STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001114	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL SURGERY CENTER LLC	5002 E SR 44 FRANKLIN, IN 46131

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Q 000 Bldg. 00	This visit was for a re-certification survey. Facility Number: 003073 Survey Date: 4-06/08-2015 QA: cjl 04/27/15	Q 000		
Q 082 Bldg. 00	416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care. (c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time. (c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	staff are familiar with these strategies. Based on document review and interview, the facility failed to include a monitor and standard for 2 directly-provided services, in its quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the directly-provided services of housekeeping and nursing. 2. In interview, on 4-8-2015 at 2:30 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.	O 082	Nursing Quality Assessment to be followed this year will be Hand washing. It will be maintained monthly by the Director of Nursing and results will be reported quarterly to the QA committee. Hand washing all staff involved with patient care will wash their hands before, after and between patients. The use of hand sanitizer will be allowed. Housekeeping Quality Assessment I have included two of the QA's that the QA committee has developed. There will be a detailed QA for all areas that are in the surgery center. These will be maintained by the Director of Nursing monthly and results will be reported to the QA committee quarterly.	06/12/2015
Q 084 Bldg. 00	416.43(e) GOVERNING BODY RESPONSIBILITIES The governing body must ensure that the QAPI program- (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods,			

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	frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. Based on document review and interview, the facility's governing board failed to review reports of the quality assessment and performance improvement (QAPI) program for directly provided nursing services. Findings: 1. Review of the governing board minutes of year 2014 indicated the governing board met on February 12, April 9, August 13, and December 10. The governing board did not review at any of the meetings, QAPI activities for the directly provided nursing services. 2. In interview, on 4-8-2015 at 2:30 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.	O 084	All Quality Assessment including Nursing will be reported to the governing board at each quarterly meeting. A new form to be followed at each meeting has been developed and will be reviewed at the next Governing board meeting for approval. The Quality Assessment report will be done at the beginning of the meeting. The Medical Director and the Director of Nursing will maintain a QA quarterly to make sure it is being maintained.	06/12/2015
Q 101 Bldg. 00	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and			

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	sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on document review and interview, the facility failed to provide evidence of preventive maintenance (PM) on 1 (wheelchair) of 12 pieces of patient care equipment and it could not be determined the facility performed defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator. Findings: 1. Review of the facility's PM reports indicated there was no documentation of PM for a wheelchair. 2. In interview, on 4-8-2015 at 2:05 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit. 3. Review of the manufacturer's manual for the Code Master XL+ defibrillator, indicated to regularly perform a test routine incorporating the following checks along with visual inspection of all cables, paddles, and controls. Further	O 101	PM on wheelchair. Spoke with our biomedical company. They will include the wheelchairs in the PM checks. A QA will be maintained by the Director of Nursing and results will be reported to the QA committee quarterly.The defib testing sheet has been updated to include inspection of cables, paddles,and controls. It includes date and time, delivered energy, shock button functional, and Quick Pacer Functionality Test.Also weekly cleaning. A QA has been developed and will be maintained by the Director of Nursing on a monthly basis with results being reported quarterly to the QA committee.	06/12/2015

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	review indicated there were to be multiple items checked under the headings of Every Shift, Every Day, Delivered Energy and Shock Button Functional Test, and Quick Pacer Functionality Test. 4. Review of a document entitled DEFIB TESTING, dated Feb 2014, indicated DAILY and WEEKLY but the document did not define which activities were done daily and weekly. Thus, it could not be determined the activities performed were according to the manufacturer's specifications. 5. In interview, on 4-8-2015 at 3:00 pm, employee #A1, confirmed it could not be determined the facility performed defibrillator checks in accordance with the manufacturer's specification and no further documentation was provided prior to exit.			
Q 105 Bldg. 00	416.44(c) EMERGENCY EQUIPMENT The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC' s operating room. The equipment must meet the following requirements: (1) Be immediately available for use during			

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	emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel. Based on policy/procedure review, administrative document review, medical record review, observation and interview, the facility failed to have available emergency drugs for malignant hyperthermia and resuscitation in 1 of 1 emergency carts. Findings include: 1. Review of the policy/procedure, "Malignant Hyperthermia", last approved 10/19/14 by the Board, indicated: 1. Dantrium will be stored in the crash cart. 2. All other emergency drugs for treating malignant hyperthermia is in the crash cart. Review of the policy/procedure, "Crash Cart Content", last approved 10/19/14 by the Board, indicated: Policy: The crash cart shall be stocked with the supplies and medications as determined by the medical staff that may be required in the event of a Code. 2. The contents of the cart shall be inspected/checked monthly or after each use. Review of the policy/procedure, "Emergency Equipment", last approved	O 105	36 vials of Dantrium has been ordered. Expired Aminophylline 10mg-25 vials has been replaced, Digoxin 500mg-3 vials has been replaced, Furosemide 20mg-25vials has been replaced, Adenosine 12mg-2 vials has been replaced, Diphenhydramine 50mg-4 vials has been replaced, Magnesium Sulfate 2mg-25vials have been replaced, Glycopyrrolate 4mg-1 vial has been replaced, Xylocaine 2% 20mg-10 vials has been replaced, Ventalin HFA Aerosol 90mcg-1 has been replaced, Hespan 500mg-2 bags has been replaced, Bacteriostatic H2O 30ml-24 vials has been replaced. Dopamine HC-2 vials backordered with estimated arrival date August 18, 2015, Lidocaine HCL 1%-2 backordered with estimated arrival date June 11, 2015.Outdated medication check list for medications and all supplies of the emergency code cart has been updated. This will be checked monthly by the Director of Nursing. The medical director will maintain a monthly QA and report the results to the QA committee quarterly.	06/12/2015

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	10/19/14 by the Board, indicated: The emergency cart is to be checked monthly for expired drugs and supplies. 2. Review of the "Defib Testing" log for 6/2/14 to 3/31/15 indicated that the contents of the cart was checked once a month. Review of the "Pharmacy Supplies Quarterly Inspection Checklist" indicated that the crash cart was checked for expiration of drugs. 3. Patients # 1, 2, 3, 4, 6, 8, 10, 12, 13, 17 and 20's medical records (MR) were reviewed and indicated that each had general anesthesia and received Sevoflorane, an anesthesia agent that is a known trigger for malignant hyperthermia, which is treated with the drug Dantrium. 4. At 1445 hours on 4/7/15, the following expired drugs were observed in the crash cart in Pre/Post Op Unit in the presence of staff #N4 (Director of Nursing): Aminophylline 10mg - 25 vials with expiration date of 11/1/14 Digoxin 500mg- 3 vials with expiration date of 6/2014 Furosemide 20mg- 25 vials with expiration date of 9/1/14 Adenosine 12mg - 2 vials with expiration date of 1/2015			

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	Diphenhydramine 50mg - 4 vials with expiration date of 11/2013 Magnesium Sulfate 2mg - 25 vials with expiration date of 2/2013 Glycopyrrolate 4mg - 1 vial with expiration date of 1/2014 Dopamine HCl 400mg - 2 vials with expiration date of 1/2013 Xylocaine 2% 20 mg - 10 vials with expiration date of 4/2014 Ventalin HFA Aerosol 90 mcg - 1 with expiration date of 3/2015 Lidocaine HCL 1% - 2 with expiration date of 4/2014 Hespan 500 mg - 2 bags with expiration date of 10/2014 Bacteriostatic H2O 30 ml - 24 vials with expiration date of 1/4/2015 Dantrium 20 mg - 18 vials with expiration date of 2/2013 5. At 1500 hours on 4/7/15, staff member #N4 (Director of Nursing) verified that the above drugs were expired. He/she indicated that there were no other vials of Dantrium at the facility.			

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Q 162 Bldg. 00	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. Based on policy/procedure review, medical record review, and interview, the facility failed to ensure that medical records were complete on 23 (MR#1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 20, 21, 23, 24, 25, 26, 27, 28, 30) of 30 medical records reviewed. Findings include: 1. Review of policy/procedure, NURSING POLICY- INCOMPLETE CHARTS, last reviewed/revised on 10/19/14 by the Board indicated:	O 162	Chart completion check list has been developed. It includes checking all charts each month for signatures completed with in 30 days, path reports, OR reports, OP notes, all orders completed or addressed on pre and post op orders. The director of nursing will complete this check each month. Each quarter the director of nursing and the medical director will check 10% of these charts check for completeness. An outside Medical Records company will also check 10% of charts each quarter for completeness. Their	06/12/2015

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	1. Any chart lacking patient information (O.R. report, tissue report, etc.) shall be considered incomplete. 2. Charts with documentation or signature deficiencies shall also be considered incomplete. 4. A follow-up system shall be maintained to assure that all charts are completed within 30 days. 2. Medical record review indicated: a. MR#1, 11 and 12's Pre General Order Set included an order for Toradol 60 mg PIV. The MR did not indicate that the medication was given. b. MR #3, 4, 8, 11,12 and 21's Operative Notes were not authenticated by the physician. c. MR #5, 6, 7, 9 and 30's did not have evidence of an Operative Note. d. MR # 3, 4, 10, 11, 12, 13, 17, 18, 20, 23, 24, 25, 26, 27 and 28's Operative Notes did not evidence of the date the record was authenticated. e. MR # 5, 7 and 9's did not have evidence of pathology report for tissue specimen. 3. On 4/8/15 at 1300 hours, staff #N4 (Director of Nursing) verified that the above information was missing from the MRs.		results will be kept and both the QA and the Medical Records report will be given to the QA committee quarterly.	

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Q 181 Bldg. 00	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on policy/procedure review, observation and interview, the facility failed to account for all controlled medications in 1 of 2 records. Findings include: 1. Review of policy/procedure, NARCOTIC COUNT, last reviewed/revised on 10/19/14 by the Board indicated: C. All narcotics removed from the cabinet must be signed for at the time of removal. D. The medicine nurse will count the narcotics with a second nurse before leaving the surgery center at the end of her shift. H. All counts are to be recorded on the narcotic count sheet. 2. During observations on 4/7/15 at 1445 hours in the pre/post op unit, the narcotic count for Versed 5mg and 10mg multidose vials were reviewed. The Versed 5mg count was incorrect. The	O 181	On April 8, 2015 the Versed log was corrected by the Director of Nursing and the Medical Director. A Quality Assessment will be maintained by the Director of Nursing. Any problems will be reported immediately to the Medical Director. The Director of Nursing will report the results to the QA committee quarterly. A Medication Error policy has been reviewed and updated.	06/12/2015

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	record indicated that 2 of 10 vials had been used. The count of the Versed indicated that a third vial had been opened and an undetermined amount of the medication was missing. 3. On 4/7/15 at 1445 hours, staff N#4 (Director of Nursing) confirmed that the above Versed 5mg vial had medication missing that was not recorded on the narcotic sign out record.			
Q 182 Bldg. 00	416.48(a)(1) ADMINISTRATION - ADVERSE REACTIONS Adverse reactions must be reported to the physician responsible for the patient and must be documented in the record. Based on document review and interview, the facility failed to have a written policy and procedure on the reporting of adverse reactions and medication errors to the practitioner responsible for the patient in 1 instance. Findings: 1. Review of facility policies and procedure, approved 10-19-2014,	O 182	A Medication Error policy has been reviewed and updated. also the Adverse Reaction policy has bee reviewed and updated. These will be taken to the next Governing Board meeting for review and approval. A Quality Assessment will be maintained by the Director of nursing each month on Medication Errors and Adverse Reactions. The results will be reported to the QA committee quarterly.	06/12/2015

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	indicated there was none which described the reporting of adverse reactions and medication errors to the practitioner responsible for the patient. 3. In interview, on 4-8-2015 at 3:15 pm, employee #A1, Director of Nursing, confirmed the above and no further documentation was provided prior to exit.			
Q 220 Bldg. 00	416.50 NOTICE - POSTING ... The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable. Based on document review and interview, the posted patient rights did not contain 9 of 12 required elements. Findings: 1. Review of a document entitled PATIEN (sic) BILL OF RIGHTS, posted in the facility's reception area, did not contain the following patient rights: The web site of the Office of the Medicare Beneficiary Ombudsman The fact that physician(s) have a financial interest or ownership in the facility	Q 220	The Patient Bill of Rights has been updated to include the web site of the Office of Medicare Beneficiary Ombudsman, that upon request by the patient advance directives from Indiana State Dept. of Health are at the Reception area and the Pre-Post op area. The grievance process including how to file a grievance is available to patients and their representatives. Patients can exercise their rights without being subjected to discrimination or reprisal this includes their representatives. Patient can voice their grievance regarding treatment or care that is or fails to be furnished. If a patient is incompetent under applicable	06/12/2015

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	The facility's policy on advanced directives, and if requested by the patient, the Indiana State Advanced Directive brochure The patient or their representative can avail themselves of the facility's grievance process, including how to file a grievance with the facility Patients can exercise their rights without being subjected to discrimination or reprisal Patients can voice grievances regarding treatment or care that is or fails to be furnished If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. The patient has a right to receive care in a safe setting, including free of		State health and safety laws that the right of the patient may be exercised by the person appointed under the State law to act on the patient's behalf. Or any legal representative designated by the patient in accordance with State law. The patient has a right to receive care in a safe setting including free of contaminated materials and unwanted visitors.The fact that physician(s) have a financial interest or ownership in the facility. This will be posted at the reception desk and a copy will be available upon request. A Quality assessment will be maintained by the Director of Nursing to make sure these are all be observed. The Director of Nursing will report the results to the QA committee quarterly.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	contaminated materials and unwanted visitors The patient has a right to be free from all forms of staff abuse, neglect or harassment 2. In interview, on 4-7-2015 at 3:15 pm, employee #A1,Director of Nursing, confirmed the above and no further documentation was provided prior to exit.			
Q 221 Bldg. 00	416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. Based on document review and interview, the patient rights given to the patient, both written and verbal, did not contain 8 of 12 required elements.	Q 221	The Patient Bill of Rights has been updated to include the web site of the Office of Medicare Beneficiary Ombudsman, that upon request by the patient	06/12/2015

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	Findings: 1. Review of a document entitled PATIEN (sic) BILL OF RIGHTS, given to the patient, both written and verbal, did not contain the following patient rights: The web site of the Office of the Medicare Beneficiary Ombudsman The facility's policy on advanced directives, and if requested by the patient, the Indiana State Advanced Directive brochure The patient or their representative can avail themselves of the facility's grievance process, including how to file a grievance with the facility Patients can exercise their rights without being subjected to discrimination or reprisal Patients can voice grievances regarding treatment or care that is or fails to be furnished If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be		advance directives from Indiana State Dept. of Health are at the Reception area and the Pre-Post op area. The grievance process including how to file a grievance is available to patients and their representatives. Patients can exercise their rights without being subjected to discrimination or reprisal this includes their representatives. Patient can voice their grievance regarding treatment or care that is or fails to be furnished. If a patient is incompetent under applicable State health and safety laws that the right of the patient may be exercised by the person appointed under the State law to act on the patient's behalf. Or any legal representative designated by the patient in accordance with State law. The patient has a right to receive care in a safe setting including free of contaminated materials and unwanted visitors. A Quality assessment will be maintained by the Director of Nursing to make sure these are all be observed. The Director of Nursing will report the results to the QA committee quarterly.	

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	exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. The patient has a right to receive care in a safe setting, including free of contaminated materials and unwanted visitors The patient has a right to be free from all forms of staff abuse, neglect or harassment 2. In interview, on 4-7-2015 at 3:15 pm , employee #A1, Director of Nursing, confirmed the above and no further documentation was provided prior to exit.			
Q 224 Bldg. 00	416.50(c)(1)(2)(3) ADVANCED DIRECTIVES The ASC must comply with the following requirements: (1) Provide the patient or, as appropriate, the patient's representative with written information concerning its policies on			

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	advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms. (2) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. Based on document review and interview, the facility failed to ensure anything written describing its policy on advance directives. Findings: 1. Review of the facility's policies and procedures, approved 10-19-2014, indicated there was nothing describing the facility's policy on advance directives. 2. In interview, on 4-7-2015 at 3:15 pm, employee #A1, Director of Nursing confirmed the above and no other documentation was provided prior to exit.	O 224	The Advance Directive will be available upon request from the patient or the patient's representative from the pre-post op nurse or the Director of Nursing. The patient or the patient's representative of the patient's rights to make informed decisions regarding the patient's care Each patient is ask upon admission to the pre-op area if they have an Advance Directive or living will It is then written in on the Admission sheet if they do or do not have one A Quality Assessment will be maintained by the Director of Nursing monthly to check that each patient is being informed of the Advance Directive and ask if they have an Advance Directive The results will be reported to the QA committee quarterly	06/12/2015
Q 225	416.50(d)(4),(5), & (6) SUBMISSION AND INVESTIGATION OF			

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Bldg. 00	GRIEVANCES The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC. The following criteria must be met: (1) The grievance process must specify timeframes for review of the grievance and the provisions of a response. (2) The ASC, in responding to the grievance, must investigate all grievances made by a patient, the patient's representative, or the patient's surrogate regarding treatment or care that is (or fails to be) furnished. (3) The ASC must document how the grievance was addressed, as well as provide the patient, the patient's representative, or the patient's surrogate with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the result of the grievance process and the date the grievance process was completed. Based on document review and interview, the facility failed to ensure an appropriate written grievance procedure. Findings: 1. Review of the facility's policies and procedures, approved 10-19-2014, indicated there were none which contained the following elements: The grievance process must specify timeframes for review of the grievance	O 225	The Grievance Policy has been reviewed and updated by the Medical Director and the Director of Nursing It will be reviewed for approval by the Governing Board at their next meeting A Quality Assessment will be maintained by the Director of Nursing to follow that this policy is approved and provided if needed The results will be reported to the QA committee quarterly	06/12/2015

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	and the provisions of a response. The facility, in responding to the grievance, must investigate all grievances made by patient, the patient's representative, or the patient's surrogate regarding treatment or care that is (or fails to be) furnished. The facility would document how the grievance was addressed, as well as provide the patient, the patient's representative, or the patient's surrogate with written notice of its decision. The decision must contain the name of a facility contact person, the steps taken to investigate the grievance, the result of the grievance process and the date the grievance process was completed. 2. In interview, on 4-7-2015 at 3:30 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.			

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Q 226 Bldg. 00	416.50(d)(1), (2), & (3) GRIEVANCES - MISTREATMENT, ABUSE .... The following criteria must be met: (1) All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented. (2) All allegations must be immediately reported to a person in authority in the ASC. Only substantiated allegations must be reported to the State authority or the local authority, or both. Based on document review and interview, the facility failed to ensure a grievance policy and procedure that was specific for grievances relating, but not limited to, mistreatment, neglect, verbal, mental or physical abuse. Findings: 1. Review of the facility's policies and procedures, approved 10-19-2014, indicated there was not a grievance policy and procedure as follows for all allegations of violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental or physical abuse: Must be fully documented	Q 226	The Grievance Policy will be updated to include mistreatment, neglect, verbal, mental, sexual or physical abuse will be fully documented All allegations will be immediately reported to the Medical Director Substantiated allegations will be reported to the State authority or the local authority This revised policy will be reviewed for approval by the Governing Board A Quality Assessment will be maintained that this policy is approved and upheld at the surgery center	06/12/2015

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	Must be immediately reported to a person in authority in the facility Only substantiated allegations must be reported to the State authority or the local authority, or both. 2. In interview, on 4-7-2015 at 3:15 pm, employee #A1, Director of Nursing, confirmed the above and no further documentation was provided prior to exit.			
Q 227 Bldg. 00	416.50(e)(1)(i) RESPECT - PROPERTY & PERSON The patient has the right to the following: (i) Be free from any act of discrimination or reprisal. Based on document review and interview, the facility failed to ensure policy and procedure that patients or their representatives may exercise their rights without fear of reprisal. Findings: 1. Review of the facility's policies and procedures, approved 10-19-2014,	Q 227	A policy on Respect of Property and Person will be developed by the Medical Director and the Director of Nursing It will include that the patient of the right to be free from any act of discrimination or reprisal A Quality Assessment will be maintained by the Director of Nursing that this will be approved by the Governing Board The results will be reported to the QA committee quarterly	06/12/2015

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	indicated there were none that patients or their representatives may exercise their rights without fear of reprisal. 2. In interview, on 4-7-2015 at 3:15 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.			
Q 233 Bldg. 00	416.50(f)(3) SAFETY - ABUSE/HARASSMENT [The patient has the right to -] (3) Be free from all forms of abuse or harassment Based on document review and interview, the facility failed to ensure a policy that patients are to be free from all forms of abuse, neglect or harassment while at the facility. Findings: 1. Review of the facility's policies and procedures approved 10-19-2014, indicated there were none that patients are to be free from all forms of abuse, neglect or harassment while at the facility. 2. In interview on 4-7-2015 at 3:15 pm, employee #A1, Director of Nursing,	O 233	A Policy on Safety-Abuse/Harassment will be updated by the Director of Nursing and the Medical Director it will include that the patient will be from all forms of abuse or harassment This will be reviewed for approval by the Governing Board at their next meeting A Quality Assessment will be maintained by the Director of Nursing to ensure these are approved and followed	06/12/2015

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	confirmed the above and no further documentation was provided prior to exit.			
Q 241 Bldg. 00	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on observation, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers in 4 (laundry area, operating suite supply room, operating suite #1, pre/post unit) of 4 instances. Findings: 1. On 4-7-2015 at 1:05 pm in the presence of employee #A1, Director of Nursing, it was observed in the laundry area, there were clean items such as scrub suits, stored on the same side, within 3 feet, of the dirty area. Thus, there was the potential for infection and risk. 2. During observations beginning at 1500 hours on 04/07/15, accompanied by staff N#4 (Director of Nursing), the following expired items were observed in	O 241	All clean items have been removed from the laundry area and moved to closets in the pre-post-op area and the cabinets in the Operating rooms At this time each area that contains supplies are being checked for expired items The Spinal needles, Versaports, endobags, GraNee needles, fixation devices, GIA Devices, Endo Snares, Naso-airways have been removed from the supply area and placed in Rubber Maid containers marked not to be used any other expired items will be placed into rubber maid containers and marked not to use A Quality Assessment will be maintained by the Director of Nursing monthly with the Medical Director doing spot checks at random the results will be reported to the QA committee quarterly	06/12/2015

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	the operating suite supply room: a. Thirty-eight (38) Spinocan Spinal Needles had an expiration date of 05/2006. b. Versaport V2 RT had the following expiration dates: - One (1) expired on 5/12. - One (1) expired on 9/13. - Two (2) expired on 6/10. - One (1) expired on 01/14. - One (1) expired on 8/10. c. Nine (9) Endo bags 10mm had expiration date of 6/12. d. Ten (10) GraNee Needles had expiration date of 10/07. e. Five (5) Disposable Fixation Devices had expiration date of 7/10. f. Six (6) endo Gia Straight Devices had expiration date of 11/12 and six (6) had expiration date of 7/11. g. Two (2) Endo Snares had expiration date of 3/10. 3. During observations beginning at 1545 hours on 04/07/15, accompanied by staff N#4, the following expired items were observed in operating suite #1: a. Naso-airways had the following expiration dates: - One (1) expired on 3/08. - Two (2) expired on 10/13. - Three (3) expired on 10/07. 4. During observations beginning at			

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	1445 hours on 04/07/15, accompanied by staff N#4, the following expired items were observed in the pre/post unit: a. The Contour Meter (blood sugar testing meter) control solution manufacturer expiration date was 10/13.			
Q 242 Bldg. 00	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. Based on personnel file review and interview, the facility failed to ensure that immunization status was completed for 1 (#N1) of 4 staff. Findings include: 1. Review of personnel file for staff #N1 (Operating Room Tech) who had a start date of 7/7/2010, did not have evidence of immunization status. 2. On 4/7/2015 at 1100 hours, staff #N4 (Director of Nursing) confirmed that	O 242	The Medical Director has given the one staff member a requisition for MMR titer since the staff person has had all the other diseases as a child but not a recent MMR The Director of Nursing and the Medical Director will write a new policy on tracking immunizations for new hires This will be reviewed by the Governing Board at their next meeting for approval The Director of Nursing will maintain a Quality Assessment that will tract all employees of their immunization records the results will be reported to the QA	06/12/2015

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	staff #1 lacked documentation of immunization status. He/she also confirmed that the facility lacked a policy for determining the immunization status of new hires.		committee quarterly	
Q 262 Bldg. 00	416.52(a)(2) PRE-SURGICAL ASSESSMENT Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals. Based on document review and interview, the facility failed to ensure a policy to update a medical history and physical (H&P) examination on the date of surgery, if the H&P was done prior to the day of surgery. Findings: 1. Review of a facility document entitled MEDICAL STAFF RULES, written but unapproved, indicated all members of the medical staff should provide the Surgery	O 262	A policy has been written by the Director of Nursing and the Medical Director for physicians to update the H&P examination that was done prior to the date of surgery This will include the physician to include anything new and to sign, date and time the update This policy will be reviewed and approved by the Governing Board at their next meeting The Director of Nursing will maintain a QA to ensure that the physicians are following this policy it will be done monthly the	06/12/2015

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	Center with a complete history and physical at least 24 hours prior to the patient's scheduled surgery. Further review of the document indicated there was no policy and procedure to update an H&P examination on the date of surgery, if the H&P was done prior to the day of surgery. 2. In interview, on 4-8-2015 at 3:30 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.		results will be reported to the QA committee quarterly	
S 000 Bldg. 00	This visit was for a State licensure survey. Facility Number: 003073 Survey Date: 4-06/08-2015 QA: cjl 04/27/15	S 000		
S 110	410 IAC 15-2.4-1			

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Bldg. 00	GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5) The governing body shall do the following: (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. Based on document review and interview, the facility's governing board failed to review reports of the quality assessment and performance improvement (QAPI) program for directly provided nursing services. Findings: 1. Review of the governing board minutes of year 2014 indicated the governing board met on February 12, April 9, August 13, and December 10. The governing board did not review at any of the meetings, QAPI activities for the directly provided nursing services. 2. In interview, on 4-8-2015 at 2:30 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.	S 110	All Quality Assessment including Nursing will be reported to the governing board at each quarterly meeting. A new form to be followed at each meeting has been developed and will be reviewed at the next Governing board meeting for approval. The Quality Assessment report will be done at the beginning of the meeting. The Medical Director and the Director of Nursing will maintain a QA quarterly to make sure it is being maintained.	06/12/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 153 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on personnel file review and interview, the facility failed to ensure new hire orientation for 1 (#N1) of 4 staff. Findings include: 1. Review of personnel file for staff #N1 (Operating Room Tech) who had a start date of 7/7/2010, did not have evidence of new hire orientation. 2. On 4/7/2015 at 1100 hours, staff #N4 (Director of Nursing) confirmed that staff #N1 lacked documentation of new hire orientation.	S 153	The Medical Director and the Director of Nursing will be in charge of orientation for new hires. The Director of Nursing will place all orientation check list and job description in the new hires personnel file. The Infection Control Nurse now has a job description for Infection Control in their personnel file. A Quality Assessment will be maintained monthly by the Director of Nursing to make sure all personnel files are up to date new hires.	06/12/2015

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S 156 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E) Require that the chief executive officer develop and implement policies and programs for the following: (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. Based on personnel file review and interview, the facility failed to provide a job description for the Infection Control Nurse. Findings include: 1. Review of personnel file for staff N#4 (Director of Nursing/ Infection Control Nurse) failed to include a job description for his/her role as the Infection Control Nurse. 2. On 4/8/15 at 1330 hours, staff N#4 verified that the facility did not have a job description for the Infection Control Nurse role.	S 156	The Director of Nursing has placed the job description of Infection Control Nurse in the Infection Control nurse's personnel file.The Director of Nursing will maintain a Quality Assessment to make sure that all job descriptions will be in the proper personnel files.The results of the QA will be reported to the QA committee quarterly.	06/12/2015

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S 162 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G) Require that the chief executive officer develop and implement policies and programs for the following: (G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care. Based on policy/procedure review, personnel file review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice for 5 of 7 physician credential files reviewed (MD#2, endoscopy physician, MD#4, obstetric/gynecological physician, MD#5, endoscopy physician, MD#6, ear, nose and throat physician, and MD#7, surgeon) and for 1 of 4 nursing staff (#N1). Findings: 1. Review of policy/procedure, CPR, last reviewed/revised on 10/19/14 by the Board indicated the following: All medical personnel employed by the Surgery Center must possess current	S 162	All employed personnel for South Central Surgery Center, completed their CPR on 4/18/2015. All certificates were placed in the appropriate personnel file. The physicians requiring CPR their offices have been notified to send us their most current CPR certificate and to please send a new one when they have recertified. The Director of Nursing has ask for these to be sent to South Central Surgery Center by June 12, 2015.The Director of Nursing will develop a QA to monitor all certificates for CPR for staff and physicians quarterly. Results will be reported to the QA committee quarterly.	06/12/2015

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	HCLS/CPR Certification as approved by the American Heart Association or by the American Red Cross. 2. Review of 7 physician credential files indicated files MD#2, endoscopy physician, MD#4, Obstetric/gynecological physician, MD, MD#6, ear, nose and throat physician, and MD#7, surgeon, did not have any documentation of CPR competence in accordance with current standards of practice. Review of file MD#5, endoscopy physician, had CPR documentation of competence with an expiration date of November, 2004. 3. On 4-8-2015 at 1:20 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit. 4. Review of personnel file for staff #N1 (Operating Room Tech) who had a start date of 7/7/2010, did not have evidence of CPR certification. 5. On 4/7/2015 at 1100 hours, staff #A1confirmed that staff #N1 lacked documentation of CPR certification.			
S 172 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES			

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	410 IAC 15-2.4-1 (c)(5) (L) Require that the chief executive officer develop and implement policies and programs for the following: (L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable. Based on policy/procedure review, personnel file review and interview, the facility failed to ensure that immunization status was completed for 1 (#N1) of 4 staff. Findings include: 1. Review of personnel file for staff #N1 (Operating Room Tech) who had a start date of 7/7/2010, did not have evidence of immunization status. 2. On 4/7/2015 at 1100 hours, staff #N4 (Director of Nursing) confirmed that staff #N1 (Operating Room Tech) lacked documentation of immunization status. He/she also confirmed that the facility lacked a policy for determining the immunization status of new hires.	S 172	the Medical Director has given the one staff member a requisition for MMR titer since the staff person has had all the other diseases as a child but not a recent MMR The Director of Nursing and the Medical Director will write a new policy on tracking immunizations for new hires This will be reviewed by the Governing Board at their next meeting for approval The Director of Nursing will maintain a Quality Assessment that will tract all employees of their immunization records the results will be reported to the QA committee quarterly	06/12/2015

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S 310 Bldg. 00	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include a monitor and standard for 2 directly-provided services (housekeeping and nursing), in its quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the directly-provided services of housekeeping and nursing. 3. In interview, on 4-8-2015 at 2:30 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.	S 310	Nursing Quality Assessment to be followed this year will be Hand washing It will be maintained monthly by the Director of Nursing and results will be reported quarterly to the QA committee. Hand washing all staff involved with patient care will wash their hands before, after and between patients. The use of hand sanitizer will be allowed. Housekeeping Quality Assessment I have included two of the QA's that the QA committee has developed. There will be a detailed QA for all areas that are in the surgery center. These will be maintained by the Director of Nursing monthly and results will be reported to the QA committee quarterly.	06/12/2015

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S 400 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers in 4 instances (laundry area, operating suite supply room, operating suite #1, pre/post unit). Findings: 1. On 4-7-2015 at 1:05 pm in the presence of employee #A1, Director of Nursing, it was observed in the laundry area there were clean items such as scrub suits, stored on the same side, within 3 feet, of the dirty area. Thus, there was the potential for infection and risk. 2. During observations beginning at 1500 hours on 04/07/15, accompanied by staff N#4 (Director of Nursing), the following expired items were observed in the operating suite supply room: a. Thirty-eight (38) Spinocan Spinal Needles had an expiration date of	S 400	All clean items have been removed from the laundry area and moved to closets in the pre-post-op area and the cabinets in the Operating rooms At this time each area that contains supplies are being checked for expired items The Spinal needles, Versaports, endobags, GraNee needles, fixation devices, GIA Devices, Endo Snares, Naso-airways have been removed from the supply area and placed in Rubber Maid containers marked not to be used any other expired items will be placed into rubber maid containers and marked not to use A Quality Assessment will be maintained by the Director of Nursing monthly with the Medical Director doing spot checks at random the results will be reported to the QA committee quarterly	06/12/2015

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	05/2006. b. Versaport V2 RT had the following expiration dates: - One (1) expired on 5/12. - One (1) expired on 9/13. - Two (2) expired on 6/10. - One (1) expired on 01/14. - One (1) expired on 8/10. c. Nine (9) Endo bags 10mm had expiration date of 6/12. d. Ten (10) GraNee Needles had expiration date of 10/07. e. Five (5) Disposable Fixation Devices had expiration date of 7/10. f. Six (6) endo Gia Straight Devices had expiration date of 11/12 and six (6) had expiration date of 7/11. g. Two (2) Endo Snares had expiration date of 3/10. 3. During observations beginning at 1545 hours on 04/07/15, accompanied by staff N#4, the following expired items were observed in operating suite #1: a. Naso-airways had the following expiration dates; - One (1) expired on 3/08. - Two (2) expired on 10/13. - Three (3) expired on 10/07. 4. During observations beginning at 1445 hours on 04/07/15, accompanied by staff N#4, the following expired items were observed in the pre/post unit:			

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	a. The Contour Meter (blood sugar testing meter) control solution manufacturer expiration date was 10/13.			
S 422 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C) The infection control committee responsibilities must include, but are not limited to: (C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk. Based on administrative document review and interview, the Infection Control Committee failed to monitor employee health exposures. Findings include: 1. Review of the Infection Control Committee meeting minutes for 04/28/14 through 12/17/14 failed to show monitoring of employee health exposures for the facility. 2. On 04/08/15 at 1300 hours, staff N#4 (Director of Nursing), verified that the Infection Control Meeting Minutes did not have evidence that employee	S 422	The Director of Nursing and the QA committee will develop a Quality Assessment to monitor employee exposure to any harm situations.The Director of Nursing will maintain this QA monthly and report the results to the QA committee quarterly.	06/12/2015

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	exposures were monitored.			
S 434 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iv) The infection control committee responsibilities must include, but are not limited to: (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: (iv) Aseptic technique, invasive procedures, and equipment usage. Based on administrative document review and interview, the Infection Control Committee failed to develop a policy/procedure for aseptic technique. Findings include: 1. Review of policy/procedures for the facility failed to show evidence of a policy/procedure for aseptic technique. 2. On 04/08/15 at 1300 hours, staff N#4 (Director of Nursing), verified that the facility did not have evidence of a policy/procedure for aseptic technique.	S 434	The Director of Nursing will develop a Quality Assessment to monitor Aseptic technique of the staff and the physicians. Annual training will also be done for Aseptic Technique.The Director of Nursing will maintain this QA monthly and results will be reported to the QA committee quarterly.	06/12/2015
S 436	410 IAC 15-2.5-1			

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Bldg. 00	INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(v) The infection control committee responsibilities must include, but are not limited to: (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: (v) Reuse of disposables. Based on administrative document review and interview, the Infection Control Committee failed to develop a policy/procedure for reuse of disposables. Findings include: 1. Review of policy/procedures for the facility failed to show evidence of a policy/procedure for reuse of disposables. 2. On 04/08/15 at 1300 hours, staff N#4 (Director of Nursing), verified that the facility did not have evidence of a policy/procedure for reuse of disposables.	S 436	The Director of Nursing and the Medical Director are developing a new policy for reuse of disposables. At this time we do not reuse disposables. The Director of Nursing along with the QA committee will develop a Quality Assessment to follow the reuse of disposables. This will be maintained by the Director of Nursing monthly and results will be reported to the QA committee quarterly.	06/12/2015
S 622 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(6) An adequate medical record must be maintained with documentation of			

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	service rendered for each patient of the center as follows: (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. Based on document review and interview, the facility failed to have documentation of a log or index that included diagnosis, procedure, and condition on discharge. Findings: 1. Review of a document entitled Standard Surgery Schedule 4 (DOB), Surgery Date: 3/21/14 (Friday), indicated it did not include diagnosis and condition on discharge. 2. In interview, on 11-14-8-2015 at 1:05 pm, employee #A1, Director of Nursing, confirmed the above and no further documentation was provided by exit.	S 622	The Director Nursing and the Scheduling Secretary are developing a log on the computer that will include the patient's name, date of surgery, diagnosis, procedure, physician, and condition on discharge. The Director of Nursing will maintain a QA to make sure this is being done on a monthly basis. The results will be reported to the QA committee quarterly.	06/12/2015
S 640 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)			

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	(e) All entries in the medical record must be as follows: (1) Legible and complete. Based on policy/procedure review, medical record review, and interview, the facility failed to ensure that medical records were complete on 23 (MR#1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 20, 21, 23, 24, 25, 26, 27, 28, 30) of 30 medical records reviewed. Findings include: 1. Review of policy/procedure, NURSING POLICY- INCOMPLETE CHARTS, last reviewed/revised on 10/19/14 by the Board indicated: 1. Any chart lacking patient information (O.R. report, tissue report, etc.) shall be considered incomplete. 2. Charts with documentation or signature deficiencies shall also be considered incomplete. 4. A follow-up system shall be maintained to assure that all charts are completed within 30 days. 2. Medical record review indicated: a. MR#1, 11 and 12's Pre General Order Set included an order for Toradol 60 mg PIV. The MR did not indicate that the medication was given. b. MR #3, 4, 8, 11,12 and 21's Operative Notes were not authenticated	S 640	Chart completion check list has been developed. It includes checking all charts each month for signatures completed with in 30 days, path reports, OR reports, OP notes, all orders completed or addressed on pre and post op orders. The director of nursing will complete this check each month. Each quarter the director of nursing and the medical director will check 10% of these charts check for completeness. An outside Medical Records company will also check 10% of charts each quarter for completeness. Their results will be kept and both the QA and the Medical Records report will be given to the QA committee quarterly.	06/12/2015

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	by the physician. c. MR #5, 6, 7, 9 and 30's did not have evidence of an Operative Note. d. MR # 3, 4, 10, 11, 12, 13, 17, 18, 20, 23, 24, 25, 26, 27 and 28's Operative Notes did not evidence of the date the record was authenticated. e. MR # 5, 7 and 9's did not have evidence of pathology report for tissue specimen. 3. On 4/8/15 at 1300 hours, staff #N4 (Director of Nursing) verified that the above information was missing from the MRs.			
S 710 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4) The medical staff shall do the following: (4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following: (A) A completed, signed application.			

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	(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A current copy of the individual's: (i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board. (ii) Indiana controlled substance registration showing number as applicable. (iii) Drug Enforcement Agency registration showing number as applicable. (iv) Documentation of experience in the practice of medicine. (v) Documentation of specialty board certification as applicable. (vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C). (D) Category of medical staff appointment and delineation of privileges approved. (E) A signed statement to abide by			

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	the rules of the center. (F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements. (G) Other items specified by the center and medical staff. Based on document review and interview, the facility failed to include in 1 of 7 physician credential files reviewed (MD#4, obstetric/gynecologic physician), a signed statement by the physician to abide by the rules of the facility. Findings: 1. Review of 7 physician credential files indicated file MD#7, obstetric/gynecologic physician, did not have a signed statement by the physician to abide by the rules of the facility. 2. In interview, on 4-8-2015 at 1:20 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.	S 710	The Medical Director and the Director of Nursing have sent a copy of the statement to be signed by the physician that they will abide by the rules of the facility.The Director of Nursing will maintain a QA that will check the physicians files to ensure that all files are complete. A report with the results wiil be given to QA committee quarterly.	06/12/2015
S 732 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2) These bylaws			

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	and rules must be as follows: (2) Be reviewed at least triennially. Based on document review and interview, the medical staff did not review the medical staff rules at least once every three (3) years. Findings: 1. Review of the medical staff bylaws and rules indicated there was no documentation of them having been reviewed by the medical staff within the past three (3) years. 2. In interview, on 4-8-2015 at 1:00 pm, employee #A1, Director of Nursing, indicated there was no documentation of the medical staff having reviewed the medical staff bylaws and rules within the past three (3) years and no other documentation was provided prior to exit.	S 732	The Medical Director and the Director of Nursing will present the medical staff by-laws to the Medical Staff and the Governing Board at their next meeting for review and approval.These were included in the Policy and Procedure Book when it was approved by the Medical Staff and the Governing Board on October 19, 2014 meeting.The Director of Nursing will maintain a Quality Assessment to ensure all policies and procedures and the medical staff by laws are reviewed and approved by the appropriate committees at the appropriate times.	06/12/2015
S 772 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M) These bylaws and rules must be as follows: (3) Include, at a minimum, the following:			

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	(M) A requirement that a medical history and physical examination be performed as follows: (i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed. (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. (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. Based on document review and interview, the medical staff failed to include in its policies a requirement, if the history and physical was completed prior to the day of surgery, there would be an update and changes noted in the record. Findings: 1. Review of a document entitled SUBJECT: MEDICAL STAFF RULES, indicated all members of the medical staff should provide the Surgery Center with a complete history and physical at	S 772	policy has been written by the Director of Nursing and the Medical Director for physicians to update the H&P examination that was done prior to the date of surgery This will include the physician to include anything new and to sign, date and time the update This policy will be reviewed and approved by the Governing Board at their next meeting The Director of Nursing will maintain a QA to ensure that the physicians are following this policy it will be done monthly the results will be reported to the QA committee quarterly	06/12/2015

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	least 24 hours prior to the patient's scheduled surgery, but did not indicate there would be an update on the day of surgery. 2. In interview, on 4-8-2015 at 3:30 pm, employee #A1, Director of Nursing confirmed the above and no further documentation was provided prior to exit.			
S 826 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E) The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following: (E) Safety training required of personnel. Based on document review and interview, the facility failed to provide documentation of safety training in areas where anesthetics are used for 7 of 7 medical staff credential files reviewed (MD#1, orthopedic surgeon, MD#2, endoscopy physician, MD#3, anesthesiologist, MD#4, obstetric/gynecology physician, MD#5, endoscopy physician, MD#6, ear, nose and throat physician,	S 826	The Medical Director and the Director of Nursing will hold a training session for all physicians that have privileges at South Central Surgery Center on Anesthetics safety A participation signed by the physician will be placed in their file. Any new physicians will also go thru this training.The Director of Nursing will develop a Quality Assessment on all physicians receiving this safety training. It will be monitored monthly and quarterly results will	06/12/2015

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	and MD#7, surgeon). Findings: 1. Review of 7 medical staff credential files indicated files MD#1, orthopedic surgeon, MD#2, endoscopy physician, MD#3, anesthesiologist, MD#4, obstetric/gynecology physician, MD#5, endoscopy physician, MD#6, ear, nose and throat physician, and MD#7, surgeon, did not contain any documentation of safety training in areas where anesthetics are used. 2. In interview, on 4-8-2015 at 1:20 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.		be reported to the QA committtee.	
S 884 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(E) Requirement for surgical services include: (2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical			

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	and patient care as follows: (E) A requirement that the patient register is complete and up to date. Based on interview, the facility failed to have a policy that the patient register is to be complete and up to date. Findings: 1. Review of facility documents indicated there was not a policy that the patient register is to be complete and up to date. 2. In interview, on 4-8-2015 at 3:20 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.	S 884	The Director of Nursing and the Medical Director will write a policy requiring the patient register is complete and up to date. For each patient admitted to the surgery center.The Director of Nursing will develop a Quality Assessment along with the QA committee to make sure this is being completed. The QA will be done monthly on all patients that month. The results will be reported to the QA committee quarterly.	06/12/2015
S 006 Bldg. 00	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(2) Pharmaceutical services must have the following: (2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed. Based on policy/procedure review, observation and interview, the facility failed to account for all controlled	S 006	On April 8, 2015 the Versed log was corrected by the Director of Nursing and the Medical Director. A Quality Assessment will be	06/12/2015

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	medications in 1 of 2 records. Findings include: 1. Review of policy/procedure, NARCOTIC COUNT, last reviewed/revised on 10/19/14 by the Board indicated: C. All narcotics removed from the cabinet must be signed for at the time of removal. D. The medicine nurse will count the narcotics with a second nurse before leaving the surgery center at the end of her shift. H. All counts are to be recorded on the narcotic count sheet. 2. During observations on 4/7/15 at 1445 hours in the pre/post op unit, the narcotic count for Versed 5mg and 10mg multidose vials were reviewed. The Versed 5mg count was incorrect. The record indicated that 2 of 10 vials had been used. The count indicated that a third vial had been opened and an undetermined amount of the medication was missing. 3. On 4/7/15 at 1445 hours, staff N#4 confirmed that the above Versed 5mg vial had medication missing that was not recorded on the narcotic sign out record.		maintained by the Director of Nursing. Any problems will be reported immediately to the Medical Director. The Director of Nursing will report the results to the QA committee quarterly. A Medication Error policy has been reviewed and updated.	

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S 020 Bldg. 00	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(D) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (D) Reporting of adverse reactions and medication errors to the practitioner responsible for the patient and the appropriate committee, and documented in the patient's record. Based on document review and interview, the facility failed to have a written policy and procedure on the reporting of adverse reactions and medication errors to the practitioner responsible for the patient. Findings: 1. Review of facility policies and procedure, approved 10-19-2014, indicated there were none which described the reporting of adverse reactions and medication errors to the practitioner responsible for the patient.	S 020	Adverse Reaction policy has bee reviewed and updated. These will be taken to the next Governing Board meeting for review and approval. A Quality Assessment will be maintained by the Director of nursing each month on Medication Errors and Adverse Reactions. The results will be reported to the QA committee quarterly.	06/12/2015

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	3. In interview, on 4-8-2015 at 3:15 pm, employee #A1, Director of Nursing, confirmed the above and no further documentation was provided prior to exit.			
S 044 Bldg. 00	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(5) Pharmaceutical services must have the following: (5) A list of available emergency drugs. Based on policy/procedure review, administrative document review, medical record review, observation and interview, the facility failed to have available emergency drugs for malignant hyperthermia and resuscitation in 1 of 1 emergency carts. Findings include: 1. Review of the policy/procedure, "Malignant Hyperthermia", last approved 10/19/14 by the Board, indicated: 1. Dantrium will be stored in the crash cart. 2. All other emergency drugs for treating malignant hyperthermia is in the crash cart.	S 044	36 vials of Dantrium has been ordered. Expired Aminophylline 10mg-25 vials has been replaced, Digoxin 500mg-3 vials has been replaced, Furosemide 20mg-25vials has been replaced, Adenosine 12mg-2 vials has been replaced, Diphenhydramine 50mg-4 vials has been replaced, Magnesium Sulfate 2mg-25vials have been replaced, Glycopyrrolate 4mg-1 vial has been replaced, Xylocaine 2% 20mg-10 vials has been replaced, Ventalin HFA Aerosol 90mcg-1 has been replaced, Hespan 500mg-2 bags has been replaced, Bacteriostatic H2O 30ml-24 vials has been replaced. Dopamine HC-2 vials backordered with estimated arrival date August 18, 2015, Lidocaine HCL 1%-2 backordered	06/12/2015

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	Review of the policy/procedure, "Crash Cart Content", last approved 10/19/14 by the Board, indicated: Policy: The crash cart shall be stocked with the supplies and medications as determined by the medical staff that may be required in the event of a Code. 2. The contents of the cart shall be inspected/checked monthly or after each use. Review of the policy/procedure, "Emergency Equipment", last approved 10/19/14 by the Board, indicated: The emergency cart is to be checked monthly for expired drugs and supplies. 2. Review of the "Defib Testing" log for 6/2/14 to 3/31/15 indicated that the contents of the cart was checked once a month. Review of the "Pharmacy Supplies Quarterly Inspection Checklist" indicated that the crash cart was checked for expiration of drugs. 3. Patients # 1, 2, 3, 4, 6, 8, 10, 12, 13, 17 and 20's medical records (MR) were reviewed and indicated that each had general anesthesia and received Sevoflorane, an anesthesia agent that is a known trigger for malignant hyperthermia, which is treated with the drug Dantrium.		with estimated arrival date June 11, 2015. Outdated medication check list for medications and all supplies of the emergency code cart has been updated. This will be checked monthly by the Director of Nursing. The medical director will maintain a monthly QA and report the results to the QA committee quarterly.	

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	4. At 1445 hours on 4/7/15, the following expired drugs were observed in the crash cart in Pre/Post Op Unit in the presence of staff #N4 (Director of Nursing): Aminophylline 10mg - 25 vials with expiration date of 11/1/14 Digoxin 500mg- 3 vials with expiration date of 6/2014 Furosemide 20mg- 25 vials with expiration date of 9/1/14 Adenosine 12mg - 2 vials with expiration date of 1/2015 Diphenhydramine 50mg - 4 vials with expiration date of 11/2013 Magnesium Sulfate 2mg - 25 vials with expiration date of 2/2013 Glycopyrrolate 4mg - 1 vial with expiration date of 1/2014 Dopamine HCl 400mg - 2 vials with expiration date of 1/2013 Xylocaine 2% 20 mg - 10 vials with expiration date of 4/2014 Ventalin HFA Aerosol 90 mcg - 1 with expiration date of 3/2015 Lidocaine HCL 1% - 2 with expiration date of 4/2014 Hespan 500 mg - 2 bags with expiration date of 10/2014 Bacteriostatic H2O 30 ml - 24 vials with expiration date of 1/4/2015 Dantrium 20 mg - 18 vials with expiration date of 2/2013			

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	5. At 1500 hours on 4/7/15, staff member #N4 (Director of Nursing) verified that the above drugs were expired. He/she indicated that there were no other vials of Dantrium at the facility.			
S 166 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii) (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: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and reqularly serviced and maintained as follows: (ii) There must be evidence of preventive maintenance on all patient care equipment. Based on interview, the facility failed to provide evidence of preventive	S 166	PM on wheelchair. Spoke with our biomedical company. They	06/12/2015

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	maintenance (PM) on 1 (wheelchair) of 12 pieces of patient care equipment. Findings: 1. Review of the facility's PM reports indicated there was no documentation of PM for a wheelchair. 2. In interview, on 4-8-2015 at 2:05 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.		will include the wheelchairs in the PM checks. A QA will be maintained by the Director of Nursing and results will be reported to the QA committee quarterly.	
S 170 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv) (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: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a			

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	discharge log with initialed entries must be maintained. Based on document review and interview, it could not be determined the facility performed defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator. Findings: 1. Review of the manufacturer's manual for the Code Master XL+ defibrillator, indicated to regularly perform a test routine incorporating the following checks along with visual inspection of all cables, paddles, and controls. Further review indicated there were to be multiple items checked under the headings of Every Shift, Every Day, Delivered Energy and Shock Button Functional Test, and Quick Pacer Functionality Test. 2. Review of a document entitled DEFIB TESTING, dated Feb 2014, indicated DAILY and WEEKLY but the document did not define which activities were done daily and weekly. Thus, it could not be determined the activities performed were according to the manufacturer's specifications. 3. In interview, on 4-8-2015 at 3:00 pm, employee #A1, Director of Nursing,	S 170	The defib testing sheet has been updated to include inspection of cables, paddles,and controls. It includes date and time, delivered energy, shock button functional, and Quick Pacer Functionality Test. Also weekly cleaning. A QA has been developed and will be maintained by the Director of Nursing on a monthly basis with results being reported quarterly to the QA committee.	06/12/2015

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH CENTRAL SURGERY CENTER LLC	5002 E SR 44 FRANKLIN, IN 46131

(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
	confirmed the above and no further documentation was provided prior to exit.			
S 220 Bldg. 00	410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAc 15-2.5-8(d) (d) Written policies and procedures must be developed, implemented, and maintained and made available to personnel. Based on interview, the facility did not have written radiological policies and procedures for its radiology services in 1 instance. Findings: 1. On 4-6-2015 at 9:30 am, employee #A1, Director of Nursing, was requested to provided documentation of written radiological policies and procedures for its radiology services. 2. In interview, on 4-8-2015 at 12:45 pm, employee #A1 indicated there were no above-requested policies and no other documentation was provided prior to exit.	S 220	A radiology policy has been developed by the Director of Nursing and the Medical Director. It will be reviewed by the Governing board for approval at the next meeting. A Quality assessment will be developed and maintained by the Director of Nursing that will cover all areas of the policy are being followed. Results will be reported to the QA committee quarterly.	06/12/2015