

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001005	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER SURGICAL CENTER OF NEW ALBANY	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 GREEN VALLEY RD NEW ALBANY, IN 47150
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Q 0000 Bldg. 00	<p>This visit was for a recertification of an ambulatory surgery center.</p> <p>Dates of survey: 1/19/16 to 1/21/16</p> <p>Facility number: 005386</p> <p>QA: cjl 02/04/16</p>	Q 0000		
Q 0083 Bldg. 00	<p>416.43(d) PERFORMANCE IMPROVEMENT PROJECTS</p> <p>(1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.</p> <p>(2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results</p> <p>Based on document review and interview, the center failed to undertake one or more specific quality improvement projects in 2015.</p> <p>Findings:</p>	Q 0083	The listed Studies were not completed. The studies will be completed by the administrator by March 31, 2016. On going documentation and monitoring of the data will be completed by the administrator monthly.	04/01/2016

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

TITLE

(X6) DATE

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

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	<p>1. Review of the policy titled Performance Improvement Studies indicated the following: Performance Improvement studies should occur at least once a quarter. The policy was approved 11/5/14.</p> <p>2. Review of Quality/Medical Advisory Committee meeting minutes dated 2/25/15, 4/29/15, 7/29/15 and 12/8/15 indicated the following on dates indicated: 2/25/15 Performance Improvement Studies: See attached Studies. Post-operative pain control on shoulder cases. Antibiotic timing starting up again; 4/29/15 Performance Improvement Studies: See attached Studies. Time study/transportation on Pain Patients to begin. Monitor of antibiotic timing continues. 7/29/15 Performance Improvement Studies: See attached Studies. Wait times for pain patients. Copier Fax vs Fax Machine. 12/8/15 Performance Improvement Studies: See attached Studies. Anesthesia cost vs. reimbursement to be studied. The documents lacked documentation of project data or monitoring.</p> <p>3. Review of the following documents indicated: The document titled Project Title: Prophylactic Antibiotics, Date 6/10/14 to 1/27/14, Performance</p>			

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Q 0100 Bldg. 00	<p>Improvement Project Summary Report. The document titled Prophylactic Antibiotics indicated 3 of 107 patients from 6/10/14 to 1/27/15...were not infused in a timely manner...Collection of data is an on-going process. Reports will be made quarterly as needed. The document titled Project Title: PR, dated 11/4-12/30/14 [sic], Performance Improvement Project Summary Report, indicated Remeasurement has been ongoing with satisfactory result. The document titled A Correlation Study In Re: Post-Op Pain Medications... indicated a study was held 11/4/14 to 12/30/14. We will continue to monitor...</p> <p>4. On 1/21/16 at 4:00pm, A4, Administrator, indicated documentation of a quality project for 2015 was not available. No further documentation was provided prior to exit.</p> <p>416.44 ENVIRONMENT The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. Based on Life Safety Code (LSC) survey, Surgical Center of New Albany was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart</p>	O 0100	Administrator will obtain consultations and estimates for moving the manifolds and tanks inside versus building an enclosed separation between the tanks and generator. The estimates and reports will be	08/31/2016

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	<p>416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>This facility was a one story fully sprinklered building determined to be of Type V (000) construction. The facility has a fire alarm system with smoke detection in corridors and some common areas.</p> <p>Based on LSC survey and deficiencies found (see 2567L), it was determined that the facility failed to ensure oxygen and nitrogen H sized cylinders stored in 1 of 1 storage locations with a capacity of non-flammable gases greater than 3000 cubic feet, were stored in a protected area (see K 076) and failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station (see K 144).</p> <p>The cumulative effect of these systemic problems resulted in the facility's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.</p>		<p>completed by March 31, 2016. Once the estimates and consults are obtained they will be addressed by the Governing Board on April 29, 2016. When the governing board votes on which action to take, the work to move or build will be scheduled. The scheduling of the service will be completed by May 31, 2016, and the work completed by August 31, 2016. On January 27, 2016 the administrator spoke with the Cummins rep who informed her that the generator which was installed in 1983 did not have a requirement for an annunciator at that time. The administrator will obtain estimates for an addition of an annunciator versus the cost of a new generator. The estimates will be obtained by March 31, 2016. Once the information and estimates are obtained, it will be addressed and voted on by the Governing Board at the meeting on April 29, 2016. New manifolds were installed, relocated, and in service on March 11, 2016. There no longer will be any tanks stored in the generator cage. Cummins was on site to check the generator for an annunciator on March 11, 2016. The Cummins engineer was not sure if the generator is capable of adding an annunciator. He was going back to do research and check the schematics for the generator. It passes all of its tests and load tests but did not</p>				

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Q 0104 Bldg. 00	<p>416.44(b) SAFETY FROM FIRE</p> <p>(1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to http://www.archives.gov/federalregister/code_of_federal-regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.</p> <p>(2) In consideration of a recommendation by the State survey agency, CMS may waive,</p>		originally have an annunciator when it was installed. The surgery center's contracted bio-med company is also researching to possibility of adding a simple annunciator. Both companies will have answers to the administrator by Friday March 18, 2016.	

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	<p>for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.</p> <p>(3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.</p> <p>(4) An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006.</p> <p>(5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if:</p> <p>(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;</p> <p>(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;</p> <p>(iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and</p> <p>(iv) The dispensers are installed in accordance with the following provisions:</p> <p>(A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m);</p> <p>(B) The maximum individual dispenser fluid capacity shall be:</p> <p>(1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(2) 0.5 gallons (2.0 liters) for</p>			

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	<p>dispensers in suites of rooms</p> <p>(C) The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other;</p> <p>(D) Not more than an aggregate of 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet;</p> <p>(E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code;</p> <p>(F) The dispensers shall not be installed over or directly adjacent to an ignition source;</p> <p>(G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments; and</p> <p>(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.</p> <p>Based on observation and interview, the facility failed to ensure oxygen and nitrogen H sized cylinders stored in 1 of 1 storage locations with a capacity of non-flammable gases greater than 3000 cubic feet, were stored in a protected area and failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station.</p> <p>Findings:</p> <p>1. Observation on 01/26/16 at 1:15 p.m.</p>	O 0104	<p>Administrator will obtain consultations and estimates for moving the manifolds and tanks inside versus building an enclosed separation between the tanks and generator. The estimates and reports will be completed by March 31, 2016. Once the estimates and consults are obtained they will be addressed by the Governing Board on April 29, 2016. When the governing board votes on which action to take, the work to move or build will be scheduled. The scheduling of the service will be completed by May 31, 2016, and the work completed by August 31, 2016. New</p>	08/31/2016

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	<p>during a tour of the facility with the Administrator, A#1, it was noted there was a concrete block building outside the back of the facility within four feet of the main building, which was storing eleven (11) H size Nitrogen tanks and twelve (12) H size Oxygen tanks that were part of the facility's piped in medical gas system. There were also thirteen (13) E size Oxygen cylinders within the block building. The facility's generator was also stored in the concrete block building within three feet of the Oxygen and Nitrogen cylinders.</p> <p>2. This was acknowledged by the Administrator at the time of observation.</p> <p>3. Observation on 01/26/16 between 12:45 p.m. and 1:45 p.m. during a tour of the facility with the Administrator, it was noted that a remote alarm annunciator for the generator was not provided in a location readily observed by operating personnel at a regular work station such as a nurses' station.</p> <p>4. In interview on 01/26/16 at 1:20 p.m., the Administrator indicated there was no remote alarm annunciator for the generator in a location readily observed by operating personnel at a regular work station such as a nurses' station or any other area of the facility.</p>		<p>manifolds were installed, relocated, and in service on March 11, 2016. There no longer will be any tanks stored in the generator cage. Cummins was on site to check the generator for an annunciator on March 11, 2016. The Cummins engineer was not sure if the generator is capable of adding an annunciator. He was going back to do research and check the schematics for the generator. It passes all of its tests and load tests but did not originally have an annunciator when it was installed. The surgery center's contracted bio-med company is also researching to possibility of adding a simple annunciator. Both companies will have answers to the administrator by Friday March 18, 2016.</p>		

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Q 0105 Bldg. 00	<p>416.44(c) EMERGENCY EQUIPMENT The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC' s operating room. The equipment must meet the following requirements:</p> <p>(1) Be immediately available for use during emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel.</p> <p>Based on document review, observation and interview, the facility failed to maintain an emergency code cart that consistently maintained emergency equipment, supplies and medications required for a potential emergency situation.</p> <p>Findings:</p> <p>1. Facility Policy Patient Care Emergencies 70.3, last update unknown, indicated: A. At least annually, the medical director, anesthesia provider(s), and Administrative Director will review the emergency equipment, supplies and</p>	O 0105	The emergency code cart inventory has been listed and approved by the MAC/GB on February 24, 2016. The inventory list of items and medications will be stored in a binder on the cart. The PACU nurse will be responsible for checking the binder monthly and assuring that any outdates are replaced.	02/29/2016

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Q 0241 Bldg. 00	<p>medications to determine if changes should occur. A written list of equipment, supplies and medications that are suitable for the potential emergencies associated with the procedures performed in the ASC and the population that the ASC</p> <p>2. On 01/20/2016, tour of the OR (operating room) and PACU (postanesthesia care unit) noted two code carts lacking a list of what is required for the code carts for this facility.</p> <p>3. List of code cart supplies was requested and no further documentation was provided by exit on 01/21/2016.</p> <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 maintain a functional and sanitary environment in the Operating Room</p>	O 0241	The administrator will oversee the cleaning of the OR suites. A cleaning checklist will be instituted 2/29/2016. The checklist will list the rooms to be	02/29/2016

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	<p>(OR) suites.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Facility Policy Infection Control Environmental Cleaning, last update unknown, indicated: At the end of each scheduled procedure day, each room's horizontal surfaces, lights and furniture is damp dusted with a clean, lint-free cloth moistened with an EPA-registered hospital disinfectant. Cleaning and disinfection methods include: All horizontal surfaces including surgical lights, booms and equipment should be damp dusted before the first surgical or other invasive procedure of the day. 2. On 01/20/2016 at 1320 hours, while touring the OR suites, with employee #4, Administrator, it was noted in ORs #1, 2, 3 and 4, the bases of the OR tables, the anesthesia machines and the C-arms were coated with a layer of dust. Two patient carts were examined in the OR corridor and the bases and lower shelf areas were also covered with a layer of dust. 3. On 01/21/2016 at 1030 hours, while observing operating room #2 turnover, it was noted that the nurse, employee #3, failed to clean horizontal surfaces which were used in the procedure to set medication and syringes on. This 		<p>cleaned. On the checklist it will be noted that the equipment was wiped down and it will be signed by the employee performing the cleaning. Nurse circulator will be responsible to monitor the room scrub to assure tables and surfaces are wiped down in between cases. Doctors and techs with hair and beards will wear bouffant caps and masks with beard covers. This will be monitored by the OR staff and the administrator.</p>	

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	<p>included a Mayo stand and a cabinet top in the area of the OR table.</p> <p>4. Employee #4 indicated that the contracted cleaning service is not responsible for cleaning medical equipment; it is nursing's responsibility. He/she further indicated the nurses are very busy here and may not put cleaning the lower portions of the medical equipment at a high priority.</p> <p>5. Facility Policy General Clinical 10.3 Dress Code Policy, last update unknown, indicated: Surgical attire, which may include scrub clothes, hair coverings, masks, protective eyewear and other protective barriers, is to be worn by all persons who enter the semi-restricted and restricted areas of the surgical suite. A disposable cap is provided by the Center. All head hair, including beard, sideburns and nape of the neck must be covered by the cap. Surgical hoods should be worn by men with long sideburns and/or beards.</p> <p>6. On 01/21/2016 at 1000 hours, while observing a surgical procedure in OR #2, it was noted that physician #1 and radiology tech #1 did not have their hair and beards covered.</p> <p>7. On 01/21/2016 at 1330 hours, staff</p>			

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Q 0243 Bldg. 00	<p>member #4 indicated that physicians have not wished to go to the bouffant caps and surgical hoods while in the ORs.</p> <p>416.51(b)(1) INFECTION CONTROL PROGRAM - DIRECTION The program is - Under the direction of a designated and qualified professional who has training in infection control. Based on document review and interview, the facility failed to have a designated Infection Control Officer, with training from a recognized organization which would qualify the individual to lead an infection control program.</p> <p>Findings:</p> <p>1. Facility Policy Infection Control 10.1 titled Infection Control Officer, last update unknown, indicated: Qualifications: Education in Infection Prevention/Control Practices through</p>			O 0243	<p>At the board meeting on April 29, 2016, a new infection control officer will be appointed from 3 possible candidates. This new officer will have training from a recognized organization. The new officer will oversee the daily operations as well as maintaining documentation and reports for compliance.</p>		04/29/2016

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S 0000 Bldg. 00	<p>reading nationally recognized standards; seminars and meetings through a variety of learning methods including attendance, webinars, conference calls; reading journals and articles pertaining to infection control.</p> <p>2. On 01/21/2016 at 1000 hours, staff member #4 indicated that the facility has an Infection Control Officer designated, but the individual has never had any formal training. Staff member #4 further indicated that resources and time have not been allotted to training at this facility.</p>	S 0000		
S 0153	<p>This visit was for State licensure survey.</p> <p>Dates of survey: 1/19/16 to 1/21/16</p> <p>Facility number: 005386</p> <p>QA: cjl 02/04/16</p> <p>410 IAC 15-2.4-1</p>			

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Bldg. 00	<p>GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review and interview, the center failed to orient 2 of 4 direct employees (P3 and P4) to applicable center and personnel policies.</p> <p>Findings:</p> <p>1. Review of 4 direct employee personnel files (P1-P4) indicated lack of documentation of orientation for P3 and P4.</p> <p>2. On 1/21/16 at 1:30pm, A4, Administrator, indicated employee files P3 and P4 did not have documentation of orientation and that documentation was not available.</p>	S 0153	<p>Documentation of orientation is now in the employee files. Orientation documentation was completed on February 29, 2016. The administrator will be responsible for maintaining the personnel records and assure that the orientation is completed and documented in the files of all employees going forward.</p>	02/29/2016
S 0172 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive</p>			

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	<p>officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review and interview, the facility failed to maintain personnel files which indicated the required guidelines for personnel were met.</p> <p>Findings:</p> <p>1. On 01/20/2016, examination of eleven employee files indicated:</p> <p>A. Three of eleven employee files, #2, 9 and 11, lacked evidence of annual education competencies.</p> <p>B. Four of eleven employee files, #2, 3, 4 and 9, lacked evidence of an annual evaluation</p> <p>C. Four of eleven employee files, #2, 3, 4 and 8, lacked evidence of a post offer physical</p> <p>D. Three of eleven, #6, 7 and 9, lacked documentation of immunization records</p> <p>E. Two employee files, #2 and 10, lacked documentation of current CPR</p>	S 0172	<p>P9 did have a completed competencies in the MC Strategies system, however it was unable to print accurately. The center is going to a new competency program; Health Stream by March 31, 2016 and all employees will have their yearly competencies completed by April 29,2016. The Administrator will oversee for compliance. 2 of the employees lacking the evaluations are prn employees which an evaluation will be completed on them by April 29, 2016. The other two employees will have evaluations completed by March 30, 2016. All new employees will have post offer physicals completed and records of immunizations or titres drawn upon hire. CPR is scheduled for all employees on March 3, 2016. P10 did have a current BLS in her file. P2 ACLS was current but the BLS was expired. P2 will attend BLS with all employees on March 3, 2016. The administrator will monitor for compliance.</p>	04/29/2016

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S 0228 Bldg. 00	<p>competency.</p> <p>No further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing body (GB) failed to ensure 3 of 8 physician medical staff (MS) members (MD#4, MD#7 and MD#8) maintained admitting privileges at one or more local hospitals.</p>	S 0228	As of February 16, 2016 of 3 physicians now have documentation in their files of admitting privileges at local hospitals. The 3rd physician does not have admitting privileges, however the center has transfer agreements with 2 local hospitals which employ	02/16/2016

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S 0230 Bldg. 00	<p>Findings:</p> <ol style="list-style-type: none"> Review of 8 physician MS credential files indicated lack of documentation of privileges to admit patients to a hospital in the same or adjacent Indiana county. On 1/21/16 at 5:00pm, A1, Business Office Manager, indicated documentation of privileges to admit patients to an appropriate hospital was not available for MD#4, MD#7 or MD#8. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the governing body (GB) failed to provide for periodic review of</p>	S 0230	<p>hospitalist. The Administrator spoke with the 3rd physician (a dentist) who is applying for privileges at the local hospital. The Administrator will oversee the credentialing department to ensure that all privileges are documented in the files.</p> <p>The governing board meeting was held on February 24, 2016. A Utilization Review Committee consisting of 3 physicians with no</p>	03/21/2016

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S 0310 Bldg. 00	<p>the center by a utilization review or other committee composed of 3 or more duly licensed physicians with no financial interest in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of facility documents indicated lack of documentation of periodic utilization review by an appropriate utilization review committee. On 1/21/16 at 4:20 pm, A4, Administrator, indicated the center did not have a utilization review or other committee of 3 or more physicians with no financial interest. <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 include 3 directly provided services (internal laboratory, internal maintenance and internal radiology) and 2 contracted services (contracted laboratory services</p>	S 0310	<p>financial interest in the facility was approved. The administrator will be responsible to meet with the committee quarterly starting on March 21, 2016.</p> <p>A governing board meeting was held on February 24, 2016. Dr. Brandon Sutton was approved to oversee and supervise the radiology services which entail the use of C-arm, maintenance, inspections of the c-arm, lead,</p>	03/29/2016	

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	<p>and contracted radiology services) in its quality assessment and performance improvement (QAPI) program for 2015.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the policy titled Performance Improvement Plan, indicated the following: Objectives of the program: 1. To improve overall patient care and services through systematic monitoring and evaluation. Areas of review: 1. Appropriate lab and radiology...5. Review of patient care services from contracted sources. 7. Review of services provided... The policy was approved 11/5/14. 2. Review of QAPI meeting minutes dated 2/25/15, 4/29/15, 7/29/15 and 12/8/15 indicated lack of documentation of quality review or evaluation of internal laboratory services, internal maintenance services, internal radiology services, contracted laboratory services and contracted radiology services. 3. On 1/21/16 at 3:30pm, A4, Administrator, indicated the QAPI had not included evaluation of internal laboratory services, internal maintenance services, internal radiology services, contracted laboratory services or contracted radiology services in its 		<p>and dosimetry. Meetings with Dr. Sutton will be documented quarterly and reported to the board beginning March 29, 2016. The Administrator will be responsible for documentation of the meetings and reporting to the governing board. There is no internal maintenance contracts. The only internal laboratory that is performed is blood sugars. The glucometer is checked every surgery day and the results of the testing will be reported in the QUAPI meeting by the administrator.</p>				

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S 0320 Bldg. 00	<p>evaluations for 2015.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the center failed to include 2 functions (discharge and response to patient emergencies) in its quality assessment and performance improvement (QAPI) program for 2015.</p> <p>Findings:</p> <p>1. Review of the policy titled Performance Improvement Plan, indicated the following: Objectives of the program: 1. To improve overall patient care and services through systematic monitoring and evaluation. 8. To monitor and evaluate important</p>	S 0320	All patient emergencies and transfers are documented in VERGE system, which is reviewed quarterly by a medical committee at the corporate level. All reports are reported to the performance improvement committee as well as the Medical Advisory and Governing Board committees. Discharge summaries are obtained on transfer patients from the admitting hospital. The summaries are included in the VERGE reports. The administrator will monitor for compliance and documentation. Chart audits, which include discharge	02/01/2016

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S 0400 Bldg. 00	<p>aspects of care... 9. To ensure identification and solution of problems. Responsibilities: 2. Monitors, coordinates and integrates all committee activities and ensures participation of all disciplines. The committee receives all reports regarding, but not limited to...patient transfers...3. Monitors and evaluates the quality...of patient care and clinical performance...The policy was approved 11/5/14.</p> <p>2. Review of QAPI meeting minutes dated 2/25/15, 4/29/15, 7/29/15 and 12/8/15 lacked documentation of quality review or evaluation of discharge and response to patient emergencies</p> <p>3. On 1/21/16 at 3:30pm, A4, Administrator, indicated the QAPI had not included evaluation of discharge or response to patient emergency functions in its evaluations for 2015.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that</p>		instructions are performed quarterly and reported to Medical Advisory and Governing Board, at the nursing staff and QUAPI meetings. The surgical center also has a medical records consultant who audits records quarterly. The consulatant's findings also are reported at the MAC, GB, nursing staff, and QUAPI meetings. The administrator will monitor the committee meeting minutes for compliance with documentation.				

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	<p>minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review, observation and interview, the facility failed to maintain a functional and sanitary environment in two (2) areas (the Operating Room (OR) suites and clean supply storage).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Facility Policy Infection Control Environmental Cleaning, last update unknown, indicated: At the end of each scheduled procedure day, each room's horizontal surfaces, lights and furniture is damp dusted with a clean, lint-free cloth moistened with an EPA-registered hospital disinfectant. Cleaning and disinfection methods include: All horizontal surfaces including surgical lights, booms and equipment should be damp dusted before the first surgical or other invasive procedure of the day. 2. On 01/20/2016 at 1320 hours, while touring the OR suites, with employee #4, Administrator, it was noted in ORs #1, 2, 3 and 4, the bases of the OR tables, the anesthesia machines and the C-arms were coated with a layer of dust. Two patient carts were examined in the OR corridor and the bases and lower shelf areas were 	S 0400	<p>As of January 25, 2016 the center has a cleaning log which is to be completed weekly by clinical staff performing the cleaning duty. The administrator will monitor the log and the cleanliness of the areas to assure completion of the tasks. The scrub will assure that the surfaces are wiped down at the beginning and end of each day as well as in between cases. The circulating nurse will be responsible to ensure that this is being completed. Beard covers have been ordered and are in use for the physicians and staff with beards. The circulators in the rooms will monitor the physicians and staff regarding the use of beard covers. The administrator will oversee the monitors for compliance. The opened tubes have been removed from the tote in the sterile supply room and staff including physicians have been instructed not to place the used tubes in the bins. The scrub techs will monitor the sterile supply room to assure compliance.</p>	01/25/2016

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	<p>also covered with a layer of dust.</p> <p>3. On 01/21/2016 at 1030 hours, while observing operating room #2 turnover, it was noted that the nurse, employee #3, failed to clean horizontal surfaces which were used in the procedure to set medication and syringes on. This included a Mayo stand and a cabinet top in the area of the OR table.</p> <p>4. Employee #4 indicated that the contracted cleaning service is not responsible for cleaning medical equipment; it is nursing's responsibility. He/she further indicated the nurses are very busy here and may not put cleaning the lower portions of the medical equipment at a high priority.</p> <p>5. Facility Policy General Clinical 10.3 Dress Code Policy, last update unknown, indicated: Surgical attire, which may include scrub clothes, hair coverings, masks, protective eyewear and other protective barriers, is to be worn by all persons who enter the semi-restricted and restricted areas of the surgical suite. A disposable cap is provided by the Center. All head hair, including beard, sideburns and nape of the neck must be covered by the cap. Surgical hoods should be worn by men with long sideburns and/or beards.</p>			

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	<p>6. On 01/21/2016 at 1000 hours, while observing a surgical procedure in OR #2, it was noted that physician #1 and radiology tech #1 did not have their hair and beards covered.</p> <p>7. On 01/21/2016 at 1330 hours, staff member #4 indicated that physicians have not wished to go to the bouffant caps and surgical hoods while in the ORs.</p> <p>8. Review of the policy titled Management of Sterile Supplies and Deliveries indicated the following: 2. STORAGE: b. Clean/Sterile Supply Area i. Only individually packed sterile supplies are stored in the supply room. c. Precautions should be maintained to avoid the mixing of sterile supplies with non-sterile supplies. The policy was approved 11/5/14.</p> <p>9. On 1/19/16, at 4:35pm, during tour of the center, in the clean/sterile bulk supply room, in the presence of A4, Administrator, the following was observed: On a shelf among sterile packaged supplies was a plastic tote, with miscellaneous non-packaged supplies, including, 2 partially used tubes Polysporin. The supplies were lying open in the tote without a lid or covering.</p>			

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S 0408 Bldg. 00	<p>10. On 1/9/16 at 4:35pm, A4 indicated the open tote with partially used supplies in the clean/sterile supply room was used by one of the physicians in the center. A4 indicated the physician takes the tote in and out of the clean/sterile supply room for use in individual patient surgical cases and that supplies and tote were not clean/sterile supplies.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(d)</p> <p>(d) The center shall designate a person qualified by training or experience as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on document review and interview, the facility failed to have a designated Infection Control Officer, with training from a recognized organization which would qualify the individual to lead an infection control program.</p> <p>Findings:</p> <p>1. Facility Policy Infection Control 10.1 titled Infection Control Officer, last update unknown, indicated:</p>	S 0408	At the board meeting on April 29, 2016, a new infection control officer will be appointed from 3 possible candidates. This new officer will have training from a recognized organization. The new officer will oversee the daily operations as well as maintaining documentation and reports for compliance.	04/29/2016

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S 0704 Bldg. 00	<p>Qualifications: Education in Infection Prevention/Control Practices through reading nationally recognized standards; seminars and meetings through a variety of learning methods including attendance, webinars, conference calls; reading journals and articles pertaining to infection control.</p> <p>2. On 01/21/2016 at 1000 hours, staff member #4 indicated that the facility has an Infection Control Officer designated, but the individual has never had any formal training. Staff member #4 further indicated that resources and time have not been allotted to training at this facility.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(1)</p> <p>The medical staff shall do the following:</p>			

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	<p>(1) Conduct outcome-oriented performance evaluations of its member at least biennially.</p> <p>Based on document review and interview, the medical staff (MS) failed to conduct outcome-oriented performance evaluations for 8 of 8 physician MS members and 3 of 3 contracted allied health (AH) MS members within the past 2 years.</p> <p>Findings:</p> <p>1. Review of the document titled Medical Staff Bylaws, Procedures, Rules and Regulations lacked documentation of an outcome oriented MS appraisal system to evaluate the competence of its members. The Bylaws were approved 4/29/15.</p> <p>2. Reivew of the policy titled Outside Service Assessment indicated the following: Outside services...will be reviewed to assure services are provided in a safe and effective manner. Each type of outside service will be reviewed... Procedure: Performance review may include: 1. Evaluation of the onsite work performed. 2. Review of compliance to nationally recognized standard. 6. Input from employees, medical staff, and patients. The policy was approved 11/5/14.</p>	S 0704	<p>PEER Review is completed quarterly and documented in the QAPI binder. Allied health evaluations will be completed by the sponsoring physicians by April 29, 2016. Two physicians will be appointed by the Medical Advisory Committee at the meeting on April 29, 2016. According to the by-laws, the appointed physicians will review and complete the evaluations of the Medical Staff and document such. The administrator will be responsible to oversee for compliance.</p>	04/29/2016

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S 0710 Bldg. 00	<p>3. Review of 8 physician MS members credential files (MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, MD#7 and MD#8) and 3 AH MS members credential files (AH#1, AH#2 and AH#3) lacked documentation of an outcome based performance evaluation within the past 2 years.</p> <p>4. On 1/21/16 at 1:25pm, A4, Administrator, indicated the MS did not conduct outcome oriented performance evaluations of its members.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the</p>			

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	<p>individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p> <p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p>			

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S 0862 Bldg. 00	<p>(G) Other items specified by the center and medical staff.</p> <p>Based on document review and interview, the medical staff (MS) failed to maintain documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C) for 3 of 8 physician MS members (MD#4, MD#7 and MD#8).</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of 8 physician MS credential files lacked documentation of privilege to perform surgical procedures in a hospital for MD#4, MD#7 and MD#8. On 1/21/16 at 5:00pm, A1, Business Office Manager, indicated documentation of privilege to perform surgical procedures in a hospital was not available for MD#4, MD#7 or MD#8. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(C)</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</p>	S 0710	<p>2 of the 3 physicians have privileges to perform surgical procedures in local hospitals. The 3rd physician is a dentist that does not have surgical privileges at a local hospital. The administrator will meet with the dentist by March 28, 2016 with the concerns of no surgical privileges and ensure that the dentist will obtain privileges. The dentist does very few cases at the center, and discussion will take place regarding his case load versus his obtaining privileges at the local hospital.</p>	03/28/2016	

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	<p>and patient care as follows:</p> <p>(C) A provision for the following equipment and supplies to be available to the surgical and recovery areas:</p> <ul style="list-style-type: none"> (i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff. <p>Based on document review, observation and interview, the facility failed to maintain an emergency code cart that consistently maintained emergency equipment, supplies and medications required for a potential emergency situation.</p> <p>Findings:</p> <p>1. Facility Policy Patient Care Emergencies 70.3, last update unknown, indicated:</p> <ul style="list-style-type: none"> A. At least annually, the medical director, anesthesia provider(s), and Administrative Director will review the emergency equipment, supplies and medications to determine if changes should occur. A written list of equipment, supplies and medications that are suitable for the potential emergencies 	S 0862	<p>On February 24, 2016, the Medical Advisory Committee and Governing Board meeting was held. The list of emergency code cart medications was approved at that meeting. An inventory of all code cart items and the medication list was documented on March 1, 2016 and the inventory documentation will reside in a binder on the emergency cart. The PACU nurse will be responsible to check the inventory monthly and update any outdates. The administrator will oversee the documentation for compliance.</p>	03/01/2016

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S 1210 Bldg. 00	<p>associated with the procedures performed in the ASC and the population that the ASC</p> <p>2. On 01/20/2016, tour of the OR (operating room) and PACU (postanesthesia care unit) noted two code carts lacking a list of what is required for the code carts for this facility.</p> <p>3. List of code cart supplies was requested and no further documentation was provided by exit on 01/21/2016.</p> <p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1)</p> <p>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:</p> <p>(1) Radiology services must be supervised by a radiologist or radiation oncologist.</p> <p>Based on document review and interview, the center failed to ensure radiology services were supervised.</p>	S 1210	A governing board meeting was held on February 24, 2016. Dr. Brandon Sutton was approved to oversee and supervise the radiology services which entail	03/29/2016

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	<p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the policy titled Radiology Services indicated the governing body must appoint an individual qualified...who is responsible for assuring that all radiologic services are provided in accordance with the requirements... A physician or health physicist may qualify to assume this responsibility. The policy was approved 11/5/14. 2. Review of the document titled Medical Staff Bylaws, Procedures, Rules and Regulations indicated in Article XVII. Rules and Regulations 17.5 Radiological services shall be provided in the Center by means of an agreement for services provided by a local Radiologist. The Bylaws were approved 4/29/15. 3. On 1/21/16 at 11:15am, A4, Administrator, indicated the center did utilize radiology equipment (C-arm) but did not have an appointed director/supervisor of radiology services and did not have a contract arrangement with a radiologist or radiology group for oversight of radiology services. 		<p>the use of C-arm, maintenance, inspections of the c-arm, lead, and dosimetry. Meetings with Dr. Sutton will be documented quarterly and reported to the board beginning March 29, 2016. The Administrator will be responsible for documentation of the meetings and reporting to the governing board.</p>		