

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001026		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/19/2012	
NAME OF PROVIDER OR SUPPLIER SURGERY ONE				STREET ADDRESS, CITY, STATE, ZIP CODE 11420 PARKVIEW CIR FORT WAYNE, IN 46845			
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005407</p> <p>Survey Date: 1/17/2012 thru 1/19/2012</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 02/02/12</p>			S0000			

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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S0116	<p>410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</p> <p>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on staff interview and document review, the facility failed to ensure the Medical Staff/Governing Board bylaws define the credentialing criteria for allied health professionals.</p> <p>Findings included:</p> <p>1. At 3:00 PM on 1/17/2012, staff member #1 indicated the facility has approximately 30 allied health professionals. The staff member indicated the CRNAs do not write scripts and PAs and NPs can write scripts.</p> <p>2. The 2012 Allied Health Professional</p>	S0116	<p>SurgeryONE restates its bylaws every 3 years. On 2-14-12, ASC Director met with attorney for ASC to implement the addition of Allied Health providers and their credentialing criteria to the bylaws. The Credentials policy was updated on 1-30-12 to reflect criteria for every category of allied health professional on staff at the ASC. The credentials files were reviewed to ensure compliance with this criteria and found to be complete on 1-30-12. Job descriptions for allied health professionals were reviewed, cross referenced and updated to reflect current criteria on 1-30-12. The Governing Body met on 2-12-12 and approved the</p>	02/15/2012			

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	<p>roster included 18 Physician Assistants, 9 Certified Registered Nurse Anesthetists and 2 Nurse Practitioners. 2 CRNAs, 2 Physician Assistants, and 1 Nurse Practitioner credentialing files were reviewed. The CRNA credentialed files did not evidence a CSR and/or DEA; however, the PAs and the NP had a copy of their CSR and DEA on file. One medical record identified PA wrote a script for a patient.</p> <p>3. The Medical Staff/Governing Board bylaws were reviewed and it does not defined the credentialing criteria for Allied Health Professionals. The policies/procedures and/or bylaws do not identify if CRNAs, PAs and/or NPs have scriptive authority or what the criteria of credentialing the allied health professionals are.</p>		<p>updated bylaws, credentials policy and job descriptions.Prevention- The Governing Body delegated ongoing responsibility for credentialing criteria and maintenance of documentation to the Credentials Committee of the ASC.Responsible Party- Governing Body</p>	

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S0146	<p>410 IAC 15-2.4-1 (c) (3)</p> <p>(c) The governing body shall do the following:</p> <p>(3) Require the chief executive officer or a designee to attend meetings of the governing body and its committees and act as its representative at medical staff meetings.</p> <p>Based on document review, the facility failed to ensure the Chief Executive Officer (CEO) attends staff meetings quarterly.</p> <p>Findings included:</p> <p>1. The CEO job description for SurgeryONE states, "Conduct quarterly monthly staff meetings with the administrative assistants and department chiefs as indicated to insure coordination and communication."</p> <p>2. Staff meeting minutes indicated Employee Sign-in Sheets with employees name typed in and the employee must sign their name to confirm attendance of the staff meetings. The sign-in sheet lacked an area for the CEO to sign. The minutes confirmed the CEO had not been attending regular staff meetings in 2011.</p>	S0146	<p>On 1-20-12, the Staff Sign In sheets for staff meetings were updated with the addition of the CEO. Under the direction of the Governing Body, the CEO's job description was updated on 2-7-12 to reflect his duty is to ensure that quarterly staff meetings are conducted. The CEO delegates this duty to teh ASC Director. The CEO did attend 1 of 4 meetings in 2011. He is always has input into the agenda at each meeting and he is always provided with the minutes from these meetings. The CEO does attend and conduct quarterly meetings of the Credentials, Infection Control, Medical Records, Quality Improvement and Risk Management Committees. In addition, the CEO attends and conducts quarterly meetings of the Governing Body. Prevention- The CEO and the ASC Director will work in conjunction with each other to ensure continued communication throughout the ASC. Responsible Party- CEO, ASC Director, Governing Body</p>	02/15/2012	

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S0616	<p>410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on review of the medical staff rules and regulations, medical record review, and interview, the facility failed to ensure author identification for nurses noting orders on 15 of 15 patient records reviewed (#P1-15).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Medical Staff Rules and Regulations, effective October 1, 2010, indicated on page 6, "...3.19. All patient records must document and contain, at a minimum, the following: ...(k) Signatures of physicians and health care workers who treated or cared for the patient." Review of patient records, #P1- 15, indicated initials only on the Physician's Standing Orders to indicate which of the orders were implemented. The Physician's Standing Orders sheets were 	S0616	<p>Procedures for transcribing physician orders were incorporated into current policy on Physician Orders on 1-25-12. The Physician Orders sheets were updated on 1-25-12 to provide an area for full signatures for nurses who are implementing the orders. The Governing Body approved the updated policy and changes to the Order sheet on 2-15-12. Nursing staff were educated on the proper procedure for transcribing physician orders and documenting their signatures at the staff meeting on 2-16-12. Prevention- The Medical Records clerk will audit charts for 30 days and present findings to the Director. Individual staff members will be re-educated if needed. If non-compliance continues, the Director will take disciplinary action per SurgeryONE policy. Responsible Party- ASC Director, Governing</p>	02/16/2012	

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	<p>signed by the physicians, but not by the nursing staff implementing the orders. There was no way to identify the authors of the initials.</p> <p>3. At 11:20 AM on 01/19/12, staff member #N2 indicated the facility had no specific policy regarding notation of orders from the Physician's Standing Orders sheets, but confirmed the lack of full signatures for the nurses implementing the specific orders to ensure author identification of the initials.</p>		Body		

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S0640	<p>410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure all medical record entries were legible and corrected according to policy in 7 of 15 records reviewed (#P1, P2, P6, P9, P10, P13, and P15).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy titled "Medical Records General Rules", last revised 11/2011, indicated, "...3. All entries in the chart shall be legible, factual, and in chronological order." The facility policy titled "Error Corrections", last reviewed 7/2010, indicated, "...Errors should be corrected in the following manner: 1. Draw a single line through the mistake; 2. Write "mistake in entry" above the mistake. This may be abbreviated "M.I.E."; 3. Record date and time of entry; 4. Sign or initial by the person correcting the mistake; 5. Enter the correction." The medical record for patient #P1, who had a procedure on 03/03/11, had entries written over/scribbled out on the 	S0640	<p>The policy and procedure for Error Corrections was updated on 1-20-12. The new policy states that errors will be corrected by 1. Draw a single line through the mistake. 2. Initial of person making error and correction. 3. Enter the correction. 4. Signature of documenter appears at bottom of form being corrected. The Director and Administrative Supervisor met with every healthcare provider individually to educate staff on the change in the policy. Examples of correct and incorrect error corrections were given. This policy was further reviewed at the staff meeting on 2-16-12. The Governing Body approved the updated policy on Error Corrections on 2-15-12. Prevention- The Medical Records Clerk will audit charts for 30 days and present the findings to the ASC Director. Individual staff members will be re-educated if needed. If noncompliance continues, the Director will take disciplinary action per SurgeryONE policy. Responsible Party- ASC Director, Governing Body</p>	02/16/2012	

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	<p>Physician's Standing Orders sheet, the Recovery Room Record, the Post Anesthesia Recovery Room Nurse Record, and the OCU Fluid Administration and Output Flowsheet.</p> <p>4. The medical record for patient #P2, who had a procedure on 04/19/11, had an entry scribbled out on the Post Anesthesia Recovery Room Nurse Record.</p> <p>5. The medical record for patient #P6, who had a procedure on 09/29/11, had entries written over/changed on the Physician's Standing Orders sheet and in the nursing narrative charting on the Progress Notes sheet.</p> <p>6. The medical record for patient #P9, who had a procedure on 10/13/11, had entries written over/changed on the Consent to Treatment form and on the Anesthesia Record.</p> <p>7. The medical record for patient #P10, who had a procedure on 11/02/11, had an entry scribbled out on the Special Procedures Flow Sheet.</p> <p>8. The medical record for patient #P13, who had a procedure on 09/09/11, had entries written over/changed on the Preoperative Nursing Record.</p>			

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	<p>9. The medical record for patient #P15, who had a procedure on 07/22/11, had entries written over/changed on the History and Physical Record and on the Post-Op Discharge Instructions sheet.</p> <p>10. At 1:15 PM on 01/19/12, the medical record findings were confirmed by staff member #N2.</p>				

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S0658	<p>410 IAC 15-2.5-3(f)(6)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(6) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure the surgical consent form was signed according to policy for 2 of 2 pediatric records reviewed (#P8 and P13).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy titled "Informed Consent", last revised 5/2011, indicated on page 2, "...7. Anyone under the age of 18 and who is not an emancipated minor must have the consent form signed by his or her parents or legal guardian." The medical record for patient #P8, an 8 year old, indicated a consent form for a procedure on 12/11/11. There was an illegible signature on the line "Signature of Patient", but no line or designation of relationship if this was not the actual patient. 	S0658	<p>The consent forms for SurgeryONE are generated in the SurgeryONE computer. On 1-20-12, the IT Dept of SurgeryONE changed the consent template to include a line to designate the relationship to the patient of the person signing the consent. Nursing staff who assist in the completion of the consent form were educated on this form at staff meetings on 2-8-12 and 2-9-12. The Governing Body approved the change to the consent form on 2-15-12. Prevention- The Medical Records Clerk will audit consent forms for all patients under the age of 18 who are not an emancipated minor for appropriate signature and designation of their relationship to the patient. Results will be presented to the ASC Director who will follow up as appropriate with re-education. If non-compliance occurs, the Director will take disciplinary action per SurgeryONE</p>	02/15/2012	

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	<p>3. The medical record for patient #P13, a 17 year old, indicated a consent form for a procedure on 09/09/11. There was a signature of someone other than the patient on the line "Signature of Patient", but no line or designation of relationship if this was not the actual patient.</p> <p>4. At 1:00 PM on 01/19/12, staff member #N2 indicated that it could not be confirmed who signed the consents since the signatures were on the line designated for the patient to sign and the form did not contain any other space to sign and designate relationship to the patient.</p>		policy.Responsible Party- ASC Director, Governing Body		

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S0676	<p>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 staff interview, the facility failed to provide a waiver for storing medical records offsite.</p> <p>Findings included:</p> <p>1. At 10:30 AM on 1/19/2012, staff member #5 indicated the facility had not requested a waiver for storing records offsite.</p>	S0676	<p>ASC Director met with CEO on 1-20-12 to discuss the need for a waiver to store medical records at an off site location. CEO approved the proposed letter on behalf of the Governing Body at this meeting. On 1-23-12, the ASC Director sent a letter requesting a waiver to store SurgeryONE medical records at an off-site facility to Ann Hamil, Program Director for Hospitals and ASCs at the Indiana State Department of Health.</p> <p>SurgeryONE was previously located at 5052 N. Clinton Street, Fort Wayne, IN until June 2010, when the ASC moved to its current location at 11420 Parkview Circle, Fort Wayne, IN. The medical records of the ASC from the opening of the facility in January 1991 through September 2009 are housed in the basement of teh former ASC on Clinton Street, which is locked for security, is well lit and is accessible only to authorized personnel. The facility also meets the requirement of being a fire resistive structure in that it is</p>	01/23/2012	

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			temperature controlled with sprinkler heads. The decision was made to leave these medical records at the Clinton Street location, which currently serves as a business office for Orthopaedics NorthEast, due to the high cost and risk of moving such a large amount of protected health information. In October 2009, SurgeryONE began scanning completed medical records into our computer system and sending the paper copies to Iron Mountain at 400 E. Washington Street, Fort Wayne, IN. SurgeryONE maintains a written contract with Iron Mountain for their services adn regularly assesses Iron Mountain's security and fire safety.Prevention- ASC Director and CEO will monitor safety and security of off site medical records.Responsible Party- ASC Director, CEO, Governing Body		

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S0782	<p>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 8 of 15 patient charts reviewed (#P1, P2, P5, P7, P8, P10, P13, and P15).</p> <p>Findings included:</p> <p>1. The facility policy titled "Verbal Orders", last revised 8/2010, indicated, "...5. The receiver will record the order in the medical record, sign and date the order, and identify it as a V.O. (verbal order) or a T.O. (telephone order). 6. The person giving the order will countersign the order within twenty-four (24) hours."</p> <p>2. A post-operative Physician's Standing Orders sheet for a procedure performed on 03/03/11 on patient #P1, indicated handwritten orders for 2 pain medications, but failed to indicate a date, signature, or identification of V.O. or T.O.</p>	S0782	<p>Physician orders were revised and updated on 1-25-12 to provide a designated area for telephone and/or verbal orders. These same orders were updated to provide an area for full signatures for nurses and physicians. The nursing staff were educated on these changes at staff meetings on 2-8-12 and 2-26-12. The Governing Body approved the updated forms on 2-15-12. Prevention- The Medical Records clerk will audit charts for 30 days and present findings to the ASC Director. Individual staff members will be re-educated if needed. If non-compliance continues, the Director will take disciplinary action per SurgeryONE policy. Responsible Party- ASC Director, Governing Body</p>	02/16/2012

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	<p>3. A post-operative Physician's Standing Orders sheet for a procedure performed on 04/19/11 on patient #P2, indicated a handwritten order for "incentive spirometer as directed by [anesthesiologist]", but failed to indicate a signature or identification of V.O. or T.O. The entire order sheet was signed by the surgeon only.</p> <p>4. A hand-written order for a pain medication was on the line for physician signatures on the Anesthesiologist's Standing Order sheet for patient #P5. No date, signature, or notation of V.O. or T.O. was identified on the sheet.</p> <p>5. A post-operative Physician's Standing Orders sheet for a procedure performed on 10/04/11 on patient #P7, indicated a handwritten order to "hold Amoxicillin/hold Vicodin", but failed to indicate a signature or identification of V.O. or T.O.</p> <p>6. A post-operative Physician's Standing Orders sheet for a procedure performed on 12/21/11 on patient #P8, indicated a handwritten order for "Tylenol w/ Codeine Elixir 1- 2 tsp. q. 4-6 hrs. prn pain", but failed to indicate a signature or identification of V.O. or T.O.</p> <p>7. A post-operative Physician's Standing</p>			

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	<p>Orders sheet for a procedure performed on 11/02/11 on patient #P10, indicated a handwritten order for "Ultram 50 mg., take 1 q. 4-6 hrs. prn pain", but failed to indicate a signature or identification of V.O. or T.O.</p> <p>8. A post-operative Physician's Standing Orders sheet for a procedure performed on 09/09/11 on patient #P13, indicated a handwritten order for "Cleocin 600 mg. 1 q. 6 h. #4", but failed to indicate a signature or identification of V.O. or T.O.</p> <p>9. A post-operative Physician's Standing Orders sheet for a procedure performed on 07/22/11 on patient #P15, indicated a handwritten order for "Soma 350 mg. 1 p.o. q. 8 h. x 10 days", but failed to indicate a signature or identification of V.O. or T.O. A hand-written order for "Norco 5/325 2 p.o. pain and Flexeril 10 mg. 1 p.o. prn muscle spasms" was on the lines for physician signatures on the Anesthesiologist's Standing Order sheet. No date, signature, or notation of V.O. or T.O. was identified on the sheet.</p> <p>10. At 11:30 AM on 01/19/12, staff member #N2 confirmed the items written in as orders without the appropriate signatures or notation of verbal or telephone orders.</p>			

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S0888	<p>410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on medical staff rules and regulations review, medical record review, and interview, the facility failed to ensure the operative report/discharge summary was signed within 30 days in 5 of 15 (#P6, P7, P11, P13, and P15) surgical records reviewed.</p> <p>Findings included:</p> <p>1. Review of the facility's Medical Staff Rules and Regulations, effective October 1, 2010, indicated on page 3, "...3.05. Operative reports shall include a detailed account of the findings of surgery as well as detail of the surgical technique. Operative reports shall be written (or dictated) by midnight of the same day and</p>	S0888	<p>Review of charts where the operative report was not signed within 30 days of the procedure found 2 separate problems. The operative report is transcribed and sent to the physician's desk top computer to be reviewed and electronically signed. Individual physicians were counseled about their noncompliance and the rule was reinforced and education provided by the Medical Director and the ASC Director. The Governing Body reinforced this policy at the All Physicians Meeting held on 2-15-12. In addition, our review discovered that our transcription service was not documenting addendums to the operative report appropriately. Procedures were reviewed and a new polciy was</p>	02/16/2012			

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	<p>the report signed or authenticated (as applicable) by the surgeon within 30 days of the date of surgery and made a part of the patient's medical report."</p> <p>2. The operative report/discharge summary for patient #P6, who had a procedure on 09/29/11, was dictated on 09/29/11, but not electronically signed by the physician until 11/15/11.</p> <p>3. The operative report/discharge summary for patient #P7, who had a procedure on 10/04/11, was dictated on 10/04/11, but not electronically signed by the physician until 11/16/11.</p> <p>4. The operative report/discharge summary for patient #P11, who had a procedure on 08/25/11, was dictated on 08/25/11, but not electronically signed by the physician until 09/30/11.</p> <p>5. The operative report/discharge summary for patient #P13, who had a procedure on 09/09/11, was dictated on 09/09/11, but not electronically signed by the physician until 10/13/11.</p> <p>6. The operative report/discharge summary for patient #P15, who had a procedure on 07/22/11, was dictated on 07/22/11, but not electronically signed by the physician until 11/14/11.</p>		<p>written on 2-7-12. The Medical Records and Transcription Staff were educated on 2-8-12 on the new policy. The new procedure ensures more accurate documentation on the dates and times when an addendum is dictated, typed and electronically signed. The old procedure did not document that date when the addendum was dictated but did document the date when the physician electronically signed the document, making it look like the physician was non-compliant. This outdated procedure accounted for at least 2 of the errors.Prevention- The Medical Records Clerk will audit charts on an ongoing basis. A report will be run through the Transcription system that shows documents waiting to be electronically signed by a physician and those physicians will be sent a reminder that they have pending documents. Providers found in violation of the policy shall be identified and reported to the ASC Director. The Director will meet with the noncompliant physician and reinforce the rule. Continued non-compliance will be reported to the Medical Director who will meet with the physician. Further non-compliance will be reported to the Governing Body for corrective action.Responsible party- ASC Director, Medical Director, Governing Body</p>				

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	7. At 1:00 PM on 01/19/12, staff member #N2 confirmed the medical record findings and indicated the last record probably had an addendum that was added and signed later, but that could not be determined by the document in the medical record.				

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S1146	<p>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 document review, observation and staff interview, the facility failed to provide current Material Safety Data Sheet (MSDS) for chemicals in which the employee will use in case of accident with the chemical(s).</p> <p>Findings included:</p> <p>1. Facilities and Environment policy and procedure states, "To provide a functionally safe and sanitary environment for SurgeryONE patients, personnel, and visitors. Ortho North East, PC dba SurgeryONE facility shall: Comply with state and local building codes and regulations, and Comply with applicable federal regulations."</p> <p>2. OSHA reference 1910.1200(g)(8) states, "The employer shall maintain in the workplace copies of the required material safety data sheets for each</p>	S1146	<p>A list of all chemicals at SurgeryONE was reviewed. This list was cross referenced with the MSDS book and missing MSDS sheets were obtained for all chemicals. It should be noted that Clorox was the only chemical for which an MSDS sheet was missing and it was obtained while the surveyor was still on site. The MSDS book is reviewed annually by the Governing Body.Prevention- The Safety Officer will obtain a MSDS sheet whenever a new chemical is added to the facility's list.Responsible- Safety Officer, ASC Director, Governing Body</p>	01/20/2012	

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	<p>hazardous chemical, and shall ensure that they are readily accessible during each work shift to employees when they are in their work area(s)."</p> <p>3. At 1:00 PM on 1/18/2012, the Environmental Service Room was toured. The storage room contained 9-1.46 gallons of Clorox Bleach.</p> <p>4. At 1:30 PM on 1/18/2012, staff member #1 indicated the facility's Material Safety Manual does not have a copy of a MSDS sheet for the Clorox Bleach that was observed in the Environmental Service Room.</p>			
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S1182	<p>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 document review and staff interview, the facility failed to ensure there was a process to evaluate and collect information about hazards and safety practices for the Safety Committee.</p> <p>Findings included:</p> <p>1. The Facilities Environment Policy states, "SurgeryONE shall have the necessary personnel, equipment, and procedures in place of the facility to evaluate an to handle medical and other emergencies that may arise in connection with services sought or provided, included but not limited to documented periodic instructions of all personnel in the proper use of safety, emergency and fire-extinguishing equipment."</p> <p>2. At 2:45 PM on 1/17/2012, staff member #6 indicated the staff member was the Safety Manager. The Safety Manager indicated the facility does not conduct safety walks to evaluate safety hazards throughout the facility. The staff</p>	S1182	The Safety Officer for SurgeryONE has always performed a variety of safety checks throughout the facility. On 2-16-12, the Governing Body approved a new policy titled Facility Safety Walks presented by the Safety Officer. This policy requires a formal and documented Safety Walk twich every month of the SurgeryONE premises. All areas internally and externally are reviewed and include, but are not limited to, trips, slips, and fall hazards, blocked exits. fire extinguishers, fire hazards, lights, floors, ceilings, sidewalks, driveways, etc. Proper steps for repair will be initiated.Prevention- Any issues identified on the Facility Safety Walk will be brought to the attention of the Safety Officer, ASC Director and the Governing Body as appropriate so proper steps for repair can be initiated and the safety of patients and staff members can be insured.Responsible Party- Safety Officer, ASC Director, Governing Body	02/16/2012			

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	member indicated he/she does not know how to set up a safety inspection walk through of the facility. The staff member confirmed a safety walk through would be the proper evaluation of safety practices in the facility.			
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S1300	<p>410 IAC 15-2.6-1(a)</p> <p>(a) If nourishments and other dietary needs of the patients are provided in the center, the center shall comply with 410 IAC 7-24.</p> <p>Based on observation and staff interview, the facility failed to ensure staff were trained on proper sanitation practices as required by 410 IAC 7-24, Retail Food Establishment Sanitation Requirements.</p> <p>Findings included:</p> <p>1. Retail Food Establishment Sanitation Requirements, 410 IAC 7-24-118 states, "Employees are visibly observing foods as they are received to determine that they are: from approved sources; delivered at the required temperatures; protected from contamination; unadulterated; and accurately presented; by routinely monitoring the employees' observations and periodically evaluating foods upon their receipt. Employees are properly cooking potentially hazardous food, being particularly careful in cooking those foods known to cause severe foodborne illness and death, such as eggs and comminuted meats, through daily oversight of the employees' routine monitoring of the cooking temperatures using appropriate temperature measuring devices properly scaled and calibrated." Microwave Cooking, 410 IAC 7-24-183 states, "Raw</p>	S1300	<p>On 2-16-12, the Governing Body reviewed policies on patient nourishment at the ASC. SurgeryONE will continue to stock food items such as crackers, nutrition bars, granola bars, jellos, yogurts and puddings and other foods that are individually packaged as a single serving. SurgeryONE will only stock food items that have been fully cooked and simply require heating, such as individually packaged, single serving soups. As in the past, SurgeryONE will continue to allow family members to bring food from outside of the facility per patient request. The nursing staff was educated at the staff meeting held on 2-16-12. Prevention- All microwavable dinners have been removed from the SurgeryONE premises. The refrigerator and freezer are monitored on a daily basis for appropriate temperatures and appropriate actions are taken if the temperature falls out of range. Responsible Party- ASC Director, Governing Body</p>	02/16/2012			

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	<p>animal foods cooked in a microwave oven shall be: rotated or stirred throughout or midway during cooking to compensate for uneven distribution of heat; covered to retain surface moisture; heated to a temperature of at least one hundred sixty-five (165) degrees Fahrenheit in all parts of the food; and allowed to stand covered for two (2) minutes after cooking to obtain temperature equilibrium."</p> <p>2. Facilities and Environment policy stated, "Food snack services and refreshments provided to patients meet their clinical needs and are pre-prepared, stored, served, and disposed of in compliance with local health department requirements."</p> <p>3. SurgeryONE was toured at 1:00 PM on 1/18/2012. The patient refrigerator located in PACU was observed with assorted microwave dinners in the freezer. The dinners included fish entrees, chopped beef entrees, etc. The label on the dinner packages stated the dinner needs to be thoroughly cooked to 165 degrees F.</p> <p>4. At 1:10 PM on 1/18/2012, staff member #1 indicated the patients in PACU who are there at the facility for a 23 hour stay are provided dinner. The facility only has juices, microwave</p>			
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	dinners, etc. for their convenience. 5. At 1:15 PM on 1/18/2012, staff member #5 indicated the dinners would be heated in the microwave. The staff member indicated the facility does not have any food thermometer to test the food temperatures and the facility does not have any policy or procedure for cooking food for the patients. The staff member confirmed he/she did not know that the microwave dinners required to be cooked to 165 degrees Fahrenheit internally.			
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