failed to have an appropriate, written grievance procedure.</p> <p>Findings:</p> <p>1. Review of a document entitled Surgery Center Plus, Inc., Policy and Procedure has been reviewed, revised and approved effective August 15, 2012, in a section entitled Submission and Investigation of Grievances, indicated it did not include the following elements: The written decision to the patient would contain the name of a facility contact</p>	Q000225	<p>1. Tag #: Q0225 2. 416.50(a)(3)(i), (v), (vi), (vii) Submission and Investigation of Grievances</p> <p>3. Plan of Correction: On 12/31/2013, SCP was purchased by Covenant Surgical Partners, and we immediately began adopting Covenant Policies, Procedures, and Guidelines. The new Covenant/SCP Grievance policy (QAPI-16) specifies that a grievance is "a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's</p>	12/01/2012			

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	<p>person, the steps taken to investigate the grievance, and the date the grievance process was completed.</p> <p>2. In interview, 10-4-12 at 2:15 pm, employee #A1 confirmed the above-stated elements were not contained in the facility's grievance policy. No other documentation was provided prior to exit.</p>		<p>representative, regarding the patient's care, abuse (verbal, mental, sexual, or physical) or neglect, mistreatment, issues related to compliance to regulatory standards, or a Medicare beneficiary billing complaint." Policy QAPI-10 goes on to specify that "In resolution of the grievance, a written notice must be provided to the complainant that contains the name of the facility contact person,, the steps taken on behalf of the patinet to investigate the grievance, the results of the grievance investigation, and the date of completion." In this way, SCP feels that we are in full compliance with the federal regulations regarding the handling of grievances.</p>		

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Q000232	<p>416.50(c)(2) SAFETY [The patient has the right to -] Receive care in a safe setting</p> <p>Based on document review and interview, the facility failed to have a policy that the patient has a right to receive care in a safe setting, including free of contaminated materials.</p> <p>Findings:</p> <p>1. Review of a document entitled Surgery Center Plus, Inc., Policy and Procedure has been reviewed, revised and approved effective August 15, 2012, indicated it did not include a policy and procedure that the patient has a right to receive care in a safe setting, including free of contaminated materials.</p> <p>2. In interview, on 10-4-12 at 2:15 pm, employee #A1 confirmed the above-stated document did not include a policy that the patient has a right to receive care in a safe setting, including free of contaminated materials. No other documentation was provided prior to exit.</p>	Q000232	<p>1. Tag #: Q0232 2. 416.50(c)(2) Safety 3. Plan of correction: On 12/31/2012 Scurgery Center Plus was purchased by Covenant Surgical Partners. Since that time, we have been adopting Covenant's policies and procedures. On 02/07/2013 the Environment of Care section of the policy and procedure manual was adopted. Policy EC-01 specifies that "The Center has established and implemented a facility -wide safety management plan that: Provides a safe physical environment free of hazards for patients, personnel, physicians, and visitors by: Managing staff activities to reduce the risk of injury; Maintaining and supervising all grounds and equipment; Conducting reik assessments that proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety; Examining safety issues by appropriate representatives from administration , clinical services, and support services; Reporting and investigating all incidents of property damage, occupational illness, and patient, physician, or visitor injury; and Conducting ongoing hazard surveillance, including response to product safety recalls." By following the</p>	12/01/2012	

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			new policy and procedure, SCP feels confident we have corrected our non-compliance with the noted tag.	

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Q000241	<p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on document review, observation and interview, the facility failed to ensure that policy/procedure for instrument cleaning and disinfection was followed.</p> <p>Findings include:</p> <p>1. Review of policy/procedure Infection Controls indicated the following: "9.13 Instrument Cleaning It is the policy of the Center to properly clean and transport all instrumentation used in the Operating Room. Procedure: 1. Washing/Rinsing/Drying. Instruments are washed in the Soiled Utility Room with approved instrument detergent, rinsed thoroughly.</p> <p>9.14 Disinfection/Cold Sterilization of Instruments and Equipment Procedure: 1. High Level Disinfectant. Approved high level disinfectant (glutaraldehyde solution) is used following manufacturer's instructions and avoid contact with skin or mucous membranes. 3. Glutaraldehyde Solution Test Strips.</p>	Q000241	<p>Q0241 416.51(a) Sanitary Environment</p> <p><u>Plan of Correction:</u> 1. It is SCP's desire to be compliant with manufacturers' guidelines for safe usage of products used within our center. It has been the practice of SCP to change the McKesson 14-day Glutaraldehyde solution every 14 days as indicated on the label and as documented on a calendar kept in the instrument room. Appropriate 1.5% test strips are used to test the solution daily, however this has not been documented. In the interest of compliance and of demonstrating our commitment to safety, a McKesson 14-day Glutaraldehyde Test/Change Log has been created. In this log the 14-day changes of the Glutaraldehyde are documented, as well as the testing with the 1.5% Glutaraldehyde Test strips done daily and prior to each usage of the cold sterilization. Center policy 9.13 entitled Instrument Cleaning states testing of glutaraldehyde solution will be done to manufacturers' guidelines, however Procedure #3 will be amended to reflect</p>	12/01/2012			

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	<p>Glutaraldehyde solution test strips are used according to manufacturer's instructions to monitor effectiveness of the glutaraldehyde solution. Testing is done daily prior to usage to guard against dilution of the solution, which may lower the concentration below MEC (minimum effective concentration). Documentation of this testing is maintained by instrument room personnel." This policy/procedure was last reviewed/revised on 08-15-12.</p> <p>2. Review of the manufacturer's recommendations for the McKesson 14-Day Glutaraldehyde solution indicated the following: "It is recommended that the McKesson 14-Day Glutaraldehyde solution be tested with a 1.5% glutaraldehyde concentration indicator prior to each usage."</p> <p>3. On 10-04-12 at 1230 hours the following was observed in the Soiled Work Room: 1 container with McKesson 14-Day Glutaraldehyde solution.</p> <p>4. On 10-04-12 at 1230 hours, staff #2 confirmed that there was no documentation of the concentration check of the McKesson 14-Day Glutaraldehyde solution.</p>		<p>testing to be done daily and prior to each usage. Center also acknowledges that Gettinge Hi Foam solution has not been measured for usage according to manufacturers' guidelines. It has been determined that the pan regularly used for instrument washing with this solution holds one gallon of water, so a measuring device holding one ounce has been placed in the instrument room for the usage of staff when measuring the Gettinge Hi Foam solution. The bottle containing the Gettinge Hi Foam solution will be marked with the reminder "Use one ounce per one gallon of water." 2. Prevention of recurrence will be accomplished use of the McKesson 14-day Glutaraldehyde Test/Change Log. Staff working in the instrument room will be re-educated in the usage of the new log as well as in the measurement of the Gettinge Hi Foam solution. 3. Director of Nursing is responsible for the creation of the log, for the placement of the measuring device, the changes to the Instrument Cleaning procedure. 4. The McKesson 14-day Glutaraldehyde Test/Change Log was created and placed into service November 5, 2012. The calibration of the wash tub and the placement of the measuring device was accomplished November 9, 2012. The changes</p>				

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	<p>5. Review of the manufacturer's recommendations for the Getinge Manual Detergent HI Foam solution recommended to use 0.2 - 1.0 ounce of Getinge Manual Detergent HI Foam solution per 1 gallon of water.</p> <p>6. On 10-04-12 at 1230 hours, staff #2 confirmed that he/she mixes an unknown amount of Getinge Manual Detergent HI Foam solution with unknown amount of water.</p>		to the procedure will be accomplished not later than December 1, 2012.		

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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005402</p> <p>Survey Date: 10-3/5-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/31/12</p> <p>02/06/13 revised due to IDR</p>	S000000		

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S000102	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(1)(A)</p> <p>The governing body shall do the following:</p> <p>(1) Ensure that the center: (A) meets all rules and regulations for licensure and certification, if applicable Based on document review and interview, the facility failed to comply with an applicable state law for 1 of 1 (PF#1) unlicensed employee file reviewed.</p> <p>Findings:</p> <p>1. Review of IC 16-28-13-4, a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee, for a copy of the person ' s state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of the file of employee P#1 indicated she was not a licensed health care provider by the State of Indiana.</p> <p>3. Review of the file of employee P#1 indicated there was a document from MD#8 to a facility employee, dated 5-1-09, that indicated after completion of orientation and training, [employee P#1] performed</p>	S000102	<p>S0102 410 IAC 15-2.4-1 (a)(1)(A) Governing Body; Powers and Duties <u>Plan of Correction:</u> 1. Ran limited criminal background check on P#1 also ran report from the state nurses aide registry. No issues were reported. 2. To prevent this deficiency from recurring, we have updated policy and procedure. It now details that all unlicensed staff in positions of direct-patient care will have a state nurse aide registry report from the state department and a limited criminal history from the Indiana State Police Department. 3. The General Manager will responsible for ensuring that these reports are run and both reports documented in the employee file. 4. Date of correction: 12/1/12</p>	12/01/2012			

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	<p>physiology testing on 4 patients under my direct supervision last month and she is clearly qualified to continue conducting these studies under direct physician guidance.</p> <p>4. Thus, employee P#1 was unlicensed and did provide patient care activities.</p> <p>5. Review of the file of employee P#1 indicated there was no documentation of the employee's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>6. In interview, on 10-4-12 at 3:15 pm, employee #A1 indicated there was no documentation of the employee's state nurse aide registry report from the state department and was no documentation of a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law. No further documentation was provided prior to exit.</p>				

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S000162	<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 document review and interview the facility failed to ensure that cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and Advanced Cardiac Life Support (ACLS) for all health care workers who provide direct patient care for 8 of 12 direct patient care personnel files reviewed. (Staff #2, 4, 5, 6, 8, 9, 10 and 11)</p> <p>Findings include;</p> <p>1. Review of staff #2, 5, 6, 8, 10 and 11's personnel file indicated each had Institute of CPR training and lacked documentation of CPR competence that met current standards of practice that met American Heart Association or Red Cross standards.</p>	S000162	<p>S0162 410 IAC 15-2.4-1 (c)(5) (G) Governing Body Powers and Duties</p> <p><u>Plan of Correction:</u> 1. Employees #2,5,6,8,10, and 11 have been scheduled for CPR hands-on training that will supplement their current online training making their training American Heart Association compliant. The training is scheduled for November 12, 2012. In the event that any staff is unable to attend, certification must be completed independently no later than December 1, 2012. Any Employee who has not completed training by December 1, 2012 will be removed from the center schedule and will not be scheduled until certification in up to date. Employee #9 also has an expired CPR certification and is scheduled for the November 12 retraining class. The three</p>	12/01/2012			

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	<p>2. Review of staff #9's personnel file indicated that he/she was a certified surgical tech hired on 07-30-12 and lacked documentation of current CPR competency.</p> <p>3. On 10-04-12 at 1100 hours staff #8 confirmed the Institute of CPR training is completed online and lacked hands on training evaluation as done with American Heart Association or Red Cross standards.</p> <p>4. Review of the Position Description for Staff Nurse - Operating Room/Pre-Op/Recovery indicated the following; "Must be ACLS certified within 12 months of hire." This policy/procedure was last reviewed/revised on 08-15-12.</p> <p>5. Review of staff #4's personnel file indicated that he/she was hired on 04-08-10 as a recovery nurse and lacked current certification in ACLS.</p> <p>6. Review of staff #10's personnel file indicated that he/she was hired on 10-04 as a Operating Room/Pre-Op/Recovery nurse and lacked current certification in ACLS.</p> <p>7. Review of staff #11's personnel file</p>		<p>nurses lacking ACLS certification were certified within 12 months of their hired date, as required by our policy, and all have recently expired. All three are PRN staff members who work, on average 2 shifts per month. However, these three nurses have all been registered for ACLS Refresher training to take place on November 27, 2012. Any nurse unable to attend the company-provided retraining will be responsible for independently completing refresher training and will be removed from the schedule as of December 1, 2012 until such training is completed.</p> <p>2. A form has been created entitled Staff Credentialing/Expiration Dates, which will assist management in keeping track of staff certifications and licensure. This form was created November 5, 2012 and will be updated when staff completes refresher training and as needed. The form is stored securely online.</p> <p>3. The Director of Nursing will be responsible for assuring that staff maintains credentialing and licensure.</p> <p>4. The classes for CPR and ACLS retraining were scheduled as of Monday November 5, 2012. The classes will be completed by November 27, 2012. All staff not recertified by December 1, 2012 will be removed from the Center schedule until such a time as recertification is completed and</p>	

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	indicated that he/she was hired on 07-10-00 as a Operating Room/Pre-Op/Recovery nurse and lacked current certification in ACLS.		proof of recertification is provided to the Director of Nursing.	

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S000404	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on interview, the facility failed to maintain a written, active, and effective center-wide infection control program that includes a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers for 1 facility.</p> <p>Findings include;</p> <p>1. On 10-03-12 at 0940 hours and on 10-04-12 at 1520 hours, it was requested to staff #40 to provide the facility's written Infection Control Program that addressed identification, surveillance and investigation. None was provided prior to exit on 10-05-12 at 1315 hours.</p>	S000404	<p>1. Tag # : S0404 2. 410 IAC 15-2.5-1(b) Infection Control Program</p> <p>3. Plan of Correction: On 2/7/2012, Surgery Center Plus adopted the new Infection Control Policy and Plan provided by our new parent company, Covenant Surgical Partners. The new plan (under the IC header in our new Policy and Procedure manual, provides for both an Infection Control Program and a Plan. The new plan addresses training of staff and the IC Officer, Risk assessment, Exposure control, Surveillance, and reporting. Risk assessment includes not only assessing current issues, but allows for a retrospective assessment of past practices with an eye toward future improvement. The Infection Control Plan includes the key components of Exposure control, Practices specific to Infection Control, Disinfection and Sterilization, Environmental care, and reporting. Training is</p>	12/01/2012			

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			<p>accomplished through company provided on-line activities and in-services. Risk assessment is accomplished through assessment of risk, assessment of services provided, assessment of the population served, prioritization strategies to decrease risk, evaluation of effectiveness of strategies, and a surveillance plan based on the analysis of previous data. Exposure control includes assessment for infectious diseases, a staff vaccination program, a sharps injury prevention plan, OSHA safety device evaluation, a TB plan, a hand hygiene program, use of personal protective equipment and safe engineering devices, use of specified hand products. Practices specific to Infection Control include familiarity with MDROs, asepsis, visitor and traffic pattern controls, and specific activities related to cleaning of devices in the center. Surveillance is accomplished through followup with patients, exposures, and reportable events. Reporting includes outbreak investigation, guideleines for potential bioterrorism, Communicable diseases in patients and staff members, and finishes with lists of 2012 reportable diseases. Surgery Center Plus feels confident that our new policies for Infection Control bring us into compliance with state regulations.</p>	

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S000432	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, observation and interview the facility failed to ensure that policy/procedures for instrument cleaning and disinfection was followed for 1 facility.</p> <p>Findings include;</p> <p>1. Review of policy/procedure Infection Controls indicated the following; "9.13 Instrument Cleaning It is the policy of the Center to properly clean and transport all instrumentation used in the Operating Room. Procedure: 1. Washing/Rinsing/Drying. Instruments are washed in the Soiled Utility Room with approved instrument detergent, rinsed thoroughly.</p> <p>9.14 Disinfection/Cold Sterilization of</p>	S000432	<p>S0432 IAC 15-2.5-1 Infection Control Program</p> <p><u>Plan of Correction:</u> 1. It is SCP's desire to be compliant with manufacturers' guidelines for safe usage of products used within our center. It has been the practice of SCP to change the McKesson 14-day Glutaraldehyde solution every 14 days as indicated on the label and as documented on a calendar kept in the instrument room. Appropriate 1.5% test strips are used to test the solution daily, however this has not been documented. In the interest of compliance and of demonstrating our commitment to safety, a McKesson 14-day Glutaraldehyde Test/Change Log has been created. In this log the 14-day changes of the Glutaraldehyde are documented, as well as the testing with the 1.5%</p>	12/01/2012

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	<p>Instruments and Equipment Procedure:</p> <p>1. High Level Disinfectant. Approved high level disinfectant (glutaraldehyde solution) is used following manufacturer's instructions and avoid contact with skin or mucous membranes.</p> <p>3. Glutaraldehyde Solution Test Strips. Glutaraldehyde solution test strips are used according to manufacturer's instructions to monitor effectiveness of the glutaraldehyde solution. Testing is done daily prior to usage to guard against dilution of the solution, which may lower the concentration below MEC (minimum effective concentration). Documentation of this testing is maintained by instrument room personnel." This policy/procedure was last reviewed/revised on 08-15-12.</p> <p>2. Review of the manufacturer's recommendations for the McKesson 14-Day Glutaraldehyde solution indicated the following: "It is recommended that the McKesson 14-Day Glutaraldehyde solution be tested with a 1.5% glutaraldehyde concentration indicator prior to each usage."</p> <p>3. On 10-04-12 at 1230 hours the following was observed in the Soiled Work Room; 1 container with McKesson 14-Day</p>		<p>Glutaraldehyde Test strips done daily and prior to each usage of the cold sterilization. Center policy 9.13 entitled Instrument Cleaning states testing of glutaraldehyde solution will be done to manufacturers' guidelines, however Procedure #3 will be amended to reflect testing to be done daily and prior to each usage. Center also acknowledges that Gettinge Hi Foam solution has not been measured for usage according to manufacturers' guidelines. It has been determined that the pan regularly used for instrument washing with this solution holds one gallon of water, so a measuring device holding one ounce has been placed in the instrument room for the usage of staff when measuring the Gettinge Hi Foam solution. The bottle containing the Gettinge Hi Foam solution will be marked with the reminder "Use one ounce per one gallon of water."</p> <p>2. Prevention of recurrence will be accomplished use of the McKesson 14-day Glutaraldehyde Test/Change Log. Staff working in the instrument room will be re-educated in the usage of the new log as well as in the measurement of the Gettinge Hi Foam solution.</p> <p>3. Director of Nursing is responsible for the creation of the log, for the placement of the measuring device, the changes to the Instrument Cleaning</p>		

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	<p>Glutaraldehyde solution.</p> <p>4. On 10-04-12 at 1230 hours staff #2 confirmed that there was no documentation of the concentration check of the McKesson 14-Day Glutaraldehyde solution.</p> <p>5. Review of the manufacturer's recommendations for the Getinge Manual Detergent HI Foam solution recommended to use 0.2 - 1.0 ounce of Getinge Manual Detergent HI Foam solution per 1 gallon of water.</p> <p>6. On 10-04-12 at 1230 hours staff #2 confirmed that he/she mixes an unknown amount of Getinge Manual Detergent HI Foam solution with unknown amount of water.</p>		<p>procedure.</p> <p>4. The McKesson 14-day Glutaraldehyde Test/Change Log was created and placed into service November 5, 2012. The calibration of the wash tub and the placement of the measuring device was accomplished November 9, 2012. The changes to the procedure will be accomplished not later than December 1, 2012.</p>		

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S000526	<p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on interview and document review the facility failed to ensure that all nursing personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the blood glucose and urine pregnancy test for 8 of 8 nursing personnel files reviewed. (Staff #4, 5, 6, 7, 8, 10, 11 and 12)</p> <p>Findings include;</p> <p>1. On 10-03-12 at 0935 hours staff #40 confirmed that nursing personnel perform the blood glucose and urine pregnancy tests on patients.</p> <p>2. Review of staff #4, 5, 6, 7, 8, 10, 11 and 12's nursing personnel file lacked documentation of annual competency for the blood glucose and urine pregnancy test.</p> <p>3. On 10-05-12 at 1145 hours staff #40 confirmed there was no annual</p>	S000526	<p>S0526 410 IAC 15-2.5-2 (h) Laboratory Services</p> <p>Plan of Correction:</p> <p>1. Competency-based education in the areas of blood glucose testing and urine pregnancy testing will be created for all nursing and medical assistant staff no later January 1, 2013.</p> <p>2. All staff engaged in bedside testing for blood glucose and urine pregnancy will be required to complete this competency-based education yearly beginning January 2013. The educational units will include pre-testing, education, and post-testing. Any staff not receiving 80% correct answers on the post-test will be required to repeat education and pass competency not later than January 31, 2013. Manufacturers' Guidelines will be used in the creation of the educational units.</p> <p>3. Director of Nursing is responsible for the creation of the competency-based educational units and testing tools. The Director of Nursing will also be</p>	01/31/2013	

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	competency for the blood glucose and urine pregnancy test documentation available to review for staff #4, 5, 6, 7, 8, 10, 11 and 12.		responsible for assuring that competency is achieved yearly. 4. Educational units will be created not later than January 1, 2013 and all staff will pass competency not later than January 31, 2013.		

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S000732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based on document review and interview, the medical staff did not review the medical staff rules at least once every three (3) years.</p> <p>Findings:</p> <p>1. Review of a document entitled Surgery Center Plus, Inc., Policy and Procedure has been reviewed, revised and approved effective August 15, 2012, indicated it was signed by the President, Medical Staff, Medical Director and Chief of Anesthesia Services.</p> <p>2. Review of the above document indicated it included the medical staff rules and regulations.</p> <p>3. Review of a document entitled RULES and REGULATION of the MEDICAL STAFF OF SURGERY CENTER PLUS, Section 2, indicated the medical direction of the Center will be assigned to a physician staff member with an unlimited license. Nowhere did it indicate this position had the authority to solely</p>	S000732	<p>1. Tag #: S0732 2. 410 IAC 15-2.5-4(b)(2) Medical Staff; Anesthesia and Surgical 3. Plan of Correction: On 12/31/2013 SCP was purchased by Covenant Surgical Partners. Since then SCP has been adopting Covenant policies and procedures. The new Leadership policies address short-comings in previous policies. LD-01 provides for annual review of the medical staff bylaws- exceeding the requirement of triennial review. The new policies also specify that The Board of Managers, which consists of the president of the medical staff, the secretary of the medical staff, the regional vice president of the center, and two representatives of the parent organization, has the responsibility for the approval of the medical staff bylaws. SCP's new medical staff bylaws were approved 2/7/2012 at a meeting of the medical staff- and that approval was signed-off by all members of the committee. By adhering to our new policies and procedures, we believe that SCP is now fully in compliance with the regulation noted with this tag.</p>	12/01/2012			

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	<p>approve the medical staff rules and regulations.</p> <p>4. Review of the document entitled RULES and REGULATION of the MEDICAL STAFF OF SURGERY CENTER PLUS, Section 8, indicated the President [of the Medical Staff] shall serve as the chief administrative officer. The document then specifies various responsibilities of this officer. Nowhere did it indicate this officer had the authority to solely approve of the medical staff rules and regulations.</p> <p>5. Review of the document entitled RULES and REGULATION of the MEDICAL STAFF OF SURGERY CENTER PLUS, did not indicate the Chief of Anesthesia Services position had the authority to solely approve of the medical staff rules and regulations.</p> <p>6. Thus, the RULES and REGULATION of the MEDICAL STAFF OF SURGERY CENTER PLUS were never reviewed within the past three years by any individual or group (including the medical staff itself), who had authority to do so.</p> <p>7. In interview, on 10-5-12 at 12:15 pm, employee #A1 indicated the RULES and REGULATION of the MEDICAL STAFF OF SURGERY CENTER PLUS were not</p>				

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	reviewed by the medical staff within the past three years. No further documentation was provided prior to exit.			

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S000782	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(O)</p> <p>These bylaws and rule must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(O) A provision for personnel authorized to take a verbal order.</p> <p>Based on document review and interview the facility failed to ensure that verbal orders were documented as required by the facility's policy & procedure for 4 of 30 patient medical records (MR) reviewed. (Patient #3, 6, 12 and 24)</p> <p>Findings include;</p> <p>1. Review of policy/procedure Pharmaceutical Services indicated the following; "5. Issuing/Dispensing of Drugs. Physicians may prescribe drugs for patients during their stay in the Center as standing Orders, or by verbal order. The following protocol shall be followed: b. Verbal medication orders may be taken from a staff physician by a Registered Nurse. There medication orders shall be entered in the patient's medical record as a verbal order and signed by the ordering physician with the date and time of the order."</p>	S000782	<p>S0782 410 IAC 15-2.5-4(b)(3)(O) Medical Staff; Anesthesia and Surgical</p> <p><u>Plan of Correction:</u> 1. On November 5, 2012 Verbal Order Policy 12.5 (b) was re-written to include more specific requirements for the documentation of verbal orders. New policy specifically states that documentation is to include "date and time the order was taken", and documentation of the "date and time the order was carried out." This policy will be submitted for approval to the Quality Assurance Committee, which meets in February 2013. Until such a time as the new policy is approved, all registered nurses will be required to attend in-service training in proper documentation of verbal orders not later than December 1, 2012. 2. Adherence to the new policy will be checked by Random Electronic Record Review conducted quarterly by the Director of Nursing. On-going</p>	12/01/2012

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	<p>This policy/procedure was last reviewed/revised on 08-15-12.</p> <p>2. Review of patient #3, 6, 12 and 24's MR indicated that a verbal order for Ofirmev, 1000 mg / 100 ml IVPB be administered. Review of the order lacked the date and time the verbal order was given.</p> <p>3. On 10-04-12 at 1410 hours staff #40 confirmed that the verbal orders for patient #3, 6, 12 and 24 lacked documentation of the date and time received.</p>		<p>education of nursing staff will also be undertaken to assure compliance.</p> <p>3. The Director of Nursing is responsible for the changes to the policy, the education of the staff, and for the on-going support to assure compliance.</p> <p>4. Policy was re-written November 5, 2012 and will be submitted to the Quality Assurance Committee at its meeting in February 2013 for approval. Functional change will commence immediately and in-service education will be accomplished not later than December 1, 2012.</p>		

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S001220	<p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAc 15-2.5-8(d)</p> <p>(d) Written policies and procedures must be developed, implemented, and maintained and made available to personnel. Based on document review and interview, the facility did not have complete written radiological policies and procedures for its radiology services.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a document entitled Surgery Center Plus, Inc., Policy and Procedure has been reviewed, revised and approved effective August 15, 2012, Section 13.12, Fluoroscanner Usage, indicated physician operating mini fluroscan and scrub will wear badges to monitor amount of radiation exposure. No further documentation was provided. In interview, on 10-5-12 at 12:30 pm, employee #A2 indicated there could be more than just a scrub in the area where the mini fluroscan was being used. Thus, the policy did not apply to all employees in the area where the mini fluroscan was being used and no further documentation was provided. 	S001220	<p>1. Tag # Disputed: S1220 2. 410 IAC 15-2.5-8(d) Radiology Services</p> <p>3. Plan of Correction: As of 2/7/2012, Sugery Center Plus adopted the Radiation Safety policy of its new parent company, Covenant Surgical Partners. The new Radiation Safety Policy adopted on that date, specifies that all staff members in the room when the mini-C-Arm is in use must wear lead aprons. Additional radiation monitoring badges have been added and each staff member in the room must wear his/her own individual badge. The control badge is clipped to the underside of the surgical drape. New policy specifies that all women under the age of 49 who have not been surgically sterilized must take a urine pregnancy test or sign a waiver. New policy is now specific that now woman with a positive pregnancy test will be a patient at Surgery Center Plus. As of 1/31/2013, new signage has been added to the waiting area, warning of the potential for use of radiation, and also requesting that any woman who is pregnant or suspects she might be pregnant</p>	12/01/2012			

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	<p>4. Review of a document entitled Surgery Center Plus, Inc., Policy and Procedure has been reviewed, revised and approved effective August 15, 2012, did not indicate a method for the facility to identify pregnant patients.</p> <p>5. In interview, on 10-5-12 at 12:30 pm, employee #A2 confirmed the radiological policies did not indicate a method for the facility to identify pregnant patients and no further documentation was provided prior to exit.</p>		inform the receptionist and the nurse. We feel that with the adoption of the new policies, SCP is now in compliance with the state regulation.	