

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 009971</p> <p>Survey Date: 3/24/2014 through 3/26/2014</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 04/03/14</p>	S000000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000104	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(a)(2)</p> <p>The governing body shall do the following:</p> <p>(2) Adopt bylaws and function accordingly.</p> <p>Based on documentation review, the Governing Board failed to conduct quarterly meetings as per Board of Directors Bylaws.</p> <p>Findings included:</p> <p>1. Board of Directors Bylaws Article III section 3.2A (last revised and approved 9/25/2012) stated, "Board meetings shall be at least quarterly."</p> <p>2. The Board Manager Meeting minutes provided by staff member #1 evidenced May 21, 2013 was the only Board of Manager meeting held in 2013.</p>	S000104	<p>410IAC 15-2.4-1 (a) (2)</p> <p>1. Board of Directors meetings will be conducted quarterly with firstmeeting conducted on 04/04/2014. 2.Subsequent meeting dates of quarterly meetings will 07/11/14, 10/03/14, and01/9/15. 3. Administrator is responsible for schedule of meeting and agendadiscussed. 4. Firstmeeting conducted on 04/04/14, meeting minutes approved and signed by Board ofDirector members.</p>	04/04/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on documentation review and staff interview, the Governing Board failed to review quarterly Quality Assessment and Improvement activities.</p> <p>Findings included:</p> <p>1. The Surgicare Board of Manager minutes were reviewed for 2013 and 2014. The meeting minutes provided by staff member #1 evidenced that there was only a meeting held 5/21/13 and 1/15/14. Neither meeting discussed Quality Assessment and Improvement activities of the surgery center.</p> <p>2. At 1:20 PM on 3/25/2014, staff</p>	S000110	<p>410 IAC 15-2.4-1 (a)(5)</p> <p>1. Meeting conducted on 04/04/2014. Quality Assurance and improvement studies were initiated to include Darob (Biohazard waste), Biomedical, Housekeeping, Labcorp, Morgan Linenservices, Pharmacy, Central Security Communications, HFI mechanical contractors, and GE Healthcare (OEC x-ray).</p> <p>2. QA studies will be ongoing to monitor each of the services provided and issues will be addressed at each Board of Directors meetings, as well as monthly staff meetings. Date of staff meeting for April is 04/28/14, with subsequent dates to be announced. Quarterly meetings for Quality Assurance will be held 07/11/2014, 10/03/2014, and 01/09/2015.</p> <p>3. Administrator and Quality Assurance nurse is responsible for studies and monitoring of findings, Administrator</p>	04/04/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	member #1 confirmed the Board of Manager's meetings that were reviewed did not address surgery activities that related to Quality Assessment and Improvement.		is responsible for presentation of findings at staff meetings and Board of Directors meetings. 4. First meeting conducted on 04/04/2014, plan of quality improvement studies presented and approved by members of the Board.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000153	<p>410 IAC 15-2.4-1 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.</p> <p>Based on policy and procedure review, interview, contracted staff document review, and facility document review, the facility failed to ensure 2 of 2 contracted cleaning staff (C1 and C2), received facility or job specific orientation.</p> <p>Findings included:</p> <p>1. Review of the facility policy "Housekeeping Services", last reviewed 09/13/13, indicated, "IV. Procedure: A. A contract service company shall be provided with appropriate procedural guides for cleaning all areas of the Center. Such procedure to be considered as an addendum to the contract. B. The Administrator shall confirm with contract services that employees are instructed in proper procedures. C. The Administrator shall monitor contract services and initiate corrective action if proper standards are not maintained."</p>	S000153	410 IAC 15-2.4-1 (c)(5)(c) 1. GEI Management, INC(Housekeeping) contacted 04/07/2014. Employees are to attend mandatoryorientation/inservices to be conducted 04/28/2014 to include handwashingtechniques, scrub attire in non-sterile and sterile areas, OSHA regulations, Blood-bornepathogen exposure control plan, TB testing. Policies and procedures to bereviewed, documentation to be kept on file for each employee; will be signed/dated upon completion by Administrator or Infection Control Nurse to verify completion and understanding of policies. Weekly cleaning schedule hasbeen initiated and maintained in specified folder. Must be dated/signed byhousekeeping personnel performing services for monitoring of compliance.Cleaning schedule will be introduced at mandatory meeting. Questions will beaddressed following	04/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. At 1:00 PM on 03/24/14, staff member A1 indicated the facility staff perform the daily cleaning and a contracted cleaning company cleaned once a week, usually on Saturday. He/she indicated a new cleaning service was recently contracted by the office staff, but he/she had not oriented or observed them in the facility.</p> <p>3. At 10:15 AM on 03/26/14, the owner of the contracted cleaning company, C1, was interviewed and presented documentation of education and requirements for cleaning the center. A form titled "Infection Control Program-Housekeeping" listed the following procedures: Handwashing, Gowning in Scrubs, Hair Covering, OSHA- Blood Spills- Infectious Waste- Needles, Trash Disposal, and Chemical Handling and was initialed by contracted cleaning staff C1 and C2 and dated 02/06/14. Another form titled "Environmental Services Job Training Form" indicated C2 received training by C1 and felt confident to do the job and was signed by C1 and C2 and dated 02/06/14. Neither form had any signature or documentation by the center staff. Documentation indicated C1 cleaned the facility 02/08/14, 02/15/14, and 02/22/14, and C2 cleaned the facility on 03/01/14, 03/08/14, 03/15/14, and</p>		<p>presentation of expectations. 2. Inspections will be performed by Administrator during cleaning hours on Saturday to monitor compliance of standards and practices. First inspection will be done on 05/03/2014 at an undisclosed time to housekeeping personnel. Future unannounced inspections will continue on a monthly basis for compliance. Problems of non-compliance will be addressed. 3. Administrator and Infection Control Officer will provide orientation/competency testing during mandatory education. Administrator will be the responsible person 4. Mandatory education and orientation will be 04/28/2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>03/22/14. When questioned about initial facility orientation, C1 indicated the office manager A10 and the facility administrator A1 reviewed all of the cleaning requirements with him/her. When questioned about training in infection control and OSHA bloodborne pathogens, C1 indicated he/she had received it previously at a hospital and taught C2, but provided no documentation of this. He/she also indicated he/she thought that the facility would notify him/her whenever they had inservices they wanted him/her to attend.</p> <p>4. At 11:00 AM on 03/26/14, staff member A1 indicated he/she did not go over the facility's cleaning requirements with C1 and had never even seen C2.</p> <p>5. The contract between the center and the contracted cleaning service was signed on 02/06/14 by office manager, A10, and the contracted company's owner, C1.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000226	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</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>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on documentation review and staff interview, the facility failed to ensure maintenance of a contract which included scope and nature of the services provided to the surgery center for one contracted housekeeping service.</p> <p>Findings included:</p> <p>1. The surgery center's contracts were reviewed with staff member #1 on 3/26/2014. The contracts on file contained a contract of the housekeeping company the surgery center previously received service from. The housekeeping company that currently provides services to the facility was not available.</p>	S000226	<p>410 IAC 15-2.4-1 (e)(3) 1. Contract received from Summit Urology. Cleaning services/expectations discussed at Board of Directors meeting held on 04/04/2014. Requirements of employees of cleaning services outlined and presented to include handwashing techniques, Blood-borne pathogen exposure control plan, scrub attire, OSHA regulations, and implementation of TB testing for employees. Each employee will have a file maintained in the Administrator's office providing documentation of education and competencies. 2. Mandatory in-service training for cleaning services will be completed. Continuing education will be provided when applicable. Employer notified of mandatory meeting via email. Response of attendance verified. 3. Monitoring of compliance will be done by Administrator and</p>	04/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. The 1/15/2015 Board of Manager Meeting minutes indicated the previous housekeeping company was not providing adequate service. However, the Board of Manager minutes did not reflect the current housekeeping company that provides cleaning services for the surgery center.</p> <p>3. At 10:30 AM on 3/26/2014, staff member #10 indicated he/her does not have a contract or a written agreement of what scope of services the current housekeeping company provides the surgery center.</p>		<p>Infection Control Nurse. Responsible person will be the Administrator 4. Mandatory inservices/training to be conducted on 04/28/2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000310	<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 staff interview, the facility failed to ensure 9 services were part of its comprehensive Quality Assurance Program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Surgicare 2013 Quality Assurance Program indicated all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. In review of the surgery center's Quality Assurance Program program, the following services were not included: Bioengineering, Biohazard Waste, Housekeeping, Lab, Laundry/Linen, Maintenance, 	S000310	<p>410 IAC15-2.4-2 (a)(1) 1. Quality Assurance Program has been initiated to evaluate performances of contracted services to include Bioengineering, Biohazard Waste, Lab, Housekeeping, laundry, Maintenance, Pharmacy, Radiology, and Security. Data collected will determine performance of services provided, identification of problems associated with provided services. Corrective actions will be taken if improvement is warranted. 2. Quality Assurance data will be collected; analyzed on quarterly basis. Findings of analysis will be presented at monthly staff meetings and Board of Directors meetings held quarterly. 3. Administrator and Quality Assurance nurse will conduct studies of services and monitor. Administrator is responsible 4. Quarterly data collection has been initiated for monitoring of contracted services on 04/11/2014.</p>	04/11/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Pharmacy, Radiology, and Security.</p> <p>3. At 11:17 AM on 3/25/2014, staff member #9 confirmed the 9 services (Bioengineering, Biohazard Waste, Housekeeping, Lab, Laundry/Linen, Maintenance, Pharmacy, Radiology, and Security) were not monitored or evaluated as part of the surgery center's comprehensive Quality Assurance Program</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000418	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(A)</p> <p>(2) The infection control committee responsibilities must include, but are not limited to the following:</p> <p>(A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the center.</p> <p>Based on interview and policy and procedure review, the infection control committee failed to follow their policy for identifying infections related to procedures performed at the center in 2013.</p> <p>Findings included:</p> <p>1. At 2:30 PM on 03/25/14, staff members A1 and A11, the nurses responsible for the facility's Infection Control Program, were interviewed. They indicated they relied on the physicians performing the procedures at the facility to inform them of any infections related to the surgeries. They indicated they would investigate and track any infections, but there had not been any since they were involved with the program which was since December 2012 for A1 and just the last few months for A11. They indicated they did not have any documentation of this process.</p>	S000418	<p>410 IAC15-2.5-1 (1)(2)(A) 1. InfectionControl worksheets (patient census reports) have been formatted for eachsurgeon to include patient number, name, procedure provided, post-operativeinfection if applicable, cause/treatment, resolution and date resolved.Provider will review findings of post-operative infections on monthly basis,sign, and return to Administrator or Infection Control Nurse for any follow-upsthat need to be addressed. Worksheets for each provider will be completed forall cases performed in 2013. 2. At month'send, worksheets (patient census report) for each provider will be printed, sentto provider for analysis, signed by provider, and returned in timely manner.All worksheets will be compiled in designated book for review. 3.Administrator and Infection Control nurse will compile data for patient censusreports, present to providers, and insure reports are completed and returned intimely manner. Administrator is</p>	04/25/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. Review of the facility policy "Infection Control Reporting", last reviewed 09/13/13, indicated, "II. Procedure: A. On a monthly basis, an alphabetical patient census report will be printed and sent to each physician's office for review of post-op infections. The completed list will be returned to the Center if there are any follow-ups that are to be completed."</p> <p>3. At 4:00 PM on 03/25/14, staff member A1 presented some infection tracking forms from 2012 that were found on another computer program. He/she confirmed this process had not been continued in 2013 because he/she was unaware of the system.</p>		ultimately responsible 4. Datacompiled for patient census reports for January, February, and March 2014 havebeen presented to providers for review on 04/11/2014. Data for patientcensus reports for 2013 is being compiled and will be presented to providersfor review on 04/25/2014.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

S000422	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk. Based on review of product information, employee files review, policy review, and interview, the facility failed to ensure TB testing was performed per policy, manufacturer's recommendations and CDC guidelines for 5 of 6 staff member files reviewed (P1, P2, P3, P5, and P6).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The manufacturer's product information for Tubersol, the solution used for TB testing, indicated the tests should be placed and read within 48 to 72 hours for accuracy. The health file for staff member P1, an RN (registered nurse) with a hire date of 09/15/10, indicated a TB test placed on 12/02/13 and read on 12/04/13, but no times were documented to determine whether the test was read within 48 to 72 hours. The health file for staff member P2, an 	S000422	<p>410 IAC15-2.5-1 (f)(2)(c) 1. Staff members P1, P2, P3, P5, and P6 will receive TB testing at mandatory education/meeting. New documentation will reflect CDC guidelines and policy of facility to include date/time administered with signature of provider. Documentation of reading of results will include date/time with signature of nurse. Date/time will reflect policy of compliance of test placed and results read in 48-72hours. Documentation will be placed in employee files. Medical history/physical updates will be completed at staff meeting on 04/28/2014 and placed in employee files. Documentation for TB testing/screening has been revised to include nursing personnel that do not receive Tubersol. 2. TB documentation has been revised to include date/time of administration;date/time screening read with provider's signature of each. Each employees file will be updated to reflect documentation to remain</p>	04/28/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>RN with a hire date of 01/15/13, lacked documentation of any TB testing or screening.</p> <p>4. The health file for staff member P3, an RN with a hire date of 03/19/13, indicated a TB test placed on 12/02/13 and read on 12/04/13, but no times were documented to determine whether the test was read within 48 to 72 hours.</p> <p>5. The health file for staff member P5, a CST (certified surgical tech), with a hire date of 02/26/13, indicated a TB test placed on 12/02/13 and read on 12/04/13, but no times were documented to determine whether the test was read within 48 to 72 hours.</p> <p>6. The health file for staff member P6, an RN with a hire date of 07/01/10, indicated a TB test placed on 12/02/13 and read on 12/05/13, but no times were documented to determine whether the test was read within 48 to 72 hours.</p> <p>7. The facility policy "Infection Control for Employee Health", last reviewed 09/13/13, indicated, "A. Pre-employment Physical Examination: ...2. A PPD test or chest X-ray for tuberculosis is completed. ...b. PPD Testing: i. PPD testing is mandatory for all employees yearly."</p>		<p>in compliance with CDCguidelines. 3.Administrator and Infection Control will administer screening and complete documentation for employees' files. Administrator is responsible 4. Re-screening will be done 04/28/2014. Screening results will be read and documented04/30/2014 to be in compliance with CDC guidelines.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8. At 11:30 AM on 03/25/14, staff member A1 confirmed the findings and also indicated the facility followed CDC guidelines which specified tests to be read between 48 and 72 hours. He/she indicated staff member A2 would not have received a TB test because of a previous positive reaction, but confirmed the lack of a chest X-ray or TB screening form.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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 facility protocol, employee files review and interview, the facility failed to ensure 5 of 5 nurses (P1, P2, P3, P4, and P6), who performed out-of-lab testing on patients of the center, had initial and/or annual competency for the testing.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the facility "Anesthesia Pre-Op Protocol", last reviewed 09/13/13, indicated, "2. Pre-op labs: ...HCG [urine for pregnancy testing] for all females of child-bearing age ...Glucometer for oral and insulin-controlled diabetics." Review of the employee file for staff member P1, an RN (registered nurse), hired 09/15/10, indicated the last out-of-lab competency testing was 01/23/12, over 2 years ago. Review of the employee file for staff member P2, an RN hired 01/15/13, lacked documentation of any competency for out-of-lab testing. 	S000526	<p>410 IAC15-2.5-2 (h) 1. All nursing personnel to include P1, P2, P3, P4, and P6 will receive competency training(inservice with return documentation) to include protocol/procedure for HCG testing and protocol/procedure for glucose testing with the HemoCue monitor. 2. Competency training will be completed upon initial employment and conducted annually thereafter. Documentation of training/inservices will be maintained in each employee file under "Education". 3.Administrator will conduct competency training to include protocol for testing,proper procedure, followed by return demonstration from staff members forverification of understanding. Administrator is responsible person 4. Competency training/evaluation will be conducted yearly commencing at scheduled mandatory staff training to be held 04/28/2014. Employee files will be updated following completion of day.</p>	04/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>4. Review of the employee file for staff member P3, an RN hired 03/19/13, lacked documentation of any competency for out-of-lab testing.</p> <p>5. Review of the employee file for staff member P4, an RN hired 07/25/13, lacked documentation of any competency for out-of-lab testing.</p> <p>6. Review of the employee file for staff member P6, an RN hired 07/01/10, indicated the last out-of-lab competency testing was 01/23/12, over 2 years ago.</p> <p>7. At 1:20 PM on 03/25/14, staff member A1 confirmed all nurses perform the out-of-lab testing for urine pregnancy and blood sugar readings and also confirmed the lack of initial and annual competencies.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000750	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(G)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(G) Criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.</p> <p>Based on document review and staff interview, the facility failed to ensure 1 of 5 physicians had current privileges for procedures they were performing at the surgery center.</p> <p>Findings included:</p> <p>1. Surgicare Professional Staff Bylaws Article II section 2.1B (last revised and approved 9/25/2012) stated, "To function as the body through which individual professionals obtain membership requirements and clinical privileges to provide medical/surgical services to patients."</p>	S000750	<p>410 IAC15-2.5-4 (b)(3)(G) 1. Physical Medicine and Rehabilitation privileges have been delineated for provider(Physician staff member #3) to include evaluation/management of patients with impaired function due to various underlying causes; supplemental privileges to include local anesthetic nerve/ motor blocks; epidural steroid injections;discography; radiofrequency ablation; and spinal cord implant trials/placementof permanent leads. Privileges signed/dated by applicant. Approved by Board of Directors and committee. 2. Upon application for provider privileges, credentials will be received; delineationof privileges will be determined, signed by provider, and presented to Board for approval to obtain privileges. Provider will be re-credentialed every two years as stated in the</p>	04/09/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. Credential files were reviewed for 5 physicians. Physician staff member #3 credential file evidenced the following privileges: Admission of Patients to the Center; Initiate the Pre Operative and Post Operative Order; Completion of the History and Physical; and Completion of the Post Operative instructions and the Discharge Summary. The approval of privileges was signed by the Medical Director and the Board Chairman. The privileges in the physician's credential file did not evidence to perform clinical procedures for the surgery center.</p> <p>3. At 11:00 AM on 3/26/2014, staff member #1 confirmed that physician staff member #3 credential files did not evidence the procedure he/she performs for the surgery center. The staff member indicated the procedure physician staff member #3 performs was Transforaminal Epidural Steroid Injections.</p>		<p>Professional Staff By-laws. 3.Administrator will initiate process of credentialing for provider and complete applicable paperwork for presentation to Board for approval of services. 4. Credential files for Physician staff member #3 updated on 04/09/2014 which reflect services provided.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

S001146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, policy review and interview, the facility failed to ensure obstruction free high voltage electrical panels in the Mechanical Room and failed to ensure a safe environment in the event of an anesthetic emergency by having a fully stocked malignant hyperthermia kit per standard of practice.</p> <p>Findings included:</p> <p>1. At 9:30 AM on 3/26/2014, the Mechanical Room was observed with wall-mounted generator transfer switch and high voltage electrical panels. The two</p>	S001146	<p>410 IAC15-2.5-7 (b)(2) 1. 1) Janitor cart, housekeeping supplies, and trash container have been moved out of "red caution tape zone". "No Parking" signs have been taped on floor of red tape area to enable access to electrical panels. 2) Area will monitored each Monday morning to ensure compliance of restricted zone. 3) Administrator will monitor 4) Restricted area in mechanical room has been cleared of janitor supply cart, assorted maintenance supplies, and trash container on 03/28/2014. 2-5. 1)Emergency policy and procedure for Malignant Hyperthermia reviewed and discussed with Medical Director (Anesthesia). 2) Eighteen additional vials of Revonto (Dantrolene generic) has been ordered from Henry Schein Distributors. Thirty-six vials will be maintained on Emergency</p>	04/18/2014
---------	---	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	electrical panels were observed with red caution tape marking off a restricted area on the cement floor in front of the panels. However, there were a janitor cart, assorted maintenance supplies, and trashcan all observed stored in the restricted area obstructing the high voltage electrical panels.		Crash Cart as reflected in Emergency Policies and Procedures. 3) Administrator placed order for additional medication, will be placed in drawer upon arrival from distributor, will be included in monthly "outdate" check of emergency cart. 4) Order placed 04/09/2014, expected date of arrival from distributor 04/18/2014.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S001146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>2. Review of the facility policy "Emergency Policies and Procedures", last reviewed 09/13/13, indicated, "Malignant Hyperthermia Caddy-Medications: 1. Dantrolene sodium IV 36 vials".</p> <p>3. During the tour of the facility at 1:00 PM on 03/24/14, accompanied by staff member A1, eighteen vials of Revonto (generic for Dantrolene) were observed with the malignant hyperthermia supplies in the emergency cart.</p> <p>4. At 1:10 PM on 03/24/14, staff</p>	S001146	<p>410 IAC15-2.5-7 (b)(2) 1. 1) Janitor cart, housekeeping supplies, and trash container have been moved out of "red caution tape zone". "No Parking" signs have been taped on floor of red tape area to enable access to electrical panels. 2) Area will monitored each Monday morning to ensure compliance of restricted zone. 3) Administrator will monitor 4) Restricted area in mechanical room has been cleared of janitor supply cart, assorted maintenance supplies, and trash container on 03/28/2014. 2-5. 1)Emergency policy and procedure for Malignant Hyperthermia reviewed and discussed with Medical Director (Anesthesia). 2) Eighteen additional vials of Revonto (Dantrolene generic) has been ordered from Henry Schein Distributors. Thirty-six vials will be maintained on Emergency</p>	04/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>member A1 indicated the facility only stocked 18 vials of the drug to start treatment for an emergency episode of malignant hyperthermia, then the patient would be transferred to the local hospital.</p> <p>5. The Malignant Hyperthermia Association of the United States recommendations were to stock 36 vials of the emergency drug because the dose of medication was based on a patient's weight and it could take up to 30 minutes to stabilize a patient for transfer.</p>		<p>Crash Cart as reflected in Emergency Policies and Procedures. 3) Administrator placed order for additional medication, will be placed in drawer upon arrival from distributor, will be included in monthly "outdate" check of emergency cart. 4) Order placed 04/09/2014, expected date of arrival from distributor 04/18/2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S001148	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(A)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals must be available, along with training or instruction, or both, of the appropriate center personnel, in the maintenance and operation of fixed and movable equipment.</p> <p>Based on documentation review, the facility failed to ensure weekly preventive maintenance was conducted on the surgery center's industrial generator.</p> <p>Findings included:</p> <p>1. The generator documentation revealed the generator run under load for 30 minutes once a month for the previous 9 months: 7/10/13;</p>	S001148	410 IAC15-2.5-7 (b)(3)(A) 1. Buckeye Power Sales contacted 04/08/2014 to provide service call/orientation for recommended weekly preventative maintenance protocol. Manual will be provided by service representative, will be placed in transfer switch compartment in mechanical room. Generator documentation will reflect weekly inspections for compliance with manufacturers' recommended practices and Surgicare Emergency Policy and Procedure Section II of generator running under load for thirty minutes on Tuesday between 4:00-4:30 p.m., line power light	04/14/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>8/12/13; 9/12/13; 10/10/13; 11/12/13; 12/10/13; 1/10/14; 2/10/14; and 3/10/14. The documentation lacked weekly inspections.</p> <p>2. Surgicare Emergency Policies and Procedures section II (Last approved 9/13/13) stated, "The power system will be checked and tested according to the manufacturer's instructions with records maintained."</p> <p>3. The facility could not produce the operating manual on the surgery center's generator; however, the Internet provided the operating manual for the Kohler Equipment model #60RZ. The operating manual recommends weekly preventive maintenance on the generator which includes checking the battery fluid levels.</p>		<p>switched to generator power light at master panel, automatic running of generator, and battery fluid levels. 2. Operating manual obtained from Buckeye Power Sales, placed in Mechanical room. 3. Administrator will revise weekly generator documentation, responsible for weekly inspections, and documentation. Administrator is responsible 4. Weekly generator inspection and documentation to begin following site visit from service representative on Monday, 04/14/2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

S001174	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following:</p> <p>(A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice.</p> <p>Based on observation, policy review, document review, and interview, the infection control committee failed to ensure environmental services were provided to ensure the safety and well-being of the patients treated in the facility.</p> <p>Findings included:</p> <p>1. During the tour of the pre/post area at</p>	S001174	<p>410 IAC15-2.5-7 (b)(5)(A) 1. 1) Wall ledges/wall mounted equipment will be dusted by housekeeping services on weekly basis. Staff will provide additional cleaning/dusting should be deemed necessary throughout the week during business hours. Cleaning requirements of staff documented on flow sheet and weekly checklist for housekeeping services will be maintained to maintain asepsis</p>	04/28/2014
---------	--	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1:00 PM on 03/24/14, accompanied by staff member A1, the wall ledges and wall mounted equipment in the patient areas were observed with a layer of dust.</p> <p>2. During the case observation in operating suite #2 at 1:20 PM on 03/24/14, the top of the lithotripsy machine and another machine in the room were observed with a layer of dust.</p> <p>3. Review of the facility policy "Cleaning O.R. Between Cases", last reviewed 09/13/13, indicated, "A. The surgical team will perform the following: ...6. Damp clean the back table, the mayo stand, operating table, and any other equipment which could have become soiled during the case, when necessary, with germicidal/virucidal/tuberculocidal solution. B. End of Day- Operating room(s): 1. All equipment, such as microscopes, monitors, video equipment, anesthesia stands and equipment, and all flat surfaces are to be damp cleaned with germicidal/virucidal/tuberculocidal solution by the surgical team. 2. Housekeeping personnel will terminally clean the rooms."</p> <p>4. Review of the facility policy "Housekeeping Services", last reviewed 09/13/13, indicated, "II. Responsibility: A. The Administrator is responsible for</p>		<p>and prevention of cross-contamination. 2) Areas will be monitored, thorough orientation and expectations will be presented to all staff members including housekeeping services at mandatory staff meeting. 3) Administrator will provide orientation and guidelines of expectations to maintain cleanliness and principles of asepsis/safe practices. Administrator is responsible 4) Orientation/ guidelines/requirements will be presented on 04/28/2014. 2. 1) Radiological technician will dust/clean lithotripsy machine on weekly basis, additional dusting/cleaning to be done when deemed necessary throughout week. 2) Lithotripsy machine will be monitored weekly to maintain cleanliness. Documentation of cleaning practices will be included on staff cleaning schedule and worksheet for accountability. 3) Radiological technician will clean, Administrator will monitor for compliance. Administrator will be responsible 4) Weekly cleaning of lithotripsy machine added to cleaning schedule 04/04/2014. 3. 1) Facility policy "Cleaning OR between Cases" will be amended to reflect housekeeping will provide terminal cleaning to rooms on designated day(Saturday). Surgical team members will be responsible for daily cleaning of ORsuite at</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>maintaining agreements for housekeeping services. The Administrator is responsible for monitoring contracted housekeeping services that are provided to assure accepted levels of cleanliness."</p> <p>5. At 10:15 AM on 03/26/14, the owner of the contracted cleaning company, C1, presented documentation of cleaning requirements provided by the center which listed numerous tasks to be completed daily, including wiping down all surfaces in the operating rooms and patient care areas. He/she also presented a check off form, which he/she created for the center, which indicated daily cleaning. One of the items for the pre/post area and operating rooms was to disinfect all wall mounted fixtures, but indicated the center staff was responsible for surgical equipment. He/she indicated anesthesia machines and keyboard equipment would not be cleaned by the contracted company, but the tops of all of the machines would be wiped down. When questioned regarding all of the tasks to be completed daily, C1 indicated that meant each time the contracted service cleaned which was weekly, not daily.</p> <p>6. At 11:00 AM on 03/26/14, staff member A1 acknowledged the discrepancies with the facility's</p>		<p>beginning of work day, to include damp cleaning of all equipment, backtables, etc. prior to start of cases, cleaning as necessary after each case, and terminal cleaning to include walls and ceiling at end of day following completion of scheduled cases.</p> <p>2) Policy will be amended to reflect surgical teams' duties, monitoring area on daily basis to maintain asepsis/prevention of cross-contamination. Additional cleaning, such as mopping after case, to be done as deemed necessary. 3) Surgical team members will monitor compliance of practices, report problems if found to Administrator who is responsible for team members and their practices. Administrator is responsible person 4) Revised cleaning requirements/worksheet will be introduced at mandatory staff meeting on 04/28/2014. 4-6. 1) GEI Building Management has been contacted to verify attendance at mandatory staff meeting/education/in services/competency training. Expectations will be defined, weekly tasks to be completed, and cleaning schedule modified to reflect services provided. Weekly schedules will be signed by employee to ensure accountability of contracted services provided.</p> <p>2) Inspections will be conducted on daily basis to ensure cleanliness of facility and compliance of contracted</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	housekeeping policies and expectations for the contracted cleaning service and confirmed there was confusion with cleaning responsibilities.		services to maintain asepsis and prevention of cross-contamination of areas. Surgicare staff will maintain cleanliness in all areas, including anesthesia equipment, and monitor effectiveness of cleaning services for areas specified for the contracted services. Additional cleaning will be done when deemed necessary. 3) Surgical team members will monitor compliance of practices, report problems if found to Administrator who is responsible for team members. Responsible person is Administrator 4) GEI Building Management contacted via phone call and email message to ensure attendance at meeting. Notice has been posted for staff regarding meeting on 04/28/2014.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S001182	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based on documentation review and staff interview, the facility failed to collect information about hazards and safety practices that are evaluated by the safety committee.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility did not provide documented evidence of safety inspections of the surgery center for 2013 and 2014. The Surgicare Staff Meeting minutes were reviewed. The staff meeting minutes did not address any topics of safety walk-through inspections of the surgery center. 	S001182	<p>410 IAC 15-2.5-7 (c)(2) 1. Information regarding hazards and safety practices will be evaluated, data collected, reviewed, and findings presented will be documented on preventative maintenance checklist which is completed monthly. Safety Committee will review findings at monthly staff meeting, minutes of meeting will reflect findings of safety practices. 2. Staff member #1 will continue walk-throughs of surgery center; document findings of hazards and unsafe practices; will be included in agenda of monthly staff meeting. Issues will be addressed during discussions of safety practices. Findings will be presented to Quality Assurance Committee for review. Potential safety/health risks will be included in preventative maintenance checklist to remain in compliance. Examples: supplies that are fluid will not be stored above dry goods; electrical outlets will have childproof covers in public areas;</p>	04/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	3. At 10:45 AM on 3/26/2014, staff member #1 indicated the monthly staff meeting did not discuss safety issues. The staff member indicated he/she conducts walk-throughs of the surgery center, however, the staff member does not document his/her findings. Therefore, those issues are never brought to the staff meeting for discussion.		nothing will be stored under sink except approved items; proper handling of trash and biohazard trash; storage carts must remain covered. 3. Administrator will be responsible for monitoring of safety practices, addressing/discussion of issues at staff meetings, Safety Committee meeting, and Quality Assurance Committee meeting. 4. Preventative maintenance checklist revised 04/10/2014		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S001188	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on documentation review and staff interview, the facility failed to conduct an unannounced fire drill one (1) per quarter for the year 2013.</p> <p>Findings included:</p> <p>1. The facility did not have documented evidence of fire drills conducted for the year 2013.</p> <p>2. In review of the Surgicare Staff Meeting minutes for 2013, Fire Drill operations were discussed.</p>	S001188	<p>410 IAC 15-2.5-7 (c)(4) 1. Fire Prevention Officer from Bloomington Fire Department will conduct Fire Drill operations to include fire safety regulations, proper evacuation of patients, family members, and staff, and proper fire control. 2. Fire Drill policy states "fire drills will be held at least annually; fire control plan will be reviewed on quarterly basis". Fire Drills will be conducted annually by the Bloomington Fire Department at scheduled education/training/competencies. 3. Administrator has scheduled fire drill with fire department. Fire Control Plan/Emergency Operations will be reviewed with staff members on quarterly basis. Responsible person is the</p>	04/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2014
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Staff explained the Fire Drill policy and explained where all the fire extinguishers were located. The Fire Drill agenda item was one of the items discussed in the surgery center's staff meetings.</p> <p>3. At 10:00 AM on 3/25/2014, staff member #1 indicated the facility did not have a fire drill in 2013. Instead of fire drills, during the staff meeting, the topic of fire drills are discussed. The staff member confirmed the surgery center should have 1 fire drill per quarter.</p>		<p>administrator 4. Fire Drill and review to beconducted 04/28/2014.</p>		