

| | | | | | | | |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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: 005914</p> <p>Survey Date: 04/24/12 through 04/26/12</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: cloughlin 05/09/12</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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
|---|---|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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 | | | |
| S0176 | <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on documentation review, the facility failed to ensure 8 of 11 Registered Nurses had annual IV Administration competency (#P1, P2, P3, P4, P5, P8, P9, and P11).</p> <p>Findings included:</p> <p>1. Employee Education policy #TM-04 states, "Employees are responsible for ensuring completion of all required annual in-services in a timely manner. Employees are responsible for demonstrating competency skills in the performance of their position at the Center."</p> <p>2. Administration of Moderate Sedation policy #AN-14 states, "The registered nurse is responsible for completion of the moderate sedation administration competency."</p> | S0176 | <p>Conscious sedation annual inservice test is currently being revised. All nursing personnel have completed current test to meet annual requirement. Revised test will be implemented for 2012 inservice year. Responsible Person: Education Coordinator (in coordination with Director)</p> | 05/15/2012 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/26/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 |
|---|--|

| (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>3. Staff Member's P1 personnel file identified the most recent Modern Sedation competency was 10/12/10.</p> <p>4. Staff Member's P2 personnel file identified the most recent Modern Sedation competency was 10/21/10.</p> <p>5. Staff Member's P3 personnel file identified the most recent Modern Sedation competency was 10/01/10.</p> <p>6. Staff Member's P4 personnel file identified the most recent Modern Sedation competency was 10/15/10.</p> <p>7. Staff Member's P5 personnel file identified the most recent Modern Sedation competency was 09/22/10.</p> <p>8. Staff Member's P8 personnel file identified the most recent Modern Sedation competency was 09/21/10.</p> <p>9. Staff Member's P9 personnel file identified the most recent Modern Sedation competency was 10/11/10.</p> <p>10. Staff Member's P11 personnel file identified the most recent Modern Sedation competency was 11/03//10.</p> | | | |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | <input checked="" type="checkbox"/> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | <input checked="" type="checkbox"/> (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | <input checked="" type="checkbox"/> (X3) DATE SURVEY COMPLETED 04/26/2012 |
|--|--|---|--|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 |
|---|--|

| (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: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
|---|---|---|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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 | | | |
| 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 staff interview, the facility failed to ensure one (1) service provided by a contractor was included in its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. The Columbus Surgery Center Quality Assessment Process Improvement Plan (QAPI) notes that all services are to be evaluated as part of its approach to a Continuous Quality Improvement.</p> <p>2. Staff member #1 provided the list of Columbus Surgery Center contracted services. #CC was not on the list. The contracted service provides selected building repairs and preventive maintenance.</p> <p>3. At 10:30 AM on 4/25/2012, staff member #1 confirmed #CC was not on</p> | S0310 | <p>Contracted service provider (referenced as #CC) was added to contract services log on 4/26/2012. Updated contracted services log will be reviewed at the next QOC meeting for 2nd quarter 2012. Contracted Service, #CC, will be reviewed and discussed with committee. Responsible Person: Director of Operations consistently monitors contracted services, as well as ensures all contracted services are routinely updated and reviewed with QOC committee.</p> | 04/26/2012 | | | |

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/26/2012 |
|---|--|--|--|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------------|--|---------------------|--|----------------------------|
| | the Contract Log and was not being evaluated by the QOC. | | | |

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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 | | | |
| S0400 | <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and policy review, the facility failed to ensure a surgical experience that minimized infection exposure in 1 of 1 case observations.</p> <p>Findings included:</p> <p>1. During the surgical case observation, beginning at 1:10 PM on 04/25/12 in Operating Suite C, the following observations were made:</p> <p>A. The surgeon, staff member #A6, in scrubs and surgical mask, but not gloves or gown, was sitting in the room while the anesthesiologist was preparing the patient. Staff member #A6 texted on a cell phone, placed the phone in the pocket of the scrub top, got it back out and texted again, then placed the phone on a counter in the room.</p> <p>B. Without performing any hand hygiene, staff member #A6 unfolded a plastic drape, dropped it on the floor, then picked it back up and fastened it underneath and around the patient's left arm.</p> <p>C. Again without performing any hand</p> | S0400 | <p>Staff member #A6 is a medical staff member, not a Center employee. Director reviewed report with medical director via telephone and the recommendation was to present Plan of Correction Report to QOC committee members for discussion/recommendation for next steps in plan of action with regard to medical staff member. QOC members reviewed plan of correction and agreed observation of aseptic practices, per protocol, of all Center personnel and medical staff members will be observed. The recommendation was to perform random, weekly observation of aspectic practices for the next three (3) months. Infection control coordinator will report findings to QOC committee at the next quarterly meeting. If there are trends noted, a QA study will be implemented. Responsible Person: Infection Control Coordinator and/or OR Charge Personnel, in collaboration with Director of Operations.</p> | 05/04/2012 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/26/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 |
|---|--|

| (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>hygiene, staff member #A6 swiped a Betadine swab across the patient's left shoulder, pressed his/her thumb into the same area, then injected medication into the shoulder (the surgical site).</p> <p>2. The facility policy "Hand Washing Guidelines", last revised 05/2011, indicated under Policy, "Hand hygiene shall be practiced before and after each patient contact (even if gloves are worn)."</p> | | | |

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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 | | | |
| 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, documentation review, and staff interview, the facility failed to ensure "Method Brand - Purple All-purpose cleaner" was a EPA-registered hospital disinfectant which was used in the surgery suites.</p> <p>Findings included:</p> <p>1. Infection Control Program #QI-10 states, "Procedure for the use of disinfectants, antiseptics and germicides in accordance with the manufacture's instructions and EPA or FDA label specifications."</p> <p>2. On 4/25/2012 at 11:30 AM, the owner of the contracted housekeeping company (#4) indicated #11 told him/her to use "Method Brand - Purple All-purpose cleaner" on cords (EKG cords, B/P cuff</p> | S0432 | <p>Professional Office Care, LLC, cleaning service company for Columbus Surgery Center, was notified immediately that the Method brand All Purpose cleaner being utilized was not a disinfectant and discontinued use immediately within the Center. As we research for an alternative cleaning solution that does not break down cords on machines, Center is utilizing Dispatch cleaning product, which is a solution we currently have in our inventory and is labeled as an EPA registered hospital disinfectant to meet criteria. A MSDS sheet is filed in our MSDS reference book. Responsible Person: Infection Control Coordinator, in collaboration with Director of Operations.</p> | 04/27/2012 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
|---|---|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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>cords, oxygen saturation cords) in pre-op because other cleaners broke down the cords. Staff member #4 indicated he/she used to have to order this product, but now he/she can buy it at Target and it is a "green product".</p> <p>3. The "Method Brand - Purple All-purpose cleaner" manufacturer label on the product did not indicate it was a disinfectant, EPA registered, on effective against any organisms.</p> <p>4. On 4/26/2012 at 10:00 AM, #11 confirmed that he/she told housekeeping staff to use the all-purpose cleaner. The staff member indicated he/she didn't think about it not being a disinfectant.</p> | | | | | | |

| | | | | | | | |
|---|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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 | | | |
| S0616 | <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 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 policy review, medical record review, and interview, the facility failed to ensure all pre and post anesthesia evaluations were authenticated to determine adherence to policy for 22 of 22 patients who received a general anesthetic (#N2, N3, N5, N6, N7, N8, N9, N10, N11, N12, N13, N14, N15, N16, N17, N19, N20, N21, N22, N23, N24, and N26).</p> <p>Findings included:</p> <p>1. The facility policy "Anesthesia Care Documentation", last reviewed 5/2011, indicated, "...A. Pre-operatively, an anesthesia assessment and patient interview will be conducted and documented. ...C. The anesthesiologist</p> | S0616 | Center's Anesthesia Record was revised to include the addition of "Signature and Time" in the Pre-Anesthesia Evaluation section on page 2 of this form. Revisions also included the addition of "Time____" in the Post-Anesthesia Note section for anesthesiologist to complete on reporting to PACU nursing personnel with patient. Revised form to be attached to Plan of Correction report. A QA study was implemented upon revision of Anesthesia Record for at least one quarter, to ensure compliance with completion of medical records, per policy. Responsible Party: Medical Record Review personnel, internal and external, in collaboration with Director of Operations. | 05/01/2012 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
|---|---|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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>will be responsible for post-anesthesia assessments and orders and the documentation of the same."</p> <p>2. The facility policy "Identification of Health Care Providers and Authentication of Medical Record Entries", last reviewed 5/2011, indicated, "...An entry into the medical record is defined as legible documentation by a health care provider who records the patient's history, assessments, progress, prescribed care and treatment. These entries are authenticated and dated by the health care provider's signature on file."</p> <p>3. The facility policy "Preparation and Documentation of Medical Record", last reviewed 5/2011, indicated, "...D. All entries into the medical record must be completed on the appropriate forms that identify the date, department, care rendered, treatment given, patient response, tests ordered, references and/or referrals if necessary, disposition, recommendations and instructions given. E. All entries into the medical record must be in black ink, legible, signed and dated by the appropriate, authorized provider of services."</p> <p>4. The medical records for patients #N2, N3, N5, N6, N7, N8, N9, N10, N11, N12, N13, N14, N15, N16, N17, N19, N20,</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/26/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 |
|---|--|

| (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>N21, N22, N23, N24, and N26 each indicated a form titled "Anesthesia Notes". The top portion of the form was designated "Pre-Anesthesia Evaluation" and the bottom portion was designated "Post-Anesthesia Note". The top portion "Pre-Anesthesia Evaluation" was completed for all of the records, but lacked a time, date, and authentication for the entry. The bottom portions of the forms were completed and the very bottoms of the sheets were dated and signed by the anesthesiologist.</p> <p>The bottom portion of the form for patient #N11 was dated 12/13/11, but the procedure was performed on 12/14/11. The bottom portions of the medical records for patients #N12, N14, N15, N17, N19, N20, N22, N23, and N24 had the time documented as when the patient arrived in the Post Anesthesia Care Unit (PACU). The "Post-Anesthesia Note" was marked "Satisfactory, No Complications" for patient #N26, a 21 month old who had difficulty maintaining an adequate oxygen level in the PACU and was transferred to the hospital.</p> <p>5. At 11:00 AM on 04/25/12, staff member #A3, who reviewed the electronic medical records confirmed the lack of timing, dating, and authenticating each of the separate pre and post</p> | | | |

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/26/2012 |
|---|--|--|--|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 |
|---|--|

| (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 |
|--------------------------|--|---------------------|--|----------------------------|
| | anesthesia evaluations. | | | |

| | | | | | |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 |
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | |
| (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 | |
| S0772 | <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on policy review, medical record review, and interview, the facility failed to follow their policy regarding the criteria for patient history and physicals for 4 of 26 records reviewed (#N11, N12, N16, and N21).</p> | S0772 | <p>Upon review of history & physical documents in patient files, surveyor was reviewing files from September 2011. A trend was noted with one practice. This practice implemented an EMR system 3rd quarter of 2011. Upon further review at this time, the date being inserted by</p> | 04/26/2012 | |

| | | | | | | | |
|---|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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>Findings included:</p> <ol style="list-style-type: none"> 1. The facility policy "History and Physicals", last reviewed 5/2011, indicated on page 2, "...A complete history and physical examination must be recorded within thirty (30) days prior to the patient's admission to the Center. A reasonably durable, legible copy of these reports may be used in the patient's medical records. The H & P must have an updated entry or progress note completed on date of service to note any changes in patient status regardless of when the history and physical was dictated." 2. The medical record for patient #N11, who had a procedure performed on 12/14/11, indicated a history and physical with an update on 12/14/11, but without a date for the original H&P. The absence of the date made it unable to determine adherence to policy. 3. The medical record for patient #N12, who had a procedure performed on 12/14/11, indicated a history and physical with an update on 12/14/11, but without a date for the original H&P. Within the documentation of the H&P was the notation, "Tests and Procedures Performed This Visit" with a date of 24 Oct. 2011. If that was the date of the | | <p>practice was the date of surgery vs. the date the H&P was performed by physicians. The practice manager educated staff to ensure H&P's were dated appropriately to meet requirements. The surveyor was shown an H&P from April 2012, noting the date on the form reflected the day the H&P was performed vs. scheduled surgery date. We are attaching an example of the current H&P format utilized by said practice, to date, with appropriate date(s). A QA study will be initiated to track trends to ensure continued process improvement. Responsible Person: Medical Record Review personnel, internal and external, in collaboration with Director of Operations.</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
|---|---|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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>H&P, it was greater than 30 days prior to the procedure.</p> <p>4. The medical record for patient #N16, who had a procedure performed on 01/05/12, indicated a history and physical with an update on 01/05/12, but without a date for the original H&P. Within the documentation of the H&P was the notation, "Tests and Procedures Performed This Visit" with a date of 30 Nov. 2011. If that was the date of the H&P, it was greater than 30 days prior to the procedure.</p> <p>5. The medical record for patient #N21, who had a procedure performed on 02/13/12, indicated a history and physical with an update on 02/13/12, but without a date for the original H&P. The absence of the date made it unable to determine adherence to policy.</p> <p>6. At 11:00 AM on 04/25/12, staff member #A3, who was reviewing the electronic medical records, confirmed the absence of dates on the H&Ps.</p> | | | | | | |

| | | | | | | | |
|---|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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 | | | |
| S1026 | <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)(i)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(i) Drug cabinets must be accessible only to authorized personnel.</p> <p>Based on observation and policy review, the facility failed to ensure prescription pads were only accessible to authorized personnel.</p> <p>Findings included:</p> <p>1. During the surgical case observation at 2:30 PM on 04/25/12, a small plastic basket containing prescription pads was observed stored in an unlocked cabinet in Operating Room (OR) C. There was a label on the cabinet door indicating the prescription pads were in that location and the cabinet did not have a lock.</p> <p>2. During the tour of the surgical area at</p> | S1026 | <p>CSC currently has a policy in force for securing narcotic keys and prescription pads in locked cabinets/drawers at all times. Director held discussions with clinical personnel, along with review of current policy, to ensure all staff are aware and complying with Center policy. Director will also review policy with staff at June 21, 2012 staff meeting. OR charge nurse personnel will be responsible for periodic inspections to ensure drawers/cabinets are secured at all times. Any noncompliance will be reported to Director immediately. Infection control coordinator will conduct monthly inspections during normal business hours to ensure</p> | 04/27/2012 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 |
|---|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | |
| (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>3:10 PM on 04/25/12, accompanied by staff member #A5, a small plastic basket containing prescription pads was observed in an unlocked cabinet in OR A. The cabinet did not have a lock. The lights were off and the room would not be used any more today. The housekeeping staff would be in later in the evening to perform the terminal cleaning.</p> <p>3. The facility policy "Narcotic Keys and Prescription Pads", last reviewed 5/2011, indicated, "Policy: Access to keys that open cabinets housing narcotics and controlled substances and prescription pads will be controlled. Staff responsible for the keys will be held accountable for their location at all times. Procedure: Narcotics, controlled substances and prescription pads shall be locked in a designated cabinet(s) and/or drawer(s). These cabinets and/or drawers shall remain locked during the course of each day, and be accessed by personnel possessing the appropriate key(s)."</p> | | <p>cabinets/drawers are secured and will report findings at quarterly QOC meeting. Responsible Person: OR charge nurse personnel/Infection Control Coordinator, in collaboration with Director of Operations.</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/26/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 |
|---|--|

| (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 |
|--------------------|---|---------------|---|----------------------|
| 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, documentation review, and staff interview, the facility failed to provide current Material Safety Data Sheet (MSDS) for "Method Brand -Purple All-purpose Cleaner" and failed to ensure patient safety by maintaining the warming cabinets according to policy.</p> <p>Findings included:</p> <p>1. Quality Improvement policy QI 06 states, "The Quality Assurance Process Improvement Plan for the Columbus Surgery Center meets the requirements of State, OSHA, Federal, and AAAHC."</p> <p>2. OSHA 1910.1200(g)(8) states, "The employer shall maintain in the workplace copies of the required material safety data sheets for each hazardous chemical, and shall ensure that they are readily</p> | S1146 | <p>Please refer to S 0432 for plan of correction for Method brand all-purpose cleaner. In reply to S1146 with regard to Amsco Warming cabinets and temperatures, director reviewed policy with staff and reiterated the importance of maintaining accurate temperatures on warmers for patient and staff safety. Staff responsible for recording daily temps were instructed to notify charge nurses (per policy) of any unit temperatures that are not within the normal range for specific unit. Charge nurse(s) are then responsible for follow up of unit for possible mechanical trouble. Infection control coordinator, during monthly OSHA checks, will implement review of warming log sheet, as well as warmers themselves, noting any temperatures out of normal range. OSHA checklists</p> | 04/27/2012 |

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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>accessible during each work shift to employees when they are in their work area(s)."</p> <p>3. At 11:30 AM on 4/25/2012, "Method Brand - Purple All-purpose Cleaner" was observed applied to EKG cords, B/P: cuff cords, and O2 saturation cords.</p> <p>4. At 10:00 AM on 4/26/2012, staff member #11 indicated the surgery center does not have a MSDS for "Method Brand - Purple All-purpose Cleaner".</p> <p>5. During the tour of the operating room (OR) area at 3:00 PM on 04/25/12, accompanied by staff member #A5, the Amsco Steris Warming cabinet in the corridor was observed with the top portion registering a temperature of 102 degrees Fahrenheit (F) and the bottom portion registering 137 degrees F.</p> <p>6. During the tour of the Post Anesthesia Care Unit (PACU) at 3:20 PM on 04/25/12, accompanied by staff member #A5, the Amsco Steris blanket warmer was observed registering a temperature of 150 degrees F.</p> <p>7. The facility policy "Blanket and Solution Warming Cabinet Temperatures", last reviewed 5/2011, indicated, "Policy: Fluids contained in semi-rigid plastic bottles utilized for patient comfort during a surgical prep and/or defogging mirrors during ENT</p> | | <p>are reviewed with Director of Operations and presented at quarterly QOC meetings for review and discussion. Director plans to review policy PC 150 with staff for education purposes at June 21, 2012 staff meeting to ensure future compliance.</p> <p>Responsible Person: Infection Control Coordinator/OR Charge personnel in collaboration with Director of Operations.</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 |
|---|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | |
| (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>cases will be dated and stored at no greater than 110 degrees Fahrenheit. All solutions greater than 30 days old will not be used and will be discarded. Blankets placed in a warming unit will not exceed 130 degrees Fahrenheit. ...The temperature of the warming units and irrigation solutions will be checked each morning and documented on the CSC morning log sheet. Any significant temperatures above or below the set standards will be reported to the nurse in charge. The nurse in charge will follow up by troubleshooting or initiating repair of the unit."</p> <p>8. The CSC Daily Log sheet for April 2012 indicated the daily temperatures for the top portion of the OR warming cabinet ranged between 101 and 105 degrees F and the bottom portion ranged between 134 and 136 degrees F. The log indicated the daily temperatures for the blanket warming cabinet in PACU ranged between 100 and 175 degrees F with 13 of the 25 days registering 150 degrees F or above. The log lacked any documentation of action taken related to the temperatures above set standards.</p> | | | | |

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 04/26/2012 | |
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 | | | |
| (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 | | | |
| S1188 | <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 document review and staff interview, the facility failed to ensure there was a written fire control plan that contains how to extinguish fires, fire drill frequency, etc.</p> <p>Findings included:</p> <p>1. 1. Quality Improvement policy QI 06 states, "The Quality Assurance Process Improvement Plan for the Columbus Surgery Center meets the requirements of State, OSHA, Federal, and AAAHC."</p> <p>2. Staff member #1 provided the Disaster Plan - Emergency Preparedness policy RM-18 on 4/24/2012 as meeting the requirement of an adequate Fire Control</p> | S1188 | <p>Fire Control Plan was presented to surveyor on day 2 of survey and was approved by surveyor. Fire Control Plan was created using individual policies the Center already has in place. Surveyor stated the Center must have a "Fire Control Plan", therefore, individual policies were referenced and information was compiled to create said Fire Control Plan. This Fire Control Plan "draft" will be reviewed by the QOC, Executive Committee and Board of Managers for final approval. We are attaching a copy of the Fire Control Plan with this report. Responsible Person: Director of Operations</p> | 04/26/2012 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/26/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>Plan. The disaster plan reference how the facility will respond in case a disaster/emergency. The policy referenced the center will participate in mock disaster drills and post drill evaluations. The policy referenced Natural disasters: Tornados; Flood; Earthquake; Fire. The policy reference Man made Disasters (Terrorism): Biological Attack; Chemical; Nuclear; and Bomb Threat. The policy did not reference fire extinguishers, fire drills frequency, etc. The Disaster Plan had only one attachment on conducting a bomb threat. Staff member #1 then provided the Risk Management Plan and it did not reference fire safety concerns at all.</p> <p>3. At 2:00 PM on 4/24/2012, staff member #1 indicated he/she will need to look for the Fire Control Plan or a policy that references fire safety. The staff member could only locate 3 fire drills for the previous 4 complete quarters; however, the facility policies do not indicate the frequency or how to conduct fire drills.</p> <p>4. At 1:15 PM on 4/25/2012, staff member #1 presented a manual named "Fire Control Plan". The plan had sections identifying frequency and how to conduct a fire drill, how to extinguish a</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/26/2012 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER COLUMBUS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 940 N MARR RD STE B COLUMBUS, IN 47201 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>fire, how to conduct a fire watch, etc. However, the manual did not have an approval date. When staff member #1 was asked did she just put the manual together, staff member #1 indicated he/she spent the previous evening putting the Fire Control Plan together to be reviewed. The staff member continued and indicated if he/she was asked for a fire control plan, his/her response would of been the facility does not have one. Therefore, the facility does not have a facility approved Fire Control Plan.</p> | | | |