

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/28/2012
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NAME OF PROVIDER OR SUPPLIER SENATE STREET SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 N SENATE BLVD INDIANAPOLIS, IN 46202
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(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
S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002403</p> <p>Survey Date: 3-26/28-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 04/10/12</p>	S0000	<p>Correction:</p> <p>Prevention of Recurrence:</p> <p>Responsibility: Kathy Newman, Director Senate Street Surgery Center 317-962-0696</p> <p>Completion Date:</p>	

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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S0110	<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 document review and interview, the facility's governing board failed to review 9 contracted services during calendar year 2011 for quality assurance performance improvement (QAPI) activities.</p> <p>Findings:</p> <p>1. Review of the facility's governing board meeting minutes for calendar year 2011, indicated the governing board failed to review QAPI activities for the contracted services of bioengineering, biohazardous waste, laboratory, laundry, maintenance, pharmacy, radiology, security and tissue transplant.</p> <p>2. On 3-28-12 at 11:55 am, upon interview, employee #A2 indicated there were no governing board minutes for calendar year 2011 which included the</p>	S0110	<p>Senate Street Surgery Center's (SSSC) managers and QAPI members reviewed quality, performance and measurement expectations with representatives from all nine contracted service providers, including quality monitoring and reporting on a quarterly basis using objective measures and the expectations for performance improvement when indicated . Quality monitoring reports will be accomplished on a quarterly basis to the QAPI and Board of Managers (BOM). To assist with reporting and tracking, future reporting of contracted services, quality monitoring will be included within the documentation maintained for QAPI and BOM meetings effective with meetings occurring from June 1, 2012 and going forward. Responsible party: The Board of Managers and SSSC Clinical Director are responsible for ensuring</p>	05/01/2012			

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	above activities and no further documentation was provided by exit.		correction and ongoing compliance.	

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S0310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for 2 services furnished by a contractor in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it lacked a monitor and standard for the contracted services of biohazardous waste and pharmacy.</p> <p>2. On 3-28-12 at 11:55 am, upon interview, employee #A2 indicated there was no documentation of inclusion of the above activities. No other documentation was provided prior to exit.</p>	S0310	<p>Senate Street Surgery Center's (SSSC) managers and QAPI members reviewed quality, performance and measurement expectations with representatives from biohazardous waste and pharmacy that are provided by a contractor, including quality monitoring and reporting on a quarterly basis using objective measures and the expectations for performance improvement when indicated. Quality monitoring reports will be accomplished on a quarterly basis to the QAPI and Board of Managers (BOM). To assist with reporting and tracking, future reporting of contracted services quality monitoring will be included within the documentation maintained for QAPI and BOM meetings effective with meetings occurring from June 1, 2012 and going forward. Responsible party: The Board of Managers and SSSC Clinical Director are responsible for ensuring correction and ongoing compliance.</p>	05/01/2012

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S0328	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the facility failed to document and take appropriate action to address the opportunities for improvement found through the Utilization Review Committee for 12 of 89 records they reviewed.</p> <p>Findings:</p> <p>1. Review of a document entitled Senate Street Surgery Center, L.L.C. Utilization Review Committee Meeting, dated April 11, 2011, indicated the committee reviewed 89 medical records. Of these, records MR#1, MR#2, MR#3, MR#4, MR#5, MR#6, MR#7, MR#8, MR#9, MR#10, MR#11 and MR#12 had evidence of non-compliance with criteria for appropriateness of care as defined by the Utilization Review Committee.</p>	S0328	Senate Street Surgery Center's (SSSC) managers and QAPI members reviewed expectations for quality monitoring and reporting, including the expectations for performance improvement and follow-up documentation when indicated with a specific emphasis for inclusion of items identified through other oversight committees such as the Utilization Review Committee. Staff and Physician are currently being re-educated regarding these expectations. Re-education efforts began 4-27-12 with written reminders through e-mail, postings, and agenda items on upcoming meetings. Quality monitoring reports, with action items and follow-up (when indicated), will be accomplished through established QAPI and Board of Managers (BOM)	05/01/2012

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	2. On 3-28-12 at 9:50 am, upon interview, employee #A2 indicated there was no documentation of having taken appropriate action to address the opportunities for improvement found through the Utilization Review Committee.		discussions. To assist with tracking, future reporting of action items and follow-up (when indicated) will be included within the documentation maintained for QAPI and BOM meetings effective with meetings occurring from June 1, 2012 and going forward. Responsible party: The Board of Managers and SSSC Clinical Director are responsible for ensuring correction and ongoing compliance.		

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S0432	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, policy and procedure review, product directions, and interview, the infection control committee failed to ensure the pre-operative area and the post-anesthesia care unit (PACU) were maintained in a clean, sanitary manner and failed to ensure the housekeeping staff were using chemicals appropriately.</p> <p>Findings included:</p> <p>1. During the tour of the perioperative area, beginning at 9:25 AM on 03/27/12, accompanied by staff members #P 3 and P4, the following observations were made:</p> <p>A. The housekeeping cart in the closet in the operative area contained 2 spray bottles of the disinfectant SaniMaster 4</p>	S0432	<p>Referenced spray-bottles with SaniMaster 4 with an unclear expiration date marked as "EXP 3" were immediately removed and discarded during the course of the survey. This was completed 3/28/12. Environmental services performed additional all-inclusive cleaning services within the PACU and pre-operative areas with special attention to address areas associated with allegations of findings of dust. This was completed by 3/30/12. Representatives from Environmental services, SSSC Leadership, and of the QAPI and Infection Control Committee reviewed expectations for cleaning practices to ensure that the SSSC is maintained in a clean, sanitary manner and that chemicals are used and maintained appropriately. SSSC policies were reviewed to ensure practice expectations were</p>	05/01/2012			

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	<p>with "EXP 3" handwritten on them.</p> <p>B. A coating of dust on the wall ledges and suction canisters in the pre-op bays.</p> <p>C. A heavy layer of dust on the bottoms of the patient beds/carts in the pre-op bays.</p> <p>D. A coating of dust on the wall ledges and suction canisters in the PACU.</p> <p>E. A heavy coating of dust on the bottoms of the patient beds/carts in the PACU and on all of the extra beds/carts stored ready for use.</p> <p>2. The facility policy "Environmental Cleaning in the Perioperative Setting", last reviewed May 2011, indicated on page 3, "...B. Areas requiring environmental cleaning and disinfection include, but are not limited to, surgical suites, procedure rooms, and all other patient care areas." The policy continued on page 4, "...b. Surfaces must remain wet for appropriate contact time, according to product manufacturer's guidelines. c. Spray bottles containing disinfectant will not be used. Disinfectant wipes and pour bottles can be used." The same page addressed Terminal Cleaning, "1. Terminal cleaning is performed by departmental housekeeping personnel, nursing staff, and ancillary staff or by a contracted vendor. ...G. Patient Care Areas (Assessment, PACU, Attendant Care Unit) ...2. All areas and equipment</p>		<p>consistent with requirements. Appropriate staff are currently being re-educated regarding these expectations. Re-education efforts began 4-27-12 with written reminders through e-mail, postings, and agenda items on upcoming meetings. Oversight of expectations will be accomplished through participation and reporting within the QAPI program. Random spot-checks of practice patterns will become effective with meetings occurring June 1, 2012 and going forward. Responsible party: The SSSS Clinical Director will be responsible for ensuring correction and ongoing compliance with the Board of Managers ultimately responsible for performance of contracted services.</p>		

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	<p>should be cleaned according to an established schedule and manufacturer's instructions."</p> <p>3. The environmental services policy "Sterile Room Cleaning", last reviewed 02/02/11, indicated on page 1, "...First raise the bed as far as it can go. Then, using SaniMaster 4 R.T.U. (Ready to use) solution, wipe the top of mattress and sides. Remove and clean the headboard. Wipe dry to prevent water spots."</p> <p>4. Another environmental services policy "Daily Cleaning Steps", last reviewed 02/02/11, addressed individual patient rooms rather than giving any specific instructions for the pre-op and PACU areas.</p> <p>5. The manufacturer's directions on the SaniMaster 4 disinfectant indicated the product was to remain on surfaces for 10 minutes to be effective.</p> <p>6. At 3:05 PM on 03/27/12, the environmental services shift leader, staff member #P11, indicated the 2 staff members who cleaned the facility, #P12 and P13, could not come in early for an interview, but he/she was the one who supervised them. He/she indicated the spray bottles were filled from the automatic wall dispenser and should not</p>			

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	<p>be mixed with anything else or diluted. He/she indicated he/she would try to contact one of the cleaning staff members to provide answers regarding the cleaning process and the labeling of the spray bottles.</p> <p>7. At 9:30 AM on 03/28/12, staff member P3 provided a typed document of staff member P11's interview with the cleaning staff member P13. According to the document, staff member P13 indicated the spray bottles were filled from the automatic dispenser and an expiration date of 7 days should have been written as 4/3 and not just 3. Normally the bottles had flip top lids, but the sprayers were used to get to hard to reach areas. The interview did not indicate anything about a 10 minute contact time for the disinfectant or any equipment or areas that they did not clean. In the document, staff member P11 indicated the caps with flip top lids should be used and not sprayers and the labeling on the SaniMaster 4 indicated a bottle fill had a 90-day expiration, not a 7-day expiration.</p> <p>After reviewing this document and the policies, staff member #P3 confirmed the discrepancies between the observations and the interview of what should be happening and also agreed that it could not be determined how the chemicals</p>				

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	<p>were used or whether a 10 minute contact time was used.</p> <p>8. At 10:00 AM on 03/28/12, the infection prevention staff member, #P15, indicated he/she did not observe the housekeepers at work.</p>			

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S0670	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAc 15-2.5-3(f)(12)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(12) Final progress note, including instructions to the patient and family, with dismissal diagnosis.</p> <p>Based on medical record review, policy and procedure review, and interview, the facility failed to follow its policy for discharge summary requirements for 14 of 17 closed patient records (#N2, N3, N4, N5, N6, N8, N9, N10, N11, N12, N13, N15, N16, and N17).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the closed medical records with staff member #P3 on the electronic medical record failed to indicate a discharge summary or final progress note by the physician for patients #N2, N3, N4, N5, N6, N8, N9, N10, N11, N12, N13, N15, N16, and N17. Review of the facility policy "Content of Medical Records", last reviewed May 2010, indicated on page 9, "...10. Discharge Summary a. The discharge summary is the responsibility of the attending physician, although the 	S0670	<p>Representatives from Medical Staff Leadership, SSSC Leadership, QAPI, and BOM reviewed findings and expectations for required components to be maintained within the patient's medical record. Relevant representatives reviewed SSSC policies to ensure practice expectations were consistent with requirements. Policies will be revised to be consistent with licensure requirements. Once revisions are completed and approved, appropriate staff will be educated regarding revised processes and expectations to ensure required documentation components are present within the patient medical records. Re-education efforts will begin once policies revisions are finalized on 5/16/12 with implementation by 6-01-12. Education will occur through e-mail, postings, and meetings. Action plans described above will be shared with appropriate individual physicians</p>	05/17/2012			

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	<p>responsibility may be delegated to a resident or credentialed non-resident provider. The discharge summary shall be completed upon discharge of the patient from the surgery center. b. The discharge summary must include at least the following: Provisional diagnosis or reason(s) for admission, Principal and additional or associated diagnoses, All relevant diagnoses established by the time of discharge, Significant findings, Procedures performed and treatment rendered, Condition of the patient on discharge, Specific instructions given to the patient and/or family (especially relating to physical activity, diet, medications, and follow-up care)."</p> <p>3. At 12:45 PM on 03/28/12, staff members #P4 and P5 confirmed the lack of any similar discharge notation on the 14 above specified records as was found on 3 of the remaining medical records that were reviewed (#N1, N7, and N14).</p>		<p>monthly for ongoing performance improvement and reported through QAPI and Operations committees for ongoing performance improvement. Responsible Party: The SSSS Clinical Director and Medical Staff Leadership will be responsible for ensuring correction and ongoing compliance.</p>	

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S0676	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or legally reproduced medical records must be maintained by the center for a period of seven (7) years in accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure.</p> <p>Based on document review and interview, for records that were less than 7 years old, the facility stored medical records offsite and failed to have a waiver to do so.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 3-28-12 at 3:30 pm, upon interview, employee #A2 indicated hard copy medical records less than 7 years old were stored in an offsite building basement and in electronic form at a server in Kansas City. The employee further indicated there was not an original or legally reproduced form of any of the records at the surgery center itself. Review of a document from the State to the facility indicated the State granted a waiver so that the records could be stored at the Kansas City facility. 	S0676	<p>We respectfully request that this Tag be reviewed through the IDR Paper Review process. We believe we were in compliance at the time of survey and continue to maintain compliance. An Order to Grant a Waiver, dated November 16, 2007, was previously received in compliance with 410 IAC 15-2.2-2 (c). The Waiver states "This waiver allows off-site storage of the Centers medical records" and the processes described upon which the Waiver was granted have not changed. (See Attachments A and B). Importantly, the Waiver is non-specific related to location but clearly permits off-site storage of medical records; additionally, the Waiver is non-specific related to the "medium" used for the stored medical records but clearly contemplates both electronic records (scanned versions and computer IT application versions)and hard copy versions because there would need to be a</p>	05/17/2012	

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	3. On 3-28-12 at 3:30 pm, employee #A2 was requested to provide documentation of a waiver so that records could be stored at the offsite basement. Upon interview on that date and at that time, the employee indicated there was no waiver to store the records at the offsite basement. No other documentation was provided prior to exit.		transfer of the hard copy records in order to facilitate the scanning process for any records not already managed through IT applications or for those paper records that might be contemplated when required for "downtime" procedures. Therefore, we request that Tag S 676 be removed. If the request outlined above is not granted for some reason, then the Center's Plan of Correction is as follows: The Center shall submit a revised "Request for Waiver" that incorporates more specific references to the storage of both hard copy records and those maintained in electronic format. Within that Request, the Center shall outline processes for storage and retrieval of records maintained in off-site locations. Responsible Party: The SSSS Clinical Director and Medical Staff Leadership will be responsible for ensuring correction and ongoing compliance.		

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S0782	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(O)</p> <p>These bylaws and rule must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(O) A provision for personnel authorized to take a verbal order.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure their policy was followed regarding verbal orders in 4 of 4 patient charts reviewed that contained verbal orders (#N1, N5, N10, and N18).</p> <p>Findings included:</p> <p>1. The facility policy "Verbal Orders", last reviewed July 2010, indicated on page 1, "...A. Physicians may give verbal orders when the medical record or electronic order system is not readily accessible, or by telephone from another location. Verbal orders should be reserved as much as possible for emergent situations. Verbal orders must be signed by the prescribing physician." The policy continued on page 2, "1. Manual Documentation: a. The authorized professional shall document the order content on the physician order form in the medical record. With manual</p>	S0782	<p>Representatives from Medical Staff Leadership, SSSC Leadership, QAPI, and BOM reviewed findings and expectations for required components to be maintained within the patient's medical record. Relevant representatives reviewed SSSC policies to ensure practice expectations were consistent with requirements. Policies will be revised to be consistent with licensure requirements. Once revisions are completed and approved, appropriate staff will be educated regarding revised processes and expectations to ensure required documentation components are present within the patient medical records. Re-education efforts will begin once policies revisions are finalized and will occur 5/16/12 with implementation by 6-01-12. Education will occur through e-mail, postings, and meetings. Action plans described above will be shared with appropriate individual physicians monthly for ongoing performance</p>	05/17/2012			

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	<p>documentation, all verbal orders shall be signed by indicating, "R.V.V.O.", [Repeated/Read Back and Verified Verbal Order], name of physician, full signature and credentials of receiving authorized professional, dated and timed."</p> <p>2. The medical record for patient #N1, who had a procedure on 10/03/11, indicated a verbal order written on the Physicians Orders sheet, but lacked a date, time, or physician signature.</p> <p>3. The medical record for patient #N5, who had a procedure on 11/01/11, indicated a verbal order written on the Physicians Orders sheet, but lacked a physician signature.</p> <p>4. The medical record for patient #N10, who had a procedure on 12/02/11, indicated a verbal order written on the Physicians Orders sheet, but lacked a date, time, or physician signature.</p> <p>5. The medical record for patient #N18, who had a procedure on 02/02/12, indicated a verbal order written on the Physicians Orders sheet, but lacked a date, time, or physician signature.</p> <p>6. At 10:30 AM on 03/28/12, staff members #P4 and P5 confirmed the medical record findings, but indicated the</p>		<p>improvement and reported through QAPI and Operations committees for ongoing performance improvement. Responsible Party: The SSSS Clinical Director and Medical Staff Leadership will be responsible for ensuring correction and ongoing compliance.</p>				

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	procedure would be for the medical records department to notify the physicians who needed to go back and sign the orders.				

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S1146	<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 and procedure review, and interview, the facility failed to ensure a safe patient environment by monitoring the warming cabinet in the PACU (post-anesthesia care unit).</p> <p>Findings included:</p> <p>1. During the tour of the PACU at 10:45 AM on 03/27/12, accompanied by staff members #P2 and P5, the temperatures in the 2 compartments of the Amsco Steris Warmer were displayed as 155 and 152 degrees F (Fahrenheit). When documentation of temperature monitoring and appropriate temperature range were requested, both staff members indicated the maintenance department/clinical engineering was responsible for the unit. The unit contained blankets for patient</p>	S1146	<p>SSSC managers and QAPI committee developed action plans on 5-01-12 to address non-compliance with "Warming Cabinets for Blankets and Fluids" policy—a daily temperature log is completed daily. This will be reviewed by SSSC managers and QAPI committee for ongoing performance improvement. Responsible Party: Clinical Director</p>	05/01/2012			

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	<p>use.</p> <p>2. Review of the facility policy "Warming Cabinets for Blankets and Fluids", last reviewed September 2010, indicated on page 1, "...B. The temperature of warming cabinets for blankets may not exceed 130 degrees F (54.5 degrees C). C. The temperature of warming cabinets used for blankets and fluids simultaneously may not exceed 110 degrees F (43 degrees C). D. The temperature of each warming cabinet will be monitored and documented daily when open for business." On the second page under Procedures, the policy continued, "A. Monitoring 1. Check warmer temperature daily and record on the appropriate log (see appendices). 2. Logs must be maintained for each warmer. 3. Logs must contain the unit/clinic/area name, month, and year. 4. Days the unit/clinic/area is closed for business are noted on the log. B. Maintenance- Notify Clinical Engineering for problems with the warmer." A copy of the monitoring log was attached to the policy.</p> <p>3. At 3:00 PM on 03/27/12, staff member #P2 indicated he/she had talked with staff member #P10 from clinical engineering and provided documentation of preventive maintenance from May 2011, but no daily monitoring documentation</p>						

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	could be provided.			

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S1148	<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 pf 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 observation and interview, the facility failed to ensure all of the equipment was maintained on a periodic inspection schedule for 2 items in the pre-op and PACU (Post-anesthesia care unit) patient care areas.</p> <p>Findings included:</p> <p>1. During the tour of the pre-op area at 10:30 AM on 03/27/12, accompanied by staff member #P2, an ice machine was observed in the nourishment room. The circular tube for dispensing ice was soiled</p>	S1148	<p>SSSC managers and QAPI committee worked with IU Health Facilities department to develop action plans to address non-compliance with criteria for: 1. cleaning the ice machine in the nourishment room—cleaned 4-25-12 2. defrosting the Gibson Freezer in PACU—defrosted 3-28-12 3. preventive maintenance for obsolete freezer—removed 3-29-12Senate Street Surgery Center's (SSSC) managers and QAPI members reviewed quality, performance and measurement expectations with representatives from applicable contracted</p>	04/27/2012			

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	<p>with a brownish material and the backsplash area and slotted ledge were stained and soiled. The bottom shelf of the machine was soiled and littered with debris. Staff member #P2 indicated this machine was the responsibility of the maintenance department.</p> <p>2. During the tour of the PACU area at 10:45 AM on 03/27/12, accompanied by staff members #P2 and P5, a Gibson freezer was observed at the nurses' station. The freezer contained a large shoulder ice pack and an empty wrapper from another ice pack and the shelves had a heavy accumulation of ice. There was no documentation of temperature monitoring and both staff members indicated the maintenance department was responsible for the unit.</p> <p>3. At 3:25 PM on 03/27/12, staff member #P2 indicated the freezer was only used for one specific orthopedic surgeon who no longer practiced at the facility. He/she indicated he/she talked with the maintenance director, staff member #P14, who reported there were no records of preventive maintenance on the freezer and it should just be removed if it wasn't being used.</p>		<p>service providers, including quality monitoring and reporting on a quarterly basis using objective measures and the expectations for performance improvement when indicated . Quality monitoring reports will be accomplished on a quarterly basis to the QAPI and Board of Managers (BOM). To assist with reporting and tracking, future reporting of contracted services quality monitoring will be included within the documentation maintained for QAPI and BOM meetings effective with meetings occurring from June 1, 2012 and going forward. Responsible party: The Board of Managers and SSSC Clinical Director are responsible for ensuring correction and ongoing compliance.</p>				

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S1170	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review, the facility failed to document defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator.</p> <p>Findings:</p> <p>1. Review of facility policy Chapter: 10-Surgical Services/POS, Sub-Chapter Surgical/OR Room, Policy Number: OR 10.18, entitled CODE CART CHECKING, indicated each Code Cart shall be checked using the attached Code Cart Check List, a two sided form, with</p>	S1170	OR educator revised current "Code Cart Checking" policy on 3-30-12 to comply with Zoll instructions for periodic checks. SSSC will collaborate with IU Health code cart committee to assure that our policy aligns with system "Code Cart Checking" policy. · Validate that all criteria from manufacturer's instructions are included in revised "Code Cart Checking" policy · Copies of revised policy provided to SSSC staff via e-mail, hard copies · Inservices provided in SSSC staff meetings by 5-04-12 Managers will review code cart checklists to assure	05/04/2012			

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	<p>instructions on the reverse side.</p> <p>2. Review of the reverse side of a document entitled CODE CART CHECK LIST, wit a heading of instructions for Using the Code Cart Check List Form, indicated check the defibrillator by performing the User Test (or follow the manufacturer's recommendation).</p> <p>3. Review of the manufacturer's manual for the facility's defibrillator indicated recommended checks and procedures to be performed weekly using the Operator's Checklist for R Series Product. Review of the Checklist indicated the checks included, but were not limited to:</p> <p>Inspect cables for cracks, broken wires, connector</p> <ul style="list-style-type: none"> A. ECG electrode cable, connector B. Defibrillator paddle cables C. OneStep cable, connector D. Other patient cables <p>Batteries</p> <ul style="list-style-type: none"> A. Fully charged battery in unit B. Fully charged spare battery available <p>4. Review of a document entitled CODE CART CHECKLIST indicated it did not include the above checks per the recommended checklist provided by the manufacturer.</p>		ongoing compliance. Responsible Party: Clinical Director				

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	<p>5. On 3-28-12 at 12:40 pm, employee #A1 was requested to provide documentation of the manufacturer's recommended checks, which included the above-stated activities and none was provided.</p> <p>6. On 3-28-12 at 12:40 pm, upon interview, employee #A2 indicated there were no documentation of checks to inspect cables for cracks, broken wires, connector and checks for a fully charged battery in the unit and a fully charged spare battery available. No further documentation was provided prior to exit.</p>			