

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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>The visit was for a State licensure survey.</p> <p>Facility #: 011735</p> <p>Date: 9-26/27-11</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Deborah Franco, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/31/11</p> <p>12/14/11 revised due to IDR</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: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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
S0104	<p>410 IAC 15-2.4-1(a)(2)</p> <p>The governing body shall do the following:</p> <p>(2) Adopt bylaws and function accordingly.</p> <p>Based on document review and interview, the governing board failed to follow their established and approved bylaws.</p> <p>Findings include:</p> <p>1. Review of the governing board bylaws on 9-26-11 and 9-27-11 indicates the following under number 17: The Governing Body reviews the Quality Management and Improvement Committee's quarterly reports and approves its implementation to assure quality patient care is being provided.</p> <p>2. Review of the governing board bylaws on 9-26-11 and 9-27-11 indicates the following under number 15: The Governing Body is responsible for the total overall operation of the Center, and the approval of Medical Staff appointments. The clinical privileges are reviewed, renewed, revised, or curtailed at intervals of two years as specified in the medical staff bylaws.</p> <p>4. Review of privileges for MD#1 on 9-26-11 indicates the privileges were last reviewed 1-06-09 and not within 2 years as required in the governing board</p>			S0104	<p>Clinical Co-ordinator has scheduld the Governing Board quarterly meetings as follows: Sept 29, 2011, Dec 21,2011, March 28, 2012, June 27, 2012, Sept 26,2012, Dec 26,2010QAPI activities will be updated and consistant with above meetings. Minutes will contain all actions presented to Governing Body.Practice AdministratorMedical Staff privedges have been reviewed and are in the process of being updated in a timely manner. All items that were requested are to be available by November 30,2011 Meetings will be conducted and minutes will be keep in order. Addenum: Responsible person is Practice Administrator.</p>		10/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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>bylaws.</p> <p>5. Review of governing board meeting minutes on 9-26-11 and 9-27-11 indicates the governing board met in November 2010 and May 2011 (no specific dates in the minutes); the meeting minutes lack evidence Quality Assurance and Performance Improvement (QAPI) activities were discussed; the minutes lack evidence that medical staff clinical privileges were reviewed, renewed, revised or curtailed.</p> <p>6. Interview with B#1 on 9-27-11 at 1030 hours confirmed the governing body bylaws, last reviewed and approved 10-13-10, require medical staff privileges to be reviewed every 2 years; B#1 confirmed 1-06-09 is last time it is documented that privileges were reviewed and approved for MD#1; B#1 confirmed the governing board meeting minutes from November 2010 and May 2011 lack specific dates of the meetings and evidence of QAPI discussion or action.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0110	<p>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 governing body failed to review, at least quarterly, reports of management operations including, but not limited to, the quality assessment and performance improvement (QAPI) program, patient services provided, results attained, recommendations made, actions taken, and follow-up activities.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of governing body meeting minutes on 9-26-11 and 9-27-11 indicate the governing body met twice in the past 12 months, November 2010 and May 2011, and lacked documentation that patient services, QAPI, or management of operations were discussed. 2. Interview with B#1 on 9-27-11 at 0910 hours confirmed the governing body meeting minutes from November 2010 and May 2011 lack specific meeting dates and documentation that patient services, 	S0110	<p>Practice Administrator and Clincial Co-ordinator are compiling Management reports, QAPI, patient services, recommendations and actions. These will be presented at the Governing Board meeting on Dec 21, 2011. Meeting set up and reports will be furnished. Addenum Quarterly Govt Board meetings will be held and will continue to do quarterly meetings. Scheduled meeting 2012 are as follows: 2/22/12. 5/23/12, 8/22/12, and 11/28/12. Meetings will continue to be quarterly thereafter.</p>	10/21/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>QAPI, or management of operations were discussed.</p> <p>3. Interview with MD#1 on 9-27-11 at 1630 hours confirmed the governing body met twice in the last 12 months, November 2010 and May 2011, and the meeting minutes lack documentation of discussion related to patient services, QAPI, or management of operations.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0156	<p>410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to perform annual performance evaluations for 6 of 6 (B#1, B#6, P1, P2, P3 and P4) personnel files reviewed per facility policy requirements.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of personnel files on on 9-26-11 lacked evidence that 2 of 2, B#1 and B#2, had received annual performance evaluations per facility policy requirements. 2. Review of facility policy III. HUMAN RESOURCES, 1. General Principles, E. Performance Assessment, last reviewed 10-13-10, indicates the following under #3: Each employee is evaluated on an annual basis. 3. Interview with B#1 on 9-26-11 at 1620 hours confirmed 2 of 2 staff members, 	S0156	<p>Medical Director/Practice Administrator Employees are scheduled through November and first part of December forevaluations to update annual performance reviews.Each employees will be automatically scheduled annually. Addenum: Medical Director/Practice Administrator</p>	10/21/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>B#1 and B#6, have not had annual performance evaluations as required per facility policy.</p> <p>4. Review of personnel records indicated P1, P2, P3, and P4 lacked documentation of an annual evaluation.</p> <p>5. During interview on 9-27-2011 at 10:05 AM with S2, S2 verified the above.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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 (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 policy review, document review and interview, the facility failed to assure competency of personnel for 4 of 6 employees.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Facility policy "Education and Training", II Procedure, 6, states "Yearly evaluations will be done to determine that individuals who provide patient care services are, and continue to be competent to do so". 2. Review of personnel records indicated P1, P2, P3, and P4 lacked documentation of competency determination. 3. During interview on 9-27-2011 at 10:05 AM with S2, S2 verified the above. 	S0176	<p>Clinical Co-Ordinator and Practice Adminsitrator Inservice Educations was presented on November 2, 2011 regarding the following: Infection Control: a. Hand washing b. Personal Protection Equip (PPE) c. Spill Kits. December Manadatory Meeting will be held December 7, 2011 to present "Exposure Incidents" and "Personal Protection Equipment" Already conducted inservices are as follows: Mock Code Blue 11/09/11 Handwashing 11/2/11 Infection Control 09/29/11 Mandatory CPR Recert 01/26/11 good for 2 years Sterilization Training on biological testing 10/28/11 Sterilization Training was done on 11/11/11. Continue training in order to fulfill assigned responsibilites will be on going with inservices. Scheduled Mandatory Monthly staff meeting will continue education. These staff meetings are held the first week of each month. Addenum: Responsible; Clinical Co-Ordinator and Practice</p>	10/21/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0182	<p>410 IAC 15-2.4-1 (c)(5) (O)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(O) Annual implementation of internal and external disaster preparedness plans with documentation of outcome.</p> <p>Based on document review and interview, the facility failed to conduct annual internal/external disaster preparedness drills with documentation of the outcome.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 9-26-11 and 9-27-11 lacked documentation the facility had conducted an internal/external disaster drill with documentation of outcomes. 2. Interview with B#2 on 9-27-11 at 0910 hours indicated an earthquake drill drill was conducted, but was unable to provide the date or documentation of the drill with the outcome. 	S0182	<p>AdministratorAddenum: Clincial staff must demo proper use of all equipment in the ASC. Testing of Clinical Staff on equipment and scenerios are given yearly. Passinggrade is 80%.</p> <p>Safety Co-ordinator Will be conducting Disaster drill on within 30 days. Both Internal and External disaster drills will be held this day. Documenation and critique will follow drill. Schedule will be maintained for training dates in the future. Outcomes will be documenated and reported to Governing Board. Clincial Co-Ordinator and Practice AdminsitratorAddenumQuarterly internal and external drills will be conducted. Next internal drill is Feb 2012 and quarerly thereafter.</p>	10/27/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S0184	<p>410 IAC 15-2.4 (c)(5)(P)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(P) Development, implementation, and monitoring of a safety management program to include, but not be limited to, the following:</p> <p>Based on document review and interview, the governing body failed to follow facility policy to oversee the safety activities in the center.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Environmental Safety plan on 9-27-11 indicates the following under SAFETY COMMITTEE, II.B: The Committee meets at least twice a year (more often as called by the Safety Coordinator or Chairperson). C: Minutes of meetings are recorded and filed in the Director's office. 2. Review of facility meeting minutes on 9-26-11 and 9-27-11 lacked documentation of meetings of the Safety Committee during the past 12 months. 3. Interview with B#2 on 9-27-11 at 1300 hours confirmed he/she is the Safety Coordinator and that there have been no meetings of the safety committee during the past 12 months to oversee safety activities in the center. 	S0184	<p>Safety Co-ordinator has scheduled the Safety Committee meeting was held on November 16, 2011. Minutes were documented, and will be reported to Governing Board.Safety Committed will be re-organized and held two times a year.Safety Committee members will be appointed for 2011 to 2012. Next meetings scheduled for June 13, 2012 and December 12, 2012.</p>	10/27/2011
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S0216	<p>410 IAC 15-2.4-1(d)(4)</p> <p>In accordance with center policy, the governing body shall do the following:</p> <p>(4) Ensure that there is a center-wide, quality assessment and improvement program that evaluates the provision of patient care and outcome.</p> <p>Based on document review and interview, the governing board failed to ensure the Quality Assurance and Performance Improvement (QAPI) program evaluates and monitors the provision of patient care, including outcomes.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 9-26-11 and 9-27-11 lacked evidence that the governing board evaluated and monitored QAPI data to ensure the safety and quality of patient care being provided in the ASC, including outcomes and actions taken. 2. Review of facility documents on 9-26-11 and 9-27-11 indicates the Governing Board met in November of 2010 and May of 2011; documentation does not include discussion of QAPI data to evaluate and monitor the provision of patient care to ensure the safety and quality of patient care being provided in the ASC. 3. Interview with B#1 on 9-27-11 at 0910 	S0216	<p>Practice Administrator and Clincial Director furnish the surveys to the ASC staff for distribution to each patient treated. Survey includes self addressed, stamped envelope. QAPI was being conducted but no mintues were documented . Minutes will be maintained and presented to the Governing Board for discussion. AddenumSafety and Quality of patient care are taken from monthly clincial staff report. These assess the patient from pre-op to post-op and discharge.24 hour follow phone calls are done.</p>	10/27/2011
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

	hours confirmed the Governing Board meeting minutes do not include discussion of QAPI data to evaluate and monitor the provision of patient care.			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711		
(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	
S0230	<p>410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the governing body failed to provide for a periodic review of the center and its operations by a utilization review committee, comprised of three or more licensed physicians who have no financial interest in the facility.</p> <p>1. Review of facility documents on 9-26-11 and 9-27-11 lacked documentation that a utilization review committee, comprised of 3 or more licensed physicians with no financial interest in the facility, had reviewed the operations of the center.</p> <p>2. Interview with B#1 on 9-27-11 at 0920 hours confirmed the facility has not established a utilization review committee, comprised of 3 or more licensed physicians with no financial interest in the facility, to review the operations of the center.</p>	S0230	Governing Body has scheduled meeting for December 8, 2011 at 6 p.m. for Utilization Review Committee to examine the ASC for its operation and services maintained. The three physicians on the UR Committee have no financial interest in the ASC. UR Committee to meet as required for up coming year 2012. Addenum: Medical Director/Practiace Admin/Clinical Co-Ordin	10/27/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711		
(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(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 Quality Assurance and Performance Improvement (QAPI) Committee failed to include all services, including those services provided by contract, in the QAPI program.</p> <p>Findings include:</p> <p>1. Review of facility documents on 9-26-11 and 9-27-11 lacked evidence that any services, direct or contracted, were evaluated through the facility QAPI program.</p> <p>2. Interview with B#1 and B#2 on 9-27-11 at 1040 hours confirm no services, direct or contracted, are evaluated through the facility QAPI program and there are no committee meetings or documentation of discussion or actions taken related to facility services to ensure quality and safety.</p>	S0310	<p>Practice Administrator and Clinicial Co-Ordinator studied the QAPI program for ancillary services not performed. Ancillary services for Repair and Maintenance contract no longer available through original contract. Practice Administrator nor Clinicial Co-Ordinator were notified of this. Contacted new facility to coordinate Repair and Maintenance in the ASC. All inspection and servicing will be completed by 12/31/2011. Responisble: Pract Admin/Clinical</p> <p>Co-OrdinAddenumASC has contracts for following services: ABK Alarms, Koester Answering, Livingston houskeeping, Bluegress Credentialing, Tri Med Equipment Medical Physicist, Koorsen fire extinguisher service, Landauer badge monitoring, MedRec Audits medical records, RHIA, Simplex Grinnel sprinkler, Whayne generator, Stericycle, Diversified Instrument ventilator, St Marys Medical Center contracted for Infection Control, Pharmacy, Lab, Transport. OEC 9800 repair,</p>	10/27/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
			Given and Spindler Management building repair and maintenance. Monthly monitoring of each service is performed. Included in our QAPI Program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0320	<p>410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the facility failed to implement a Quality Assurance and Performance Improvement (QAPI) program to monitor discharges, transfers, infection control, medication errors, and the response to patient emergencies.</p> <p>Findings include:</p> <p>1. Review of facility documents on 9-26-11 and 9-27-11 lacked evidence that discharges, transfers, infection control, medication errors, and the response to patient emergencies were monitored and evaluated through the facility QAPI program.</p> <p>2. Interview with B#1 and B#2 on 9-27-11 at 1040 hours confirmed that no services, including discharges, transfers, infection control, medication errors, and the response to patient emergencies are monitored and evaluated through the</p>	S0320	Medical Director, R.N., Clincial Co-Ordinator Was appointed by Governing Board. Monitoring was conducted, but was not documentated properly.Proper documenation will be maintained by QAPI Committee.QAPI will document all areas monitor such as discharges, transfers, infection control, and medication errors. Meetings have been scheduled for QAPI.	10/19/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

	facility QAPI program and there are no committee meetings or documentation of discussion or actions taken related to facility services to ensure quality and safety.			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0328	<p>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 ASC failed to monitor opportunities for improvement and document the outcomes of actions taken to ensure patient safety and quality of care through the Quality Assurance and Performance Improvement (QAPI) Committee.</p> <p>Findings include:</p> <p>1. Review of facility documents on 9-26-11 and 9-27-11 lacked evidence that the QAPI committee monitored opportunities for improvement and documented the actions taken, including follow-up action, to ensure the quality and safety of patient care.</p> <p>2. Interview with B#1 and B#2 on 9-27-11 at 1040 hours confirmed that the QAPI committee has not monitored opportunities for improvement and documented the actions taken, including follow-up action, to ensure the quality and</p>	S0328	<p>Medical Director, R.N. and Clincial Co-Ordinator appropriate actions were discussed in October meeting concerning action to be taken on patient equipement in the ASCfor impact on patient care.Documentation was done to support study issues. Ongoing monitoring is being conducted.</p>	10/19/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------------	--	---------------------	--	----------------------------

	safety of patient care.			
--	-------------------------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0332	<p>410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the center:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations:</p> <p>(AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded:</p> <p>(AA) Objects intentionally implanted as part of a planned intervention.</p> <p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries that were the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>reason for admission to the center.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is progression from Stage 2 or Stage 3 if the</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the center.</p> <p>Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the center.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p> <p>Based on document review and interview,</p>	S0332	Safety Co-Ordinator and Practice	10/27/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711		
(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>the facility failed to include serious adverse events, reportable to the Indiana State Department of Health (ISDH), in the facility's Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 9-26-11 and 9-27-11 lacked evidence that serious adverse events, reportable to the ISDH, were included in the facility QAPI program. 2. Interview with B#1 and B#2 on 9-27-11 at 1050 hours confirmed that serious adverse events, reportable to the ISDH, are not included in the facility's QAPI program. 		<p>Administrator Unusual Occurance Report will be submitted to the Governing Board for the course of the year on December 21, 2011. All occurrences will be listed. Ancillary service contracted with new company for repairs and maintainence. All patient occurences will be reported Reports will be made on a quarterly basis for the ASC in 2012. Responsible Safety Co-Ordinator and Practice Admin. Addenum Quarterly reports are taken from the monthly report listed QAPI Reportable Adverse Events. Listed on the forms; surgery performed on body part with informed consent, wrong patient procedures performed, incorrect procedure performed on patient, foreign object, patient deaths, discharge of patient to authorized person, medication errors, patient disability associated with a fall, patient or staff injury from electric, oxygen, burn, etc., injury of a patient or staff from physical assault</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S0334	<p>410 IAC 15-2.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) center employee involved;</p> <p>or any other information.</p> <p>(2) A potential reportable event may be identified by a center that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(b) admits a patient subsequent to discharge; from another health care facility subject to a</p>			
-------	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>reportable event requirement. In the event that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually.</p> <p>(e) Any serious reportable listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the center between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)</p> <p>Based on document review and interview, the facility failed to develop a policy and procedure to determine the occurrence of</p>	S0334	Medical Director, Clincial Co-Ordinator, and Practice Administrator In case of any adverse events reports will be	10/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711		
(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>reportable events and a procedure to report the events to the Indiana State Department of Health (ISDH).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility policies and procedures on 9-26-11 and 9-27-11 lacked evidence that the facility had developed a policy and procedure to determine the occurrence of reportable events and a procedure to report events to the ISDH. 2. Interview with B#1 and B#2 on 9-27-11 at 1050 hours confirmed the facility has not developed a policy/procedure to identify and report the occurrence of reportable events to the ISDH. 		<p>submitted no later than 15 working days after reportable event. In case none occur report will still be made to the Governing Board. Policy & Procedure to report any occurrence's is in the process of being updated to comply with the ISDH rule. AddendumAs reported in 332</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0418	<p>410 IAC 15-2.5-1(f)(2)(A)</p> <p>(2) The infection control committee responsibilities must include, but are not limited to the following:</p> <p>(A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the center.</p> <p>Based on policy review and interview, the infection control committee failed to implement its policy " Infection Control Plan" during the first and second quarter of 2011.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Facility policy "Infection Control Plan", last reviewed/ revised 3-1-2011, states on page 1 under "Surveillance of infections" that "ongoing monitoring for infections among the patients and staff and subsequent documentation if infections occur"and on page 2 that the infection control officer must keep a "line listing of all infections". 2. During interview with S2 on 9-27-2011 at 12:05 PM, S2 indicated: <ol style="list-style-type: none"> a. No documentation could be provided proving any ongoing monitoring activities for patient and staff infection. b. No documentation could be provided proving a line listing of infections for patients and staff. 	S0418	Safety Co-Ordinator reported documentation shows no procedure related infections identified Jan 20, 2011 to October 2011.Documentation was coordinated with the ancillary contracted service.Report of Employee illness surveillance shows several employee upper respiratory illnesses and gastro infections in late October 2011.Ongoing monitoring will continue.	10/03/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0420	<p>410 IAC 15-2.5-1(f)(2)(B)</p> <p>The infection control committee responsibilities must include, but are not limited to, the following:</p> <p>(B) Recommending corrective action plans, reviewing outcomes, and assuring resolution of identified problems.</p> <p>Based on document review and interview, the infection control committee failed to recommend corrective action plans, review outcomes, or assure resolution of identified problems for the first and second quarter of 2011.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The facility records lacked documentation of any meetings of the infection control committee during 2011. 2. During interview with S2 on 9-27-2011 at 12:05 PM, S2 indicated that: <ol style="list-style-type: none"> a. The infection control committee had not met in 2011. b. The infection control committee had not identified any problems, devised any corrective action plans, or reviewed outcomes during 2011. c. No facility policy could be produced requiring the infection control committee to meet and make recommendations, review outcomes, and assure resolution of problems. 	S0420	<p>Infection Control Ancillary Service member will be contacted to schedule a quarterly meeting. Quarterly meetings and inspections will be taken to the contracted services ancillary board for reporting. Safety Co-Ordinator, Practice Administrator and Ancillary member will continue to monitor and document.</p>	10/20/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------------	--	---------------------	--	----------------------------

--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0424	<p>410 IAC 15-2.4-1(f)(2)(D)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(D) Written reports of quarterly meetings.</p> <p>Based on document review and interview, the infection control committee failed to keep written reports of quarterly meetings for the first and second quarter of 2011.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of facility documents indicated lack of any written reports of infection control quarterly meetings for 2011. 2. During interview with S2 on 9-27-2011 at 12:05 PM, S2 confirmed that no written reports of quarterly meetings of the infection control committee existed for 2011 because the committee had not met since May 2009. 	S0424	Safety Co-Ordinator, Practice Administrator and Ancillary service member Apporopriate documentation will be kept of each scheduled meeting. Quarterly meetings scheduled.	10/19/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0440	<p>410 IAC 15-2.5-1(f)(2)(E)(vii)</p> <p>The infection control committee responsibilities must include, but not be 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>(vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases.</p> <p>Based on policy review, document review, and interview, the facility failed to apply its Tuberculosis Screening policy for 4 (S2, P2-4) of 6 employees.</p> <p>Findings included:</p> <p>1. Facility policy "Tuberculosis Screening" states:</p> <p>a. On page 250, "It is the policy of this facility to properly screen all employees for the presence of inactive or active Tuberculosis at the time of employment and at least annually thereafter".</p> <p>b. On page 252, 7. Response to Screening, For positive test results " Yearly tuberculosis counseling will be done, following educations concerning signs and symptoms of active Tuberculosis infection".</p> <p>c. On page 253, A, under Subsequent</p>	S0440	<p>Safety Co-Ordinator/LPN will complete the tuberculosis injection by end of December 2011. The tuberculosis screenings will be completed each year from this point on. Personnel files shall reflect yearly counseling and TB testing. All employees personnel files will show the PPD's. Counseling will be done on signs and symptoms of TB infections. Chest x-rays will be ordered when necessary for those unable to tolerate TB testing.</p>	10/19/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>Annual Screening, "All employees who previously had a significant PPD reaction will fill out an annual TB questionnaire".</p> <p>2. S2 was hired on 1/31/2009 and personnel file indicated that:</p> <p>a. S2 had a documented positive tuberculin skin test in 2002.</p> <p>b. S2 lacked documentation of yearly counseling and an annual TB questionnaire for 2011.</p> <p>3. P2 was hired on 1/31/2009 and personnel file lacked documentation of PPD since 3/10/2009.</p> <p>4. P3 was hired on 4/4/2011 and on 9-27-2011 personnel file lacked documentation of screening PPD upon hire.</p> <p>5. P4 was hired on 1/31/2009 and personnel file lacked documentation of any PPDs.</p> <p>6. During interview with S2 on 9/27/2011 at 10:05 AM, S2 verified the above.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0452	<p>410 IAC 15-2.5-1(g)(1)</p> <p>Sterilization services must be directed by a qualified person or persons and must provide for the following:</p> <p>(1) Biological indicators must be used to check sterilization processes at least monthly. Chemical sterilizing indicators must be used to check the sterilizing process of individual packs.</p> <p>Based on observation, policy review, document review, and interview, the facility failed to assure biological indicators were correctly used to check sterilization for two (2) of two (2) steam autoclaves inspected.</p> <p>Findings include:</p> <p>1. On 9-27-2011 at 11:30 AM, during tour of the surgical services area and in the presence of S2, the biological record sheet for the two (2) steam autoclaves was observed to contain >35 entries in which the biological indicator control was recorded as negative.</p> <p>2. Facility policy "Prevention" on page 220, VII, 3a states "Flash autoclaves are tested weekly with the use of a spore test".</p> <p>3. Manufacturer's instructions for</p>	S0452	<p>Safety Co-Ordinator and Practice Administrator instructed staff in proper procedure to use in the biological indicators. Following McKesson Protocol directions of manufacturer weekly spore testing will be done. New recording sheets have been added to the sterilizer book. Biological indicator controls are now being used in proper manner. Safety Co-Ordinator will continue to monitor use.</p>	10/19/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>McKesson biological indicators and incubator states:</p> <p>a. under use "Use of Controls" that "As a Control, an unprocessed Biological Indicator (BI) from the same lot should be crushed and incubated each time the sterilizer is tested. Positive results are expected and should be recorded."</p> <p>b. under "Monitoring Frequency" that "Per AAMI, ADA, and CDC recommendations, steam sterilizers should be biologically tested at least weekly, preferably daily and every load that contains an implant".</p> <p>4. During interview with S6 on 9-27-2011 at 11:30 AM, S6 indicated that:</p> <p>a. the facility uses McKesson BI's and incubator.</p> <p>b. BI (spore test) is performed twice a month.</p> <p>c. the control for the Biological Indicator should test negative.</p> <p>d. S6 could not recall any training on the manufacturer's directions for use of McKesson BI's and incubator.</p> <p>5. During interview with S2 on 9-27-2011 at 12:05 PM, S2 verified the above.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
---	--	--	--

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------------	--	---------------------	--	----------------------------

--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711		
(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	
S0454	<p>410 IAC 15-2.5-1(g)(2)</p> <p>Sterilization services must be directed by a qualified person or persons and must provide for the following:</p> <p>(2) Written policies and procedures must be available and followed by personnel responsible for sterilizing equipment and supplies, including, but not limited to, the following:</p> <p>(A) Minimum time and temperature for processing various size bundles and packs.</p> <p>(B) Instructions for loading, operating, cleaning, and maintaining sterilizers.</p> <p>(C) Instructions for cleaning packaging, storing, labeling, and dispensing of sterile supplies.</p> <p>(D) Procedure for maintaining and recording the particular sterilizing cycle.</p> <p>(E) Sterilization of heat labile reusable equipment.</p> <p>Based on observation and interview, the facility failed to assure that written policies and procedures for loading, operating, cleaning, maintaining of the autoclaves, or maintenance and recording the sterilizing cycle were available for personnel responsible for operation of 2 of 2 steam autoclaves.</p>	S0454	Safety Co-Ordinator and Practice Administrator have corrected the protocol for biological Indicator (BI). Indicator is being crushed and incubated each time the sterilizer is tested, (same lot)Further training on operation will be done in mandatory monthly staff meeting on sterilizer and will be done by CD furnished by McKesson. Complete by	10/27/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711		
(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. During tour of the ASC on 9-27-2011 at 11:05 AM and in the presence of S2, two (2) Ritter M9 steam autoclaves were observed available for use by staff which had no policies or procedures available to personnel regarding instructions for loading, operating, cleaning, maintaining of the autoclaves, or maintenance and recording the sterilizing cycle. 2. During interview with S2 on 9-27-2011 at 12:05 PM, S2 verified the above. 		<p>December 31, 2011.M9/M11 sterilizers operation guide instructions will be followed as per manual operating, cleaning, loading and maintaining.Scheduled training to be included in monthly meetings throughout the year.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S0466	<p>410 IAC 15-2.5-1(g)(3)</p> <p>Sterilization services must be directed by a qualified person or persons and must provide for the following:</p> <p>(3) Records of results must be maintained and evaluated periodically in accordance with 410 IAC 15-2.4-2 to include, but not limited to, the following:</p> <p>(A) Records of recording thermometers or a daily record of the sterilizing cycle (date, time, temperature, pressure, and contents) for each sterilizer load.</p> <p>(B) Results of biological indicators used in testing the sterilizing processes.</p> <p>Based on observation, document review, and interview, the facility failed to periodically evaluate the results of biological indicators for two (2) of two (2) steam autoclaves inspected.</p> <p>Findings include:</p> <p>1. On 9-27-2011 at 11:30 AM, during tour of the surgical services area and in the presence of S2, the biological record sheet for the two (2) steam autoclaves was observed to contain >35 entries in which the biological indicator control was recorded as negative.</p>	S0466	<p>Safety Co-Ordinator/Clinical Co-Ordinator, Practice Admin Training done by DC through McKesson. Sterilization book revised to show: Date, time, temp, pressure, and contents along with initial of employees doing load. Results are recorded in Bio Indicator book. Checking on entries will be done weekly. Unprocessed biological indicators from same lot being used according to directions of contol.</p>	10/27/2011
-------	---	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

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

	<p>2. Review of the manufacturer's instructions for use "Use of Controls" states "As a Control, an unprocessed Biological Indicator (BI) from the same lot should be crushed and incubated each time the sterilizer is tested. Positive results are expected and should be recorded".</p> <p>3. During interview with S2 on 9-27-2011 at 12:05 PM, S2 indicated:</p> <p>a. the infection control committee had not periodically evaluated the records of results for the BI's.</p> <p>b. S2 was not aware that the BI control should not be processed in the autoclave prior to incubation.</p> <p>c. S2 was not aware that the control BI control should test positive after incubation to verify that the BI is viable and that the incubator is functioning properly.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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(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 document review and interview, the facility failed to ensure the integrity of the authentication of medical records entries.</p> <p>Findings include:</p> <p>1. Review of facility policy V. PERFORMANCE IMPROVEMENT, 3. Medical Records, C. Authentication on 9-26-11 indicates the following under #2: When rubber-stamp signatures are used, the individual whose signature the stamp represent signs a statement that he or she, alone will use the stamp. The exception to this would be the H & P are stamped with the physician's signature, after being proofed by a nurse. #3. Such a stamp is not used by another individual.</p> <p>2. Interview with B#1 on 9-26-11 at 1430 hours confirms the physician has a rubber stamp for signatures that is used by other</p>	S0616	Practice AdminPhysician use of stamp: Stamp will be used for H&P and letters to other physicians or insurance companies by physician only.No other individuals will be using stamp.AddenumPhysician stamp will be accessible for use only by the physician.	09/29/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>individuals.</p> <p>3. Interview with B#5 on 9-27-11 at 1325 hours confirmed he/she is not a nurse and uses the physician's signature stamp to stamp the physician's signature on procedure notes.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711		
(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	
S0620	<p>410 IAC 15-2.5-3(c)(5)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(5) Plain paper facsimile orders, reports, and documents are acceptable for inclusion in the medical record if allowed by the center policies.</p> <p>Based on document review and interview, the facility failed to develop a policy and procedure related to receiving facsimile orders, reports, and documents on plain paper for inclusion in the medical record.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility policies/procedures on 9-26-11 lacked evidence that the facility had developed a policy on receiving facsimile orders, reports, and documents on plain paper for inclusion in the medical record. 2. Interview with B#1 on 9-26-11 at 1130 hours confirmed the facility has not developed a policy on receiving facsimile orders, reports, and documents on plain paper for inclusion in the medical record. 	S0620	<p>Practice Admin and Clinicial Co-OrdinatorIf a document is faxed to us, it sutomatically prints on plain paper.If a fax is mailed that is thermal paper, we will copy and discard thermal by shredding.Written policy and procedure will be obtained and inservice in incrementsAddenum: Thermal paper policy started 10/27/2022. Completion inincrements</p>	10/27/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0622	<p>410 IAC 15-2.5-3(c)(6)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(6) The center shall have a system of coding and indexing medical records which allows for timely retrieval of records by diagnosis and procedure, physician, and condition on discharge, in order to support continuous quality assessment and improvement activities.</p> <p>Based on document review and interview, the facility failed to maintain a system of indexing which allows for timely retrieval of records by procedure and condition on discharge in order to support Quality Assurance and Performance Improvement (QAPI) activities.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility surgical log on 9-26-11 lacked documentation related to the patients' diagnosis and condition on discharge for a 12 month period of time. 2. Interview with B#2 on 9-26-11 at 1130 hours confirmed the surgery schedule is the only log of patients maintained by the facility and it does not contain the patients' diagnosis or condition on discharge. 	S0622	Practice Admin and Clincial Co-OrdinatorEHR systems is being used in the ASC. The scheduling log contains diagnosis, condition on discharge, procedure done.Inservice was held to explain where all information is to be listed.	10/05/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
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 medical record review and interview, the facility failed to document informed consent for a procedure in 1 of 30 patients.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Facility policy "Surgical Consent" states " All patients undergoing any type of operating procedure, special diagnostic examination or procedure or special treatment must sign a surgical consent". 2. N4 had a procedure on 2/14/2011 and the medical record lacked evidence of an informed consent. 3. During interview with S2 on 9-27-2011 at 3:00 PM, S2 verified the above. 	S0658	Practice Admin and Clinical Co-Ordinator Informed consent is obtained from pre-procedure clinical staff. Second check will be before procedure begins. Standing order in place. Re-education has been conducted	10/27/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0670	<p>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 and interview, the facility failed to document in the patient record a final progress note in 5 (N4, N8, N12-13 and N15) of 30 patient records reviewed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> N4 had a procedure on 2/14/2011 and the medical record lacked evidence of a final progress note with dismissal diagnosis. N8 had a procedure on 6/14/2011 and the medical record lacked evidence of a final progress note with dismissal diagnosis. N12 had a procedure on 4/5/2011 and the medical record lacked evidence of a final progress note with dismissal diagnosis. N13 had a procedure on 3/29/2011 and the medical record lacked evidence of a final progress note with dismissal diagnosis. 	S0670	Practice Admin and Clincial Co-OrdinatorPolicy re-education for chart requirements done. Progress note to be consistenton Op note, Pre/post recovery, and final diagnosis on discharge.Converting to EHR.	10/05/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>5. N15 had a procedure on 6/24/2011 and the medical record lacked evidence of a final progress note with dismissal diagnosis.</p> <p>6. During interview with S2 on 9/27/2011 at 3:00 PM, S2 verified the above and indicated the facility could not provide a policy requiring a discharge summary/final progress note.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0708	<p>410 IAC 15-2.5-4(a)(3)</p> <p>The medical staff shall do the following:</p> <p>(3) Make recommendations to the governing body on the appointment or reappointment of the applicant for a period not to exceed two (2) years. Based on document review and interview, the medical staff failed to make recommendations to the governing body on the reappointment of 1 of 1 physician (MD#1) for a period not to exceed 2 years.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the credential file of MD#1 on 9-26-11 indicates the medical staff/governing board last approved privileges on 1-06-09, which exceeds 2 years. 2. Review of facility documents on 9-26-11 and 9-27-11 lacks documentation of a medical staff meeting during the past 12 months. 3. Review of governing board meeting minutes for November 2010 and May 2011 (no specific dates) lacks evidence medical staff privileging was discussed. 4. Interview with B#1 on 9-27-11 at 0850 hours confirmed the medical staff has not conducted meetings during the past 12 months and the governing board meeting minutes from November 2010 and May 	S0708	<p>Medical Staff/Practice Admin/Clinical Co-Ordinator/R.N Medical staff met and made the recommendation to reappoint physician to the ASC staff. Meeting held on 10/05/2011. at 7:30 am. Admin reported credentialing is in progress and will be able to reappoint when all information is received. By end of November. Meeting Staff meeting is scheduled for 11/28/2011. Ongoing monitoring.</p>	10/27/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

	2011 do not contain documentation of medical staff privileging being discussed. 5. Interview with MD#1 on 9-27-11 at 1630 hours confirmed the medical staff/governing board last approved privileges fro MD#1 on 1-06-09 and the medical staff has not met during the past 12 months.			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S0736	<p>410 IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based on document review and interview, the medical staff failed to address the frequency of medical staff meetings in the Medical Staff ByLaws.</p> <p>Findings include:</p> <p>1. Review of the Medical Staff ByLaws on 9-26-11 and 9-27-11 lacked documentation of the frequency required for Medical Staff meetings.</p> <p>2. Review of facility documents on 9-26-11 and 9-27-11 lacked evidence that the medical staff had held meetings with documentation of discussion and actions taken over the past 12 months.</p> <p>3. Interview with B#1 on 9-27-11 at 0850 hours confirmed the Medical Staff ByLaws/Rules and Regulations do not address the frequency of medical staff meetings; B#1 confirmed there is no documentation of medical staff meetings over the past 12 months with</p>	S0736	<p>Physician/Practice Admin/Clinician Co-ordinator/R.N. Medical staff meeting will be conducted quarterly Member attendance will be documented. Addendum: By laws states meeting will be quarterly.</p>	10/05/2011
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

	documentation of discussion and actions taken. 4. Interview with MD#1 on 9-27-11 at 1630 hours confirmed the Medical Staff ByLaws/Rules and Regulations do not address the frequency of medical staff meetings; B#1 confirmed there is no documentation of medical staff meetings over the past 12 months with documentation of discussion and actions taken.			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711		
(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	
S0754	<p>410 IAC 15-2.5-4(b)(3)(I)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(I) A process for reporting practitioners who fail to comply with state professional licensing law requirements as found in IC 25-22.5, and for documenting enforcement actions against practitioners who fail to comply with the center and medical staff bylaws and rules.</p> <p>Based on document review and interview, the medical staff failed to include a process for reporting practitioners who fail to comply with state professional licensing law requirements as found in IC 25-22.5, and for documenting enforcement actions against practitioners who fair to comply with the center and medical staff bylaws/rules and regulations in the Medical Staff Bylaws/Rules and Regulations.</p> <p>Findings include:</p> <p>1. Review of the medical staff bylaws/rules and regulations on 9-26-11 and 9-27-11 lacked a process reporting practitioners who fail to comply with state professional licensing law requirements as found in IC 25-22.5, and for documenting enforcement actions against practitioners who fair to comply with the</p>	S0754	<p>Practice Admin/Clinical Co-OrdinPage 88-94 States failure to comply with requested information shall result in null and void.Page 102-106 Compiled through information developed thru course of performance evaluation, incident report or by complaint from a medical staff member, patient or center employee.Written request made on behalf of Gov Board that includes grounds for request, formal study (renew investigation). Meeting with Medical staff is outlined on pages 99.Addendum: Any problems would be reported to the IN Professional Licensing Board.</p>	09/28/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>center and medical staff bylaws/rules and regulations.</p> <p>2. Interview with B#1 on 9-27-11 at 1030 hours confirmed the medical staff bylaws/rules and regulations lack a process for reporting practitioners who fail to comply with state professional licensing law requirements as found in IC 25-22.5, and for documenting enforcement actions against practitioners who fail to comply with the center and medical staff bylaws/rules and regulations.</p> <p>3. Interview with MD#1 and B#1 on 9-27-11 at 1630 hours confirmed the ORGANIZATIONAL FUNCTIONS, 6. Medical Staff, B. Objectives, page 80 is the complete Medical Staff Bylaws/Rules and Regulations.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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(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 document review, medical record review, and interview, the medical staff failed to assure that a medical history and physical was performed and noted in the medical record for 2 (N5 and N25) of 30 patients.</p> <p>Findings included:</p> <p>1. Policy "Patient Admission Policies</p>	S0772	<p>Medical DirectorThe office visit prior to a procedure (30 days) should have been titled H&P.This will be changed to include the words History & Physical.The examination was completed within 30 days, but was incorrectly titled as to state information. Addenum: EMR transition. Nursing staff checks H&P to verify date is within 30 days.</p>	10/27/2011
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>Criteria" page 171, 6 states " A history and physical examination are completed within 30 days before an operative or other invasive procedure".</p> <p>2. N5 had a procedure on 2/25/2011 and the medical record lacked documentation that a history and physical had been performed within 30 days prior to the procedure.</p> <p>3. N25 had a procedure on 7/8/2011 and the medical record lacked documentation that a history and physical had been performed within 30 days prior to the procedure.</p> <p>4. During interview with S2 on 9-27-2011 at 3:00 PM, S2 verified the above.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S0908	<p>410 IAC 15-2.5-5(a)(3)</p> <p>(a) Patient care services must require the following:</p> <p>(3) That a registered nurse serves as head nurse supervising patient care services personnel.</p> <p>Based on document review and interview, the facility failed to provide a registered nurse to serve as head nurse supervising patient care services personnel.</p> <p>Findings included:</p> <p>1. Policy "Policies of Nursing Personnel" under IV Staffing Policy "Members of the staff will be assigned for daily patient care responsibilities and auxiliary tasks by the Nursing Administrator or clinical coordinator".</p> <p>2. During interview with S2 on 9-26-2011 at 10:30 AM, S2 stated:</p> <p>a. S2 is an LPN and is the supervisor in the ASC for all patient care services personnel.</p> <p>b. The ASC does not have a registered nurse serving as head nurse supervising patient care services personnel.</p> <p>3. During interview with S1 on 9-26-2011 at 10:30 AM, S1 verified the above.</p>	S0908	<p>Medical Director R.N. serves in the procedure room and circulation, with assist from LPN and EMT. The staff serves under the guidance of the R.N. and Physician. Question was misinterpreted by staff answering.</p>	09/28/2011
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S0912	<p>410 IAC 15-2.5-5(a)(5)</p> <p>(a) Patient care services must require the following:</p> <p>(5) That an experienced registered nurse supervise all nursing personnel, including, but not limited to, registered nurses, licensed practical nurses, and surgical technologists, in surgical areas and recovery unit(s) as follows:</p> <p>(A) Licensed practical nurses, and surgical technologist may serve as scrub personnel under the supervision of a qualified registered nurse.</p> <p>(B) Circulating duties in the operating room shall be performed by a qualified registered nurse. Licensed practical nurses and surgical technologists may assist in circulating duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies, in accordance with applicable state law and approved medical staff policies and procedures.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure circulating duties in the operating room were performed by an RN, an LPN, or a Surgical Technologist.</p> <p>Findings included:</p> <p>1. Facility policy "Staff Nurse-Surgery" under IV. Qualifications states "LPN or Certified Medical Assistant".</p>	S0912	Medical Director LPN, CMA, and EMT assist in circulating duties. At time of inspection R.N. was immediately available. R.N. was circulating. LPN was being interviewed by ISDH. LPN usually in procedure area. Being class B our facility is 3583 sq ft. Pre & Post are across from each other. LPN normally available. Addendum: LPN or RN will be present in procedure room Addendum: RN is	09/28/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. During tour on 9-27-2011 at 10:50 AM, and in the presence of S2, two (2) procedures were performed in Operating Room One by physician, M1, with the assistance of P2, a CMA, and a Radiologic Technician. An RN or LPN was not in the room to supervise patient care during either of these procedures, nor was an RN immediately available. In the recovery room, one patient was monitored by an EMT and an RN was not immediately available.</p> <p>2. During interview with S2 on 9-26-2011 at 10:30 AM, S2 stated:</p> <p>a. The ASC employs and assigns for patient care duties: one Registered Nurse and several Medical Assistants and Emergency Medical Technicians as nursing personnel.</p> <p>b. M1 routinely performs invasive procedures and operative procedures with the assistance of a CMA but no RN or LPN in the room. MAs and EMTs provide patient care in the recovery room without an RN immediately available.</p> <p>c. An RN is not assigned to the operating room and is not present for invasive procedures and operative procedures. The RN is not always immediately available to assist the CMAs during a procedure because the only RN on duty also supervises the MAs/EMTs in the recovery</p>		available on premises & sufficiently free to respond rapidly to any situation.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

	room. 3. During interview with S1 on 9-26-2011 at 10:35 AM, S1 verified the above.			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S0926	<p>410 IAC 15-2.5-5(b)(3)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following:</p> <p>(3) A provision for instruction(s) to be given to the patient, responsible adult, and/or family regarding follow-up care and transportation needed by the patient on discharge.</p> <p>Based on policy review, document review, and interview, the facility failed to provide discharge instructions to 2 (N4 and N28) of 30 patients.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Facility policy "Perioperative Nursing Care" states the nursing personnel are responsible to "Complete patient teaching as need to provide knowledge to the patient and significant other for home care management". 2. N4 had a procedure on 2/14/2011 and the medical record lacked documentation that discharge instructions had been given to N4. 3. N28 had a procedure on 8/12/2011 and the medical record lacked documentation that discharge instructions had been given to N28. 	S0926	<p>Medical DirectorVol 1 Book II pages 174,175,176 Numbers 1,2,3Any and all procedures or injections (hips,ribs, coccyx) that are provided are now given discharge instruction. Perioperative patient teaching is being done and recorded on discharge instructions.Instructions for discharge are to be reviewed by clinical staff with patient in post op.</p>	10/13/2011
-------	--	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

	4. During interview with S2 on 9-17-2011 at 3:00 PM, S2 verified the above.			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S1008	<p>410 IAC 15-2.5-6(3)</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>Based on document review and interview, the facility failed to develop pharmacy policies which were available to facility personnel to ensure medications are provided in a safe and effective manner according to acceptable standards of care.</p> <p>Findings include:</p> <p>1. Review of facility documents on 9-26-11 and 9-27-11 lacked evidence the facility had developed pharmacy policies which were available to facility personnel, to ensure medications are provided in a safe and effective manner according to acceptable standards of care.</p> <p>2. Interview with B#1 on 9-27-11 at 1450 hours confirmed the facility has not developed pharmacy policies and procedures, available to facility personnel, to ensure medications are provided in a safe and effective manner according to acceptable standards of care.</p>	S1008	<p>Medical DirectorMetal bolted storage box with combination and key lock is now mounted inside cabinet for use for schedule II drugs during procedures.All other medications are stored in lock box during procedures.Schedule II drugs are stored after procedures in safe in Physicians office. Log of drugs and dosages given to each patient is listed in patient chart and log in cabinet.Addenum: Policy adapted to specify safe and effective way to handle medications.</p>	10/27/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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(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 interview, the facility failed to ensure that drug cabinets were accessible only to authorized personnel in 1 of 1 operating rooms toured.</p> <p>Findings included:</p> <p>1. During tour of facility's operating rooms on 9-27-2011 at 10:45 AM and in the presence of S2, the following drugs were observed to be stored in operating room one (1) in an unlocked wall cabinet: 12 vials of Depomedrol, 9 vials of 2% Lidocaine, 9 vials of Cefazolin, 12 vials of 8.4% Sodium Bicarbonate, 14 vials of 0.25% Bupivacaine, 2 vials of Midazolam 2 mg, and 29 vials of Fentanyl 100 micrograms. In the crash cart, a drawer of</p>	S1026	<p>Medical DirectorCrash cart is unlocked during procedure, key stored in top drawer, in procedure room.Relocked at end of procedure day, key is placed in secured lock box in cabinet.</p>	10/27/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>drugs were stored and a keyed lock was available to lock the drawer of the crash cart. The key to the crash cart is stored in the top drawer; an unlocked drawer.</p> <p>2. During interview on 9-27-2011 with S2, S2 indicated that:</p> <p>a. Drugs, including Schedule II drugs such as Fentanyl, are routinely stored in the operating room in the unlocked wall cabinet.</p> <p>b. Only Schedule II drugs are locked at the end of the day in the Medical Director's office.</p> <p>c. Housekeeping personnel have unsupervised access to the operating room at the end of the day.</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S1028	<p>410 IAC 15-2.5-6(3)(E)(ii)</p> <p>Pharmaceutical service 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-designed, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(ii) Drug cabinets for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse must be permanently affixed compartments that are separately locked.</p> <p>Based on observation and interview, the facility failed to ensure that Schedule II drugs were stored in permanently affixed compartments that are separately locked in one (1) of one (1) operating rooms toured.</p> <p>Findings included:</p> <p>1. During tour of facility's operating rooms on 9-27-2011 at 10:45 AM and in the presence of S2, the following Schedule II drugs were observed to be stored in operating room one (1) in an unlocked wall cabinet: 2 vials of</p>	S1028	<p>Medical Director Bolted metal storage box with combination and lock is now permanently in place. Lock combination box .Addendum: Pharmacy policy addresses that schedule II drugs are in permanently fixed drug box. It is now adapted as a pharmacy policy.</p>	10/27/2011
-------	--	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>Midazolam 2 mg, and 29 vials of Fentanyl 100 micrograms.</p> <p>2. During interview on 9-27-2011 with S2, S2 indicated that:</p> <p>a. Schedule II drugs are routinely stored in the operating room in the unlocked wall cabinet.</p> <p>b. Schedule II drugs are locked at the end of the day in the Medical Director's office (M1).</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S1164	<p>410 IAC 15-2.5-7(b)(4)(B)(i)</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>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on observation, policy review, document review, and interview, the facility failed to document preventative maintenance on 2 of 2 Ritter M9 Ultraclaves (steam sterilizers).</p> <p>Findings included:</p> <p>1. During tour of facility's operating rooms on 9-27-2011 at 11:15 AM and in the presence of S2, two (2) Ritter M9 Ultraclaves were inspected and lacked any documentation of performance of preventative maintenance.</p> <p>2. Facility policy "Prevention" on page</p>	S1164	<p>ASC Clinical staff and R.N. Autoclave training was held to reeducate staff on proper sterilization method and preventative maintenance. Correct protocol to be followed per McKesson book. CD (McKesson CD) training for staff will be conducted at mandatory monthly meeting. Cleaning schedule and preventive maintenance will be documented. Addendum Contracted service is done by TriMed Repair, Autoclave log is kept bi-weekly on cleaning outside and gasket. Weekly cleaning of chamber and tray. Monthly clean of chambers plumbing and valve per manual.</p>	10/27/2011
-------	--	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>218, I, 3 states " 3. Preventative maintenance on all sterilizers is performed by qualified individuals using the manufacturer's operator's manual quarterly."</p> <p>2. Manufacturer's Operation Guide for the Ultraclaves, pg. 24-27, sets forth preventative maintenance to be performed on a daily (disinfect exterior, clean gasket); weekly (clean chamber and trays); and monthly (clean chamber and plumbing and perform pressure valve check) schedule.</p> <p>3. During interview with P4 on 9-27-2011 at 3:30 PM, P4 indicated: a. P4 duties include sterilizing instruments and other supplies in the M9 Ultraclaves. b. P4 had not performed any preventative maintenance on the M9 Ultraclaves. c. P4 stated that only one other employee, S7, works with the M9 Ultraclaves.</p> <p>4. During interview with S7 on 9-27-2011 at 3:45 PM, S7 indicated: a. S7 duties include sterilizing instruments and other supplies in the M9 Ultraclaves when S6 is not on duty. b. S7 had not performed any preventative maintenance on the M9 Ultraclaves.</p> <p>5. During interview on 9-27-2011 with</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

	S2 at 2:05 PM, S2 verified the above and indicated that the facility lacked documentation of preventative maintenance for the autoclaves.			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

S1174	<p>410 IAC 15-2.5-7(b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following:</p> <p>(A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice.</p> <p>Based on policy review, observation, document review, and interview, the facility failed to provide housekeeping services for the previous 3 weeks and one disinfectant used was not in contact with surfaces a sufficient time to kill organisms.</p> <p>Findings included:</p> <p>1. Facility policy "Cleaning Services" states in pertinent part:</p> <p>a. The policy's basic function is to "keep</p>	S1174	Practice Admin/Clinical Co-OrdinCleaning was being done "in-house" during transition of new cleaning service.Physician was doing floor in evenings. PR employee was taking trash to dumpster. Clinical staff was cleaing surfaces.Redi Wipes no longer used.Cavicide is used on all surfaces.New cleaning staff is in place and trained as of 10/13/11.	10/13/2011
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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>the center clean and sanitized with the purpose of preventing infection ..".</p> <p>b. Under II Responsibilities, 3, "follows the housekeeping procedures including cleaning of the entire center and disinfection of the surgical suite ..".</p> <p>c. Under II Responsibilities, 5, "follows the terminal cleaning of the operating room at the end of the schedule".</p> <p>2. During tour of the ASC on 9-29-2011 at 10:55 AM and in the presence of S2, it was observed that staff used Redi-Wipes to clean the mayo stand and desk work area between procedures; the disinfectant was left on the surface for 10 seconds; dried with a cloth; and then used as a surface for sterile supplies.</p> <p>2. Redi Wipes manufacturer's instructions state:</p> <p>a. Wipe surface and allow to remain wet for 10 minutes before use.</p> <p>b. Let surface dry.</p> <p>3. During interview with S1 on 9-27-2011 at 3:50 PM, S1 verified the above and indicated that:</p> <p>a. Housekeeping services were last provided by a contractor on August 31, 2011.</p> <p>b. Staff are performing cleaning between procedures but not end of day cleaning, cleaning of floors and walls, or general</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<input checked="" type="checkbox"/> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	<input checked="" type="checkbox"/> (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	<input checked="" type="checkbox"/> (X3) DATE SURVEY COMPLETED 09/27/2011
--	--	---	--

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

	cleaning of the equipment, fixtures and furnishings.			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S1178	<p>410 IAC 15-2.5-7(b)(5)(B)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following:</p> <p>(B) Refuse, biohazards, infectious wastes, and garbage must be collected, transported, sorted and disposed of by methods that will minimize nuisances or hazards according to federal, state, and local laws and rules.</p> <p>Based on document review and interview, the facility failed to develop a policy related to transport, sorting, and disposal methods for refuse, biohazards, infectious waste, and garbage.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 9-26-11 and 9-27-11 lacked evidence that the facility had developed a policy related to transport, sorting, and disposal methods for refuse, biohazards, infectious waste, and garbage. 2. Interview with B#1 on 9-27-11 at 0850 hours confirmed the facility has not 	S1178	Practice Admin/Safety Co-OrdinatorStericycle transports and disposes of all biohazardd materials. Documentation is received via manafest of destruction.Written policy will be adapted by Dec 16, 2011	10/27/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
--------------------	--	---------------	---	----------------------

	developed a policy related to transport, sorting, and disposal methods for refuse, biohazards, infectious waste, and garbage.			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S1180	<p>410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on document review and interview, the safety committee failed to review and document the safety functions of the center during the past 12 months.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the Environmental Safety plan on 9-27-11 indicates the following under SAFETY COMMITTEE, II.B: The Committee meets at least twice a year (more often as called by the Safety Coordinator or Chairperson). C: Minutes of meetings are recorded and filed in the Director's office; II, A, 1: Membership on the committee includes representation from Administration, Nursing Service, and Physical therapy. Review of facility meeting minutes on 9-26-11 and 9-27-11 lacked documentation of meetings of the Safety Committee during the past 12 months. Interview with B#2 on 9-27-11 at 1300 hours confirmed he/she is the Safety Coordinator and that there have been no 	S1180	<p>Safety Committe Meeting will be conducted on Dec 16, 2011 thereafter twice yearly. Membership on committee will include nursing and administration.Meeting will address center wide assessment for safety and hazards. Addenum: Corrective action started 10/27/2011, completion date will be in increments.</p>	10/27/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/27/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
---	--

(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
	meetings of the safety committee during the past 12 months to oversee safety activities in the center.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
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 interview, the safety committee failed to provide and document an ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Environmental Safety plan on 9-27-11 indicates the following under SAFETY COMMITTEE, II.B: The Committee meets at least twice a year (more often as called by the Safety Coordinator or Chairperson). C: Minutes of meetings are recorded and filed in the Director's office. 2. Review of facility meeting minutes on 9-26-11 and 9-27-11 lacked documentation of meetings of the Safety Committee during the past 12 months. 3. Interview with B#2 on 9-27-11 at 1300 hours confirmed he/she is the Safety Coordinator and that there have been no meetings of the safety committee during the past 12 months to evaluate and collect 	S1182	<p>Safety Co-Ordinator Meeting scheduled for Dec 16, 2011 for evaluatiion of safety and problems. Discussion will be held on hazard and safety concerning ASC and surrounding areas. Ongoing monitoring will be done. Addenum: Procedure will be official adapted by 12/16/2011</p>	10/27/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001167		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2011	
NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711			
(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			
S1198	<p>information about hazards and safety practices at the center.</p> <p>410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the facility failed to coordinate emergency and disaster preparedness with an appropriate community, state, or federal agency.</p> <p>Findings include:</p> <p>1. Review of facility documents on 9-26-11 and 9-27-11 lacked documentation that the facility had coordinated emergency and disaster preparedness with an appropriate community, state, or federal agency.</p> <p>2. Interview with B#1 on 9-27-11 at 1010 hours confirmed the facility has not coordinated emergency and disaster preparedness with a community, state, or federal agency.</p>	S1198	<p>Safety Co-OrdinatorContacted local EMA official for county. Coordination with county for preparedness.Trying to have in place by 12/30/2011 Addenum: We will send policy to the local emergency disater preparedness team.Contact will be continued with phone calls.At this time no responce has been receivedAddenum: Contacted EMA Local Division, S. Greer. dates are as follows:11/10/11, 01/24/12 and call 1/26/12. No response, will continue effort.</p>	10/27/2011			