

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2016
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NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882
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Q 0000 Bldg. 00	<p>This visit was for the recertification of an ambulatory surgery center.</p> <p>Dates of survey: 2/1/16 to 2/2/16</p> <p>Facility number: 003633</p> <p>QA: cjl 03/02/16</p>	Q 0000		
Q 0081 Bldg. 00	<p>416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES</p> <p>(a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.</p> <p>(a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC.</p> <p>(c)(1) The ASC must set priorities for its performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>(ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care.</p> <p>Based on document review and interview, the Quality Assurance and Performance Improvement (QAPI) program failed to measure and analyze quality indicators for 11 service and function monitors (Biomedical engineering, biohazardous waste, housekeeping, laboratory, pharmacy, discharge, transfer, infection control, medication errors, response to patient emergencies and reportable events).</p> <p>Findings:</p> <p>1. Review of the policy titled Quality Assessment and Improvement indicated the following: Principles: 4. It is impossible to know how we are doing without measurements. Program Components: 2. Measurement: Planned and systematic measurement and assessment of key processes and functions are the basis for the performance improvement program. 3. Assessment: Evaluation of measurements should consider use of objective criteria...The policy was reviewed/approved 6/10/15.</p> <p>2. Review of 2015 quality monitoring documents and reports lacked</p>	O 0081	<p>1 QA's have been implemented on Biomedical Engineering, Biohazardous Waste, Housekeeping, Laboratory, Pharmacy, Discharges, Transfers, Infection Control, Medication Errors, Patient Emergencies, and Reportable Events There will be units of measurement included in each of the QA's 2 Education provided in QA for RN 3 Theresa Gilbert, RN 4 3/07/16</p>	03/07/2016

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Q 0082 Bldg. 00	<p>documentation of a measurable standard or evaluation of outcomes for the following: Biomedical engineering, biohazardous waste, housekeeping, laboratory, pharmacy, discharge, transfer, infection control, medication errors, response to patient emergencies and reportable events.</p> <p>3. On 2/2/16 at 11:30am, A1, RN (registered nurse), indicated the quality committee had not implemented measurable standards or done evaluations of the following: Biomedical engineering, biohazardous waste, housekeeping, laboratory, pharmacy, discharge, transfer, infection control, medication errors, response to patient emergencies and reportable events.</p> <p>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</p>			

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	<p>to improvements and changes in its patient care.</p> <p>(c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.</p> <p>(c)(3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies. Based on document review and interview, the Quality Assurance and Performance Improvement (QAPI) program failed to monitor the effectiveness of services by analysis of performance for 12 service and function monitors (Biomedical engineering, biohazardous waste, housekeeping, laboratory, laundry/linen, nursing, discharge, transfer, infection control, medication errors, response to patient emergencies and reportable events).</p> <p>Findings:</p> <p>1. Review of the policy titled Quality Assessment and Improvement indicated the following: Principles: 4. It is impossible to know how we are doing without measurements. Program Components: 2. Measurement: Planned and systematic measurement and assessment of key processes and</p>	O 0082	<p>1 Effectiveness of Services and Performance Analysis will be monitored by Quality Committee</p> <p>2 Quality Committee will meet quarterly</p> <p>3 C Lim Administrator</p> <p>4 3/07/16</p>	03/07/2016

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Q 0083	<p>functions are the basis for the performance improvement program. 3. Assessment: Evaluation of measurements should consider use of objective criteria...The policy was reviewed/approved 6/10/15.</p> <p>2. Review of 2015 quality monitoring documents and reports lacked documentation of evaluation of outcomes for the following: Biomedical engineering, biohazardous waste, housekeeping, laboratory, laundry/linen, nursing, discharge, transfer, infection control, medication errors, response to patient emergencies and reportable events.</p> <p>3. On 2/2/16 at 11:30am, A1, RN (registered nurse), indicated the quality committee had not conducted evaluations of the following monitors: Biomedical engineering, biohazardous waste, housekeeping, laboratory, laundry/linen, nursing, discharge, transfer, infection control, medication errors, response to patient emergencies and reportable events.</p>			

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Bldg. 00	<p>PERFORMANCE IMPROVEMENT PROJECTS</p> <p>(1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.</p> <p>(2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results Based on document review and interview, the center failed to undertake one or more specific quality improvement projects in 2015.</p> <p>Findings:</p> <p>1. Review of the policy titled Performance Improvement Plan indicated the following: All performance improvement projects should be documented...Review of the attached document titled Performance Improvement Plan lacked documentation of plan to conduct a quality improvement project. The policy was reviewed/approved 6/10/15.</p> <p>2. Review of 2015 Quality monitors and reports and minute documents titled Medical Staff Meeting dated 3/13/15, 6/9/15, 9/8/15 and 12/23/15 indicated lack of documentation of the Center having undertaken any improvement</p>	O 0083	<p>1 Project for QA has been implemented on Infection Control and shall include measurements, program components, and an assessment. Evaluation of measurements should consider objective criteria 2 RN will work on ongoing QA project on Infection Control throughout the year and document measurements, program components and an assessment 3 Theresa Gilbert, RN 4 3/07/16</p>	03/07/2016	

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Q 0100 Bldg. 00	<p>project within the past year</p> <p>3. On 2/2/16 at 11:30am, A1, RN (registered nurse)/Acting Administrator, indicated the Quality Committee did not have a quality improvement project within the past year.</p> <p>416.44 ENVIRONMENT The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. Based on Life Safety Code (LSC) survey, Sullivan Surgicenter LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 20, New Ambulatory Health Care Occupancies.</p> <p>This three story facility was determined to be of Type I (332) construction and partially sprinklered. The facility has a fire alarm system with smoke detection in corridors and hazardous areas. Sprinklers were located in the laundry, maintenance shop, and rooms 101 and 309.</p>	O 0100	<p>1 Koorsen Fire & Safety has been contacted to perform quarterly testing of sprinkler system and a five year internal pipe inspection The State Fire Marshall has also been contacted on information on the steps necessary to remove the system System will be tested and inspected until removed 2 We will contact Koorsen when services are due and they will send a technician 3 C Lim, MD Administrator 4 3/07/16</p>	03/07/2016			

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Q 0104 Bldg. 00	<p>Based on LSC survey and deficiencies found (see CMS 2567L), it was determined that the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 3 of 4 quarters and failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years (see K 130).</p> <p>The cumulative effect of these systemic problems resulted in the facility's inability to ensure that all locations from which it provides services are constricted, arranged and maintained to ensure the provision of quality health care in a safe environment.</p> <p>416.44(b) SAFETY FROM FIRE (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center,</p>			

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	<p>7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to http://www.archives.gov/federalregister/code_of_federal-regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.</p> <p>(2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.</p> <p>(3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.</p> <p>(4) An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006.</p> <p>(5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if:</p> <p>(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;</p> <p>(ii) The dispensers are installed in a</p>			

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	<p>manner that minimizes leaks and spills that could lead to falls;</p> <p>(iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and</p> <p>(iv) The dispensers are installed in accordance with the following provisions:</p> <p>(A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m);</p> <p>(B) The maximum individual dispenser fluid capacity shall be:</p> <p>(1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms</p> <p>(C) The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other;</p> <p>(D) Not more than an aggregate of 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet;</p> <p>(E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code;</p> <p>(F) The dispensers shall not be installed over or directly adjacent to an ignition source;</p> <p>(G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments; and</p> <p>(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.</p> <p>Based on document review and interview, the facility failed to ensure</p>	O 0104	1 Quarterly testing and 5 year pipe inspection have been arranged with Koorsen Fire &	03/07/2016	

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	<p>sprinkler waterflow alarm devices were tested quarterly for 3 of 4 quarters, failed to ensure 1 of 1 automatic sprinkler system was continuously maintained in reliable operating condition and failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the sprinkler system inspection reports on 02/08/16 at 11:20 a.m. with the Director of Nursing (D.O.N.), S1, indicated the only sprinkler system inspection report available during the past twelve months was dated 08/28/15 for the third quarter (July, August and September) of 2015. 2. In interview at the time of record review, the D.O.N. said the sprinkler system was inspected only once per year and confirmed there were no quarterly inspection reports for the sprinkler system performed during the first quarter (January, February and March), second quarter (April, May and June) and fourth quarter (October, November and December) of 2015. 3. Review of the facility's annual sprinkler system inspection on 02/08/16 at 11:25 a.m. with the D.O.N. indicated the 08/28/15 inspection report stated 		<p>Safety 2 We will monitor the inspections and schedule when due date is approaching 3 C Lim MD Administrator 4 3/07/16</p>		

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	<p>"Sprinklers are dated 1958 and should be replaced due to being over 50 years. No smooth bore on inspectors outlet. Customer does not want quote, stated he would take care of deficiencies on his own". There was no supporting documentation to show these items have been corrected.</p> <p>4. The above was acknowledged by the D.O.N. at the time of record review.</p> <p>5. Review of sprinkler system inspection reports on 02/08/16 at 11:45 a.m. with the D.O.N. indicated there was no documentation to show the sprinkler system has had an internal pipe inspection.</p> <p>6. In interview at the time of record review, the D.O.N. acknowledged the sprinkler system has not had an internal pipe inspection.</p> <p>7. The above was confirmed with the sprinkler system vendor via phone interview at the time of record review.</p>			

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Q 0122 Bldg. 00	<p>416.45(b) REAPPRAISALS</p> <p>Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.</p> <p>Based on document review and interview the governing body (GB) failed to establish and follow processes for reappraising medical staff (MS) privileges for 1 of 1 MS members (MD#1) within the past 24 months.</p> <p>Findings:</p> <p>1. Review of the policy titled Governing body: Powers and Duties indicated the following: Guidelines: 1. Ensure all rules and regulations for licensure an certification are met... 2. Responsible for the conduct of the MS. The policy was approved 6/10/15 by A1, RN (registered nurse), but lacked documentation of GB review/approval.</p> <p>2. Review of the document titled Medical Staff Bylaws indicated the following: ARTICLE VI DETERMINATION OF CLINICAL PRIVILEGES: 6.2.2 The basis for privileges determinations to be made in connection with periodic reappointment</p>	O 0122	<p>1 Medical Staff Priveges shall be reappraised by Governing Body and documented in meeting minutes</p> <p>2 Every other year the Governing Body shall document in their meeting minutes</p> <p>3 C Lim, MD</p> <p>4 3/08/16</p>	03/08/2016

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Q 0201 Bldg. 00	<p>or otherwise shall include documentation of observed clinical performance and the documented results of patient care evaluation... The Bylaws were approved 6/1/15</p> <p>3. Review of MS member MD1's credential file lacked documentation of a performance evaluation within the past 2 years.</p> <p>4. On 2/2/16 at 12:00pm, A1, RN/Acting Administrator, indicated the MS was not big enough to conduct outcome oriented performance evaluations of its members and no outside evaluation had been conducted for MD1.</p> <p>416.49(a) LABORATORY SERVICES If the ASC performs laboratory services, it must meet the requirements of Part 493 of this chapter. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of this chapter. The referral laboratory must be certified in the appropriate specialties and subspecialties of services to perform the referral test in accordance with</p>			

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Q 0221 Bldg. 00	<p>the requirements of Part 493 of this chapter. Based on document review and interview, the center failed to possess a valid certificate to provide one laboratory service (glucose by glucose monitoring device).</p> <p>Findings:</p> <ol style="list-style-type: none"> On 2/1/16 at 9:45am, A1, Registered Nurse, indicated the center does provide blood sugar/glucose monitoring by means of a glucose monitoring device. On 2/2/16 at 5:00pm, A1 indicated the center did not possess/could not produce a valid certificate to perform laboratory services. <p>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.</p>	O 0201	<p>1 A current CLIA Waiver Certificate has been located and a copy was sent to inspector</p> <p>2 CLIA Waiver Certificate will be renewed upon expiration</p> <p>3 C Lim, MD Administrator</p> <p>4 3/08/16</p>	03/08/2016			

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	<p>Based on document review and interview, Center policies failed to address 6 patient rights (the right to be informed of physician ownership; the right to have all grievances relating to mistreatment, neglect, verbal, mental, sexual, or physical abuse fully documented and reported; the right to exercise rights without being subjected to discrimination or reprisal; the right to have patient rights exercised by an appointed person; the right to personal privacy; and the right to be free from all forms of abuse or harassment).</p> <p>Findings:</p> <p>1. Review of Center policies lacked documentation of a policy for patient's, or their representatives, to receive verbal and written notice of the following patient rights: the right to be informed of physician ownership; the right to have all grievances relating to mistreatment, neglect, verbal, mental, sexual, or physical abuse fully documented and reported; the right to exercise rights without being subjected to discrimination or reprisal; the right to have patient rights exercised by an appointed person; the right to personal privacy; and the right to be free from all forms of abuse or harassment.</p>	Q 0221	<p>1. Policy shall be kept on file for all Patient Rights Documentation has been added to information given to patients 2 Policy shall be reviewed and to ensure all pertinent information is included 3 C Lim, MD Administrator 4 3/11/16</p>	03/10/2016	

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Q 0241 Bldg. 00	<p>2. On 2/2/16 at 1:45pm, A1, RN (registered nurse)/Acting Administrator, indicated specific polices for patient rights of the following: the right to be informed of physician ownership; the right to have all grievances relating to mistreatment, neglect, verbal, mental, sexual, or physical abuse fully documented and reported; the right to exercise rights without being subjected to discrimination or reprisal; the right to have patient rights exercised by an appointed person; the right to personal privacy; and the right to be free from all forms of abuse or harassment, were not available and he/she was not certain the Center had a policy addressing each right. No further documentation was provided.</p> <p>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 document review, observation and interview, the facility failed to ensure a safe and healthful environment in patient preoperative and operative areas, the dining area of the cafeteria room, first floor ladies restroom, reception/waiting</p>	Q 0241	<p>1 Housekeeping shall be performed according to CDC Guidelines We have contacted The Bug Man, Inc our pest control and have implemented a log showing areas targeted, chemicals used</p>	03/10/2016

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	<p>area, 1st floor housekeeping closet and the 3rd floor housekeeping closet.</p> <p>Findings:</p> <p>1. Policy 500.10 a.k.a. 1400.1, Infection Control of Outpatient Surgical Services, last updated 02/7/2013, indicated:</p> <p style="padding-left: 40px;">A. 5. Housekeeping:</p> <p style="padding-left: 80px;">5.2 All flat surfaces will be washed with germicidal solution daily, and when soiled. Grossly soiled walls should be wiped off.</p> <p style="padding-left: 80px;">5.3 Floors will be mopped daily with a germicidal solution and when grossly soiled.</p> <p style="padding-left: 80px;">5.4 Sinks will be cleaned daily with a germicidal solution.</p> <p style="padding-left: 80px;">5.5 Walls will be spot cleaned monthly or as needed to remove soiling.</p> <p>2. During a tour of the pre-operative (pre-op) area and family waiting areas on 02/02/2016 at 0930 hours, accompanied by staff member #P1, Director of Nursing (DON), the following was noted:</p> <p style="padding-left: 40px;">A. In pre-op area Rooms # 207 and 208, dust was noted on the floor and the bathrooms had a layer of dried liquid soap and other debris on the sinks and toilets. The floor had dust and dried liquid appearing substances on them.</p> <p style="padding-left: 40px;">B. The pre-op pantry had what appeared to be dried reddish substance on</p>		<p>and problem areas that need to be addressed</p> <p>We will monitor and make notes for future visits on which areas are a need for concern</p> <p>Medical staff shall have hair properly covered including beards by caps and beard guards</p> <p>No one shall be allowed in surgical area without adhering to these guidelines</p> <p>2 Logs will be kept on file when performed and a Quality Assessment has been started on the cleaning of facility</p> <p>There is a separate pest control log book that shall be kept up to date</p> <p>Medical staff shall adhere to proper dress code 3 C Lim, MD Administrator 4 3/10/16</p>				

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	<p>the wall tiles. The storage cabinet drawers had crumbs and dried liquid appearing substances in them.</p> <p>C. The four corners of the pre-op storage area had dusty, dark appearing substances in them.</p> <p>3. Staff member #P3, housekeeping, indicated that he/she cleans one time a week, and tries to get everything accomplished, but doesn't have time.</p> <p>4. Policy 200.22 a.k.a. 140018, Operating Room Sanitation, last updated 5/19/2011, indicated:</p> <p style="padding-left: 40px;">2.5 End of day cleaning includes, but is not limited to</p> <p style="padding-left: 80px;">2.5.3 Cleaning of cabinet doors and operating room doors</p> <p style="padding-left: 40px;">2.6 Cycle cleaning includes, but is not limited to a minimum of</p> <p style="padding-left: 80px;">2.6.1 Weekly cleaning of cabinets, shelves, walls ceilings, and air-conditioning grills.</p> <p>4. During the observation of a patient procedure in operating room (OR) #3, on 02/02/2016, it was noted that the small item storage cart had reddish appearing substance on the sides of the drawers, as well as dust on the top of the cart.</p> <p>5. Policy 200.02, Operating Room Attire, last update unknown, indicated:</p>			

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	<p>All personnel entering the semi-restricted and restricted areas of the OR are required to wear appropriate apparel.</p> <p>2. Appropriate attire</p> <p>2.1 Proper attire in the restricted area of the OR shall include and is provided by the facility</p> <p>2.1.1 Disposable bouffant cap</p> <p>2.1.2 Disposable hood for personnel with facial hair</p> <p>6. On 02/02/2016, while observing a patient procedure in OR#3, it was observed that staff members #P3 and #P11 had on surgical skull caps which did not cover their hair completely. In addition, staff member # P3 had a beard which was not completely covered by his/her mask.</p> <p>7. Staff member #P1 concurred with these findings.</p> <p>8. Review of the policy titled Infection Control in Environmental Services indicated the following: The Center environment shall be maintained in a clean and a sanitary condition,... 3. Pest Control. The policy was review/approved 6/10/15.</p> <p>9. Review of the policy titled Pest Control Program indicated the following:</p> <p>5. Depending upon the nature of the area...insect/pests problems and severity</p>			

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	<p>of the problem, the Environment Services Department chief has the authority to call the pest management service. At the minimum, the Environmental Service Department chief will record the problem and ensure the servicemen to treat the area during next scheduled visit. The policy was reviewed/approved 6/10/15.</p> <p>10. On 2/1/16 at 9:30am, in the cafeteria dining area, the following was observed: On the floor, near the table designated as the station, were 2 cockroach type blackish brown insects lying on their backs with legs moving and one, not moving, in front of a treadmill. At 11:30am, in the 1st floor ladies restroom, whitish debris was noted on the floor, splash type brownish marks behind the first toilet, dark colored water ring in the second toilet, blackish dust/dirt type grime on sink surface and only one functioning faucet. At 12:45pm, the following was observed in the cafeteria: Heavy web-like structures with egg-like sacs hanging out from under 11 surrounding chairs. A heavy, dusty appearing, web-like structure was also noted above the Exit sign. Window sills and window corners were observed with heavy dust and dead appearing insects. Small brownish droplet type stains were noted on the floor in various areas.</p>			

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	<p>11. On 2/1/16 at 11:00am, A1, RN (registered nurse) indicated cleaning is done by individuals in the facility and a contracted service. A1 indicated restrooms are typically cleaned by a person who helps P2, housekeeper.</p> <p>12. On 2/2/16 during tour of the facility, between 2:30pm and 3:30pm, in the presence of A1 and A2, Maintenance, the following was observed: In the Reception/Waiting area were 3 ceiling tiles with brownish stains, heavy dust and debris in the window sills and corners and dust on the blinds. Behind the Exit sign above the reception desk heavy cob-web like structures were observed. In the 1st floor housekeeping closet was a floor style basin with leaves and other type brownish debris. In the 3rd floor housekeeping closet was a floor style basin with dirt/debris.</p> <p>13. On 2/2/16 at 3:30, A1 indicated the facility did not have one individual for cleaning and that the responsibility was shared, but most was done by P3, CNA (certified nursing assistant) and that is who was designated to have oversight.</p>			

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Q 0243 Bldg. 00	<p>416.51(b)(1) INFECTION CONTROL PROGRAM - DIRECTION The program is - Under the direction of a designated and qualified professional who has training in infection control. Based on interview, the facility failed to ensure a designated professional with training in infection control who is responsible for ongoing infection control activities and education.</p> <p>Findings:</p> <p>1. On 02/02/2016, at 1300 hours, while discussing Infection Control (IC) practices, staff member #P1, Director of Nursing, indicated that the facility does not have a professional staff or contracted person designated as director of its IC program, who carries out the required IC activities or has any IC training. The facility lacks a policy requiring this regulation. He/she indicated that the only staff designated as an IC person is the physician/owner who had been named as the head of the IC committee, and since the staff is so small, there has not been time for anyone to assume the role of a designated IC professional. He/she further indicated that the facility IC training is having staff read through some small booklets and sign a sheet that they have read them. The facility has not</p>	O 0243	<p>1 RN has been appointed for ongoing infection control activities and staff education She will be receiving certification and will be in charge of educating staff 2 She will be keeping of all documentation of her training and staff education 3 Theresa Gilbert, RN 4 3/10/16</p>	03/10/2016			

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S 0000 Bldg. 00	required any ancillary or contracted staff to have IC education.			
S 0106 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 003633</p> <p>Dates: 02/01/16 to 02/02/16</p> <p>QA: cjl 03/02/16</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Review the bylaws at least triennially.</p> <p>Based on document review and interview, the governing body failed to review their bylaws within the past 3</p>	S 0000		
		S 0106	<p>1 Governing Body will review and approve Governing Body Bylaws every 3 years</p> <p>2 Governing Body will discuss at</p>	03/08/2016

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	<p>years.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of facility documents indicated governing body responsibilities were described in policies. Policy 1000.02 titled Governing body: Powers and Duties indicated the following: <ol style="list-style-type: none"> Ensure all rules and regulations for licensure and certification are met...1.1 Adopt bylaws and function accordingly. initiate review of the bylaws triennially. The policy lacked documentation of governing body review or approval. Review of documents, indicated to be governing body (GB) meeting minutes, indicated annual meetings were held 1/23/14 and 12/23/15, the meeting minutes lacked documentation of governing body review of governing body bylaws. Review of documents titled Medical Staff Meeting minutes dated 3/13/15, 6/9/15, 9/8/15 and 12/23/15 lacked documentation of governing body review of governing body bylaws. On 2/1/16 at 10:00 am, A1, Registered Nurse in charge in absence of administrator, indicated the Medical Staff 		<p>next meeting 3 C Lim, MD Administrator 4 3/08/16</p>		

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S 0230 Bldg. 00	<p>(MS) meetings were actually meetings of all committees, due to the center being so small. A1 verified that no other committees were identified in the meeting minutes titled Medical Staff Meeting.</p> <p>5. On 2/2/16 at 4:30pm, A1, indicated all policies were approved/reviewed on the date indicated by the list at the front of the policy binder (6/10//15). A1 further indicated that it was his/her signature indicating approval, that he/she is not a member of the GB, and that both GB meeting minutes and MS meeting minutes lacked documentation of GB review or approval of the GB bylaws within the past 3 years.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 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>				

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	<p>Based on document review and interview, the governing body (GB) failed to provide for periodic review of the center by a utilization review (UR) or other committee composed of 3 or more duly licensed physicians with no financial interest in the facility.</p> <p>Findings:</p> <p>1. Review of the policy titled Governing body: Powers and Duties indicated the following: Guidelines: 5. 5.5 Provide for 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 Center. The policy was review/approved 6/10/15.</p> <p>2. Review of the policy titled Utilization Review Management Program indicated the following: 2. The Utilization Review Committee is a multidisciplinary committee composed of the following: 2.1 One member of the MS..., 2.2 Administrator, 2.3 Nursing Chief, 2.4 Medical Records Chief, 2.5 Utilization Review Coordinator, 2.6 Quality Improvement Coordinator. 3. The UR Committee shall meet quarterly and provide quarterly report of its findings and recommendations. The policy was reviewed/approved 6/10/15.</p>	S 0230	<p>1 Center will have 3 physicians with no financial interest perform utilization review</p> <p>2 When the review is performed by the 2 physicians that have performed the review in the past, the 3rd will also be contacted for the review</p> <p>3 C Lim, MD Administrator</p> <p>4 3/10/16</p>	03/10/2016			

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S 0310	<p>410 IAC 15-2.4-2</p> <p>3. Review of facility documents indicated lack of documentation of evaluation of the Center and its operations by a utilization review or other committee composed of 3 or more physicians with no financial interest in the facility.</p> <p>4. Review of check-list type documents titled 1st/2nd Quarter 2015 indicated 2 physicians completed 16 check-list forms for review of medical records. The documents lacked documentation of outcomes, review/analysis of findings or committee activity/meeting minutes.</p> <p>5. On 2/2/16 at 4:35pm, A1, RN (registered nurse)/Acting Administrator, indicated there were only 2 physicians on the Utilization Review Committee, that they reviewed charts 2 times per year, did not hold meetings or provide meeting minutes or reports.</p> <p>6. On 2/2/16 at 5:15pm, A3/MD1, Owner, indicated the UR Committee, at present, did not consist of 3 physicians without financial interest.</p>			

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Bldg. 00	<p>QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the center failed to include 2 directly provided services (internal laboratory and internal maintenance) and 1 contracted services (contracted medical records) in its quality assessment and performance improvement (QAPI) program for 2015.</p> <p>Findings:</p> <p>1. Review of the policy titled Quality Assessment and Improvement, Number 1100.01, indicated the following: Quality design shall be incorporated into the routine planning and design activities of all Departments and functions. The policy was reviewed 6/10/15.</p> <p>2. Review of documents titled Medical Staff Meeting dated 3/13/15, 6/9/15, 9/8/15 and 12/23/15 indicated lack of documentation of quality review or evaluation of internal laboratory services, internal maintenance services or</p>	S 0310	<p>1 QA's will be added for contracted medical records, internal laboratory and internal maintenance department 2 QA's will be monitored and kept up to date 3 Theresa Gilbert, RN 4 3/07/2016</p>	03/07/2016			

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S 0400 Bldg. 00	<p>contracted medical records services.</p> <p>3. Review of QAPI reports between 1/1/2015 and 12/31/15 indicated lack of documentation of quality review/monitor or evaluation of internal laboratory services, internal maintenance services, or contracted medical records services.</p> <p>4. On 2/2/16 at 11:30am, A1, RN (registered nurse)/Acting Administrator, indicated the QAPI had not included evaluation of internal laboratory services, internal maintenance services, or contracted medical records services in its monitors or evaluations for 2015 and that documents titled Medical Staff Meeting were all inclusive of all committee meetings, i.e. QAPI.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>1. Policy 500.10 a.k.a. 1400.1, Infection Control of Outpatient Surgical Services, last updated 02/7/2013, indicated:</p>	S 0400	1 Facility will be cleaned daily, weekly and monthly according to CDC guidelines Disposable bouffant caps and	03/07/2016

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	<p>A. 5. Housekeeping:</p> <p>5.2 All flat surfaces will be washed with germicidal solution daily, and when soiled. Grossly soiled walls should be wiped off.</p> <p>5.3 Floors will be mopped daily with a germicidal solution and when grossly soiled.</p> <p>5.4 Sinks will be cleaned daily with a germicidal solution.</p> <p>5.5 Walls will be spot cleaned monthly or as needed to remove soiling.</p> <p>2. During a tour of the pre-operative (pre-op) area and family waiting areas on 02/02/2016 at 0930 hours, accompanied by staff member #P1, Director of Nursing (DON), the following was noted:</p> <p>A. In pre-op area Rooms # 207 and 208, dust was noted on the floor and the bathrooms had a layer of dried liquid soap and other debris on the sinks and toilets. The floor had dust and dried liquid appearing substances on them.</p> <p>B. The pre-op pantry had what appeared to be dried reddish substance on the wall tiles. The storage cabinet drawers had crumbs and dried liquid appearing substances in them.</p> <p>C. The four corners of the pre-op storage area had dusty, dark appearing substances in them.</p> <p>3. Staff member #P3, housekeeping,</p>		<p>Disposable Hoods for personnel with facial hair will be worn in the Operating Room</p> <p>2 Cleaning Checklists will be incorporated to ensure cleaning is done</p> <p>No personnel shall enter Operating Room without proper hair coverings (bouffant cap and disposable hood for facial hair)</p> <p>3 Reno Lim, Maintenance Dept for cleaning</p> <p>C Lim, MD for Operating Room hair coverings</p> <p>4 03/07/16</p>				

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	<p>indicated that he/she cleans one time a week, and tries to get everything accomplished, but doesn't have time.</p> <p>4. Policy 200.22 a.k.a. 140018, Operating Room Sanitation, last updated 5/19/2011, indicated:</p> <p>2.5 End of day cleaning includes, but is not limited to</p> <p>2.5.3 Cleaning of cabinet doors and operating room doors</p> <p>2.6 Cycle cleaning includes, but is not limited to a minimum of</p> <p>2.6.1 Weekly cleaning of cabinets, shelves, walls ceilings, and air-conditioning grills.</p> <p>4. During the observation of a patient procedure in operating room (OR) #3, on 02/02/2016, it was noted that the small item storage cart had reddish appearing substance on the sides of the drawers, as well as dust on the top of the cart.</p> <p>5. Policy 200.02, Operating Room Attire, last update unknown, indicated: All personnel entering the semi-restricted and restricted areas of the OR are required to wear appropriate apparel.</p> <p>2. Appropriate attire</p> <p>2.1 Proper attire in the restricted area of the OR shall include and is provided by the facility</p> <p>2.1.1 Disposable bouffant cap</p>			

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S 0408 Bldg. 00	<p>2.1.2 Disposable hood for personnel with facial hair</p> <p>6. On 02/02/2016, while observing a patient procedure in OR#3, it was observed that staff members #P3 and #P11 had on surgical skull caps which did not cover their hair completely. In addition, staff member # P3 had a beard which was not completely covered by his/her mask.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(d)</p> <p>(d) The center shall designate a person qualified by training or experience as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on interview, the facility failed to ensure a designated professional with training in infection control who is responsible for ongoing infection control activities and education.</p> <p>Findings:</p> <p>1. On 02/02/2016, at 1300 hours, while discussing Infection Control (IC) practices, staff member #P1, Director of</p>	S 0408	<p>1 RN is being trained and shall receive Certification in Infection Control and shall be in charge of ongoing infection control activities and education 2 Documentation is kept on file for all Infection Control Training Courses and employee inservices 3 C Lim, MD Administrator 4 3/08/16</p>	03/08/2016			

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S 0522 Bldg. 00	<p>Nursing, indicated that the facility does not have a professional staff or contracted person designated as director of its IC program, who carries out the required IC activities or has any IC training. The facility lacks a policy requiring this regulation. He/she indicated that the only staff designated as an IC person is the physician/owner who had been named as the head of the IC committee, and since the staff is so small, there has not been time for anyone to assume the role of a designated IC professional. He/she further indicated that the facility IC training is having staff read through some small booklets and sign a sheet that they have read them. The facility has not required any ancillary or contracted staff to have IC education.</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2(f)</p> <p>(f) The center shall assure that all laboratory services provided to its patients are performed in a facility possessing a valid certificate, in accordance with 42 CFR 493 (excluding Subparts F, R, Q, and T) authorizing the performance of testing in the specialty of service or subspecialty of service for level of complexity in</p>			

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S 0704 Bldg. 00	<p>which the test is categorized. Based on document review and interview, the center failed to possess a valid certificate to provide one laboratory service (glucose by glucose monitoring device).</p> <p>Findings:</p> <ol style="list-style-type: none"> On 2/1/16 at 9:45am, A1, Registered Nurse, indicated the center does provide blood sugar/glucose monitoring by means of a glucose monitoring device. On 2/2/16 at 5:00pm, A1 indicated the center did not possess/could not produce a valid certificate to perform laboratory services. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(1)</p> <p>The medical staff shall do the following:</p> <p>(1) Conduct outcome-oriented performance evaluations of its member at least biennially.</p> <p>Based on document review and interview, the medical staff (MS) failed to conduct outcome-oriented performance evaluations for 1 of 1 MS</p>	S 0522	<p>1 CLIA Waiver Certificate has been located and shall be kept on file</p> <p>2 CLIA Waiver Certificate will be renewed as necessary</p> <p>3 C Lim, MD Administrator</p> <p>4 3/08/16</p>	03/08/2016
		S 0704	<p>1 Medical Staff shall perform evaluation for all Medical Staff Members every 2 years</p> <p>2 Medical Staff shall discuss evaluation and approval for all</p>	03/08/2016

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S 1042 Bldg. 00	<p>members (MD1) within the past 2 years.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the document titled Medical Staff Bylaws indicated the following: ARTICLE VI DETERMINATION OF CLINICAL PRIVILEGES: 6.2.2 The basis for privileges determinations to be made in connection with periodic reappointment or otherwise shall include documentation of observed clinical performance and the documented results of patient care evaluation... The Bylaws were approved 6/1/15 Review of MS member MD1's credential lacked documentation of a performance evaluation within the past 2 years. On 2/2/16 at 12:00pm, A1, RN (registered nurse)/Acting Administrator, indicated the MS was not big enough to conduct outcome oriented performance evaluations of its members and no outside evaluation had been conducted for MD1. <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(4)</p>		<p>Medical Staff Members at meeting every 2 years 3 C Lim, MD Administrator 4 3/08/16</p>		

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	<p>Pharmaceutical service must have the following:</p> <p>(4) A formulary. Based on document review, observation and interview, the pharmaceutical service failed to maintain an accurate formulary for 11 medications.</p> <p>Findings:</p> <p>1. Review of the document titled Annual Formulary Review & Update July 6, 2016 [sic] indicated the following formulary drugs had been reviewed and approved... 31 drugs were listed on the first page Table of Contents, 5 drugs were on the following page, and 8 drugs were listed on the page titled Table of Contents EMERGENCY MEDICATIONS. The formulary was indicated to be approved 7/6/15.</p> <p>2. Review of the policy titled Formulary and take home medications indicated the following: Guidelines: 2. All drugs listed in the formulary are to be available at anytime in the Pharmacy. 3. There should be quarterly updates and revisions of the formulary. The policy was reviewed/approved 6/10/15.</p> <p>3. On 2/2/15 at 3:00pm, during tour of the Center, in the presence of A1,</p>	S 1042	<p>1 Formulary shall be kept current and include only medications within facility</p> <p>2 Medications that are no longer kept in stock shall be removed from the formulary and any new medications used shall be added</p> <p>3 Theresa Gilbert, RN</p> <p>4 3/08/16</p>	03/08/2016

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S 1142 Bldg. 00	<p>Registered Nurse, in the drug supply cabinet, the following drugs could not be located: Apresoline, Brevibloc, Calcium, Demerol, Droperidol, Fentanyl, Heparin, Ketamine, Lasix, Morphine, Propanolol.</p> <p>4. On 2/2/15 at 3:00pm, A1 indicated the 11 drugs were listed on the formulary and were not available in the Center due to change in procedure types performed.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(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>(1) No condition in the center or on the grounds may be maintained which may be conducive to the harboring or breeding of insects, rodents, or other vermin.</p> <p>Based on document review, observation, and interview the Center failed to maintain the overall condition of the environment and created conditions conducive to the harboring/breeding of insects in 4 areas.</p> <p>Findings:</p>	S 1142	<p>1 We have contacted the contracted pest control company to target problem areas Maintenance has been notified that the facility cleanliness is lacking in several areas Tasks have been delegated to all employees and Quality Assessments have been implemented to ensure they have been completed</p>	03/07/2016	

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	<p>1. Review of the policy titled Infection Control in Environmental Services indicated the following: The Center environment shall be maintained in a clean and a sanitary condition,... 3. Pest Control. The policy was review/approved 6/10/15.</p> <p>2. Review of the policy titled Pest Control Program indicated the following: 5. Depending upon the nature of the area...insect/pests problems and severity of the problem, the Environment Services Department chief has the authority to call the pest management service. At the minimum, the Environmental Service Department chief will record the problem and ensure the servicemen to treat the area during next scheduled visit. The policy was reviewed/approved 6/10/15.</p> <p>3. On 2/1/16 at 9:30am, in the cafeteria dining area, the following was observed: On the floor, near the table designated as the station, were 2 cockroach type blackish brown insects lying on their backs with legs moving and one, not moving, in front of a treadmill. At 11:30am, in the 1st floor ladies restroom, whitish debris was noted on the floor, splash type brownish marks behind the first toilet, dark colored water ring in the second toilet, blackish dust/dirt type grime on sink surface and only one</p>		<p>2 A pest control log has been implemented to show areas sprayed and which chemicals were used Cleaning logs have been implemented to ensure facility is kept clean 3 C Lim, MD administrator 4 3/07/16</p>				

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	<p>functioning faucet. At 12:45pm, the following was observed in the cafeteria: Heavy web-like structures with egg-like sacs hanging out from under 11 surrounding chairs. A heavy, dusty appearing, web-like structure was also noted above the Exit sign. Window sills and window corners were observed with heavy dust and dead appearing insects. Small brownish droplet type stains were noted on the floor in various areas.</p> <p>4. On 2/1/16 at 11:00am, A1, RN (registered nurse) indicated cleaning is done by individuals in the facility and a contracted service. A1 indicated restrooms are typically cleaned by a person who helps P2, housekeeper.</p> <p>5. On 2/2/16 during tour of the facility, between 2:30pm and 3:30pm, in the presence of A1 and A2, Maintenance, the following was observed: In the Reception/Waiting area were 3 ceiling tiles with brownish stains, heavy dust and debris in the window sills and corners and dust on the blinds. Behind the Exit sign above the reception desk heavy cob-web like structures were observed. In the 1st floor housekeeping closet was a floor style basin with leaves and other type brownish debris. In the 3rd floor housekeeping closed was a floor style basin with dirt/debris.</p>			

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S 1164 Bldg. 00	<p>6. On 2/2/16 at 3:30, A1 indicated the facility did not have one individual for cleaning and that the responsibility was shared, but most was done by P3, CNA (certified nursing assistant) and that is who was designated to have oversight.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 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 document review, observation,</p>	S 1164	1 Preventative Maintenance per	03/08/2016			

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	<p>and interview, the Center failed to ensure preventive maintenance (PM) was per manufacturer's recommended practice for 1 AED (automated external defibrillator), 1 nurse call system and 4 wheelchairs.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the policy titled Environment Maintenance indicated the following: Policy: 2. All equipment utilized by the facility will be checked for safety and functional capabilities by an outside agency... Guidelines: 2. This agency performs preventive and corrective maintenance and conduct functional and safety testing on all equipment utilized by the Center. ATTACHMENT 2 - ITEMS GENERALLY INCLUDED IN ENVIRONMENTAL MAINTENANCE, included, but was not limited to: Nurse Call System and Wheel Chairs. The policy was approved 6/10/15. 2. Review of the manufacturer's manual for the AED indicated Daily, Monthly and Annual maintenance procedures to be performed. 3. Review of annual and semi-annual 2015 contracted preventive maintenance services documents indicated the AED had annual PM on 11/1/15. The 		<p>manufacturer's recommendation shall be performed on AED, nurse call system and 4 facility wheelchairs 2 Log books shall be kept and remain current on these maintenance checks 3 Reno Lim, Maintenance 4 3/08/16</p>		

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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
	<p>documents lacked documentation monthly PM of the AED and of any PM on the Nurse Call System or wheel chairs.</p> <p>4. Review of center documents indicated the following: On a document titled 2015 Monthly Wheelchair Maintenance; 1/28 ok, 2/23 ok, 3/20 ok, 4/27 ok, 5/18 clean & lube all wheelchair [sic], 6/26 ok, 7/28 ok, 8/28 ok 9/30 ok, 10/26 ok, 11/30 clean all wheelchair, 12/21 ok. The document lacked documentation of number of wheelchairs and what PM or inspection was done per manufacturer's recommendations.</p> <p>5. On 2/2/15 at 2:30pm, during tour of the Center, in the presence of A1, RN (registered nurse), and A2, Maintenance, 4 wheelchairs were observed in an alcove off the main hall of the first floor. A4, medical assistant, indicated he/she does the PM for the wheelchairs.</p> <p>6. On 2/1/15 at 4:00pm, A1 indicated the Center does have an emergency call system that is used in the Center, but does not believe it has a scheduled PM, and is uncertain if the manufacturer's manual can be located. A1 indicated the AED is checked daily, but not monthly per manufacturer's recommendations.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/02/2016
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882		
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	7. On 2/2/15 at 3:45pm, A2 indicated he/she does not document which individual wheelchairs are inspected. A2 indicated he/she looks them over and checks for cracks, but does not follow a PM checklist and is not aware of manufacturer's recommendations.				