

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001139	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
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NAME OF PROVIDER OR SUPPLIER THE SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2030 SHERMAN DR PRINCETON, IN47670
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O0000	<p>This visit was for a Federal recertification survey.</p> <p>Facility #: 004101</p> <p>Survey Dates: 10-11/12-11</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 11/01/11</p>	O0000	<p>This is a copy of the letter that was sent to the Indiana State Department of Health notifying the change of ASC operating hours. November 9, 2011 Dear Ms. Hamel: The Princeton Surgery Center is officially notifying the Indiana State Department Of Health that the hours of operation have been changed. The new Business hours for the Princeton Surgery Center are: Monday 6:30 am – 1:00 pm Tuesday 6:30 am – 1:00 pm Wednesday 6:30 am – 5:00 pm Thursday 6:30 am – 1:00 pm Friday 6:30 am – 1:00 pm The new business hours have been posted on the main entrance doors. Thank You, Melissa Johnson Princeton Surgery Center Operation Manager 2030 Sherman Dr. Princeton, IN 47670 812-385-1111</p>	
O0002	<p>As used in this part: Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of this part. The ambulatory surgical center must comply with state licensure requirements.</p> <p>Based on document review, observation and interview, the facility failed to ensure</p>	O0002	<p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November</p>	11/09/2011

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>it operated as a distinct entity as an ASC.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Policy titled "DAYS AND HOURS OF OPERATION" last reviewed/revised 3/09 states "The surgery Center maintains the following days and hours of operation: Monday through Friday 6:30 a.m.-5:00 p.m. 2. Review of the schedule for the clinic practice of M.D. #3 and the surgery schedule for the ASC for 10/4/11 indicated that a patient was scheduled for surgery at 11:15 a.m. and a patient was scheduled for the clinic practice at 11:15 a.m as well. 3. During observation in the preoperative area at 1:00 p.m. on 10/11/11 staff member #1 indicated that M.D. #3 and AH #2 utilized an exam room in the preoperative area and the procedure room for their clinic and pain management practices. Additionally, he/she indicated the same waiting room was utilized for the practices and the ASC patients. The pain management and clinic practice was in operation during observation of the area. 4. Staff member #3 indicated in interview at 2:55 p.m. on 10/12/11 that M.D. #3 had 		<p>9, 2011 Re: Plan of Correction ID Prefix Tag Q 002 Corrective Action: The official operating hours for the Princeton Surgery Center have been changed to the following schedule. The ASC is open Monday, Tuesday, Thursday and Friday from 6:30 am until 1:00 pm. The ASC is open on Wednesday from 6:30 am until 5:00 pm. The Indiana State Department of Health has been advised by letter of the new ASC hours. This letter was mailed to Ann Hamel, RN, MSN on 11-10-11. The hours of operation have been changed on the main doors to the center.</p> <p>Prevention: All ASC staff members have been advised of the new hours of operation and that there is to be no overlapping of ASC patients with any other individuals. The participating physician offices have been sent letters as well as phone calls notifying them of the new hours of operation. The electronic scheduling system has now been blocked to prevent any scheduling past the posted ASC hours. Responsible Individuals: Melissa Johnson, Operation Manager and Stephanie Adams, Office Administrator Date of Correction: November 9, 2011</p>		

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Q0041	<p>his/her clinic practice within the ASC from 1:00-5:00 p.m. on Tuesdays and 8:30 a.m.-12:00 p.m. on Thursdays and AH #2 had his/her pain management practice within the ASC on Tuesdays.</p> <p>When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner. Based on document review and interview, the ASC failed to assure the contracted services of Radiology, Transcription and Security are included in the facility Quality Assurance of Performance Improvement (QAPI) program</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 10-11-11 lacked evidence that the contracted services of radiology, transcription, and security are included in the facility Quality Assurance of Performance Improvement (QAPI) program to ensure they are provided in a safe and effective manner. 2. Interview with B#1 on 10-11-11 at 1515 hours confirmed the contracted 	Q0041	<p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 10, 2011 Re: Plan of Correction ID Prefix Tag Q 041 Corrective Action: QA studies on Transcription, Radiology, and Security began on November 1, 2011 and will run for a time period of three months. Results will be reported to the Governing Body at completion and then annually thereafter. <u>Prevention:</u> On November 1, 2011 The Surgery Center began utilizing the ASC QA/QI revised worksheet provided by the Indiana state surveyors during their inspection on October 12, 2011. Radiology, Transcription, and Security have been added to the list of contracted services to be monitored under our QA/QI</p>	11/01/2011

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O0043	<p>services of radiology, transcription, and security are not included in the facility QAPI program.</p> <p>(1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC.</p> <p>(2) The ASC coordinates the plan with State and local authorities, as appropriate.</p> <p>(3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.</p> <p>Based on document review and interview, the facility failed to coordinate emergency and disaster preparedness with a an appropriate community, state, or federal agency.</p> <p>Findings include:</p> <p>1. Review of facility documents lacked evidence that the facility emergency and disaster preparedness program is</p>	O0043	<p>program. This worksheet will give the Center a guideline to follow to maintain compliance with State requirements. <u>Responsible Individuals:</u> Tracy Maglis RN, RN Coordinator <u>Date of Correction:</u> QA studies on Transcription, Radiology, and Security began on November 1, 2011 and will run for three months. Results will be reported to the Governing Body at completion and then annually thereafter.</p> <p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 9, 2011 Re: Plan of Correction ID Prefix Tag Q 043 <u>Corrective Action:</u> Terry Hedges with the local Emergency Management Association was contacted to register the Princeton Surgery Center with the local agency. Terry requested that the center contact Susan Woods with Gibson General Hospital to provide information regarding the</p>	11/09/2011	

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	<p>coordinated with an appropriate community, state, or federal agency.</p> <p>2. Interview with B#2 on 10-12-11 at 1300 hours confirmed the ASC emergency and disaster preparedness is not coordinated with any community, state, or federal agency.</p>		<p>center. Susan informed the center that there is a District 10 hospital emergency management planning committee. This committee meets at various times throughout the year and has invited the center to participate. The next meeting is scheduled for Dec. 2011 at Gibson General Hospital. Susan has added the center to the listing of facilities to participate in the annual disaster preparedness drill. She has also enrolled the center to participate in the upcoming emergency evacuation training drill scheduled for April 2012. Susan will be visiting the center after the first of the year to look over the space available and supplies that we have on the premises. The center will also be attending the Local Emergency Preparedness Committee meetings where members from all county wide services are present to review and update information.</p> <p><u>Prevention:</u> The center is now registered with the emergency services providers for Gibson County and District 10. These agencies will be notifying the center of all meetings and drills scheduled. There are attendance schedules maintained for all of the functions <u>Responsible Individuals:</u> Melissa Johnson, Operation Manager <u>Date of Correction:</u> November 9, 2011.</p>		

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O0061	<p>A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.</p> <p>Based on staff interview and document review, the facility failed to ensure a physician examined the patient immediately before surgery for all pain management procedures.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Staff member #2 indicated the following in interview beginning at 3:10 p.m. on 10/12/11: (A) AH #2 performs pain management procedures with the oversight of M.D. #3. (B) M.D. #3 may not always be in the facility during the pain management procedures. Patients #1, 2, and 3 had no physician examination prior to surgery on 8/31/11. Review of schedules for 8/31/11 indicated that AH #2 performed three (3) pain management procedures and M.D. #3 was documented as out of town 8/28/1-8/31/11. 	Q0061	<p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 9, 2011 Re: Plan of Correction ID Prefix Tag Q 061 Corrective Action: Pain Management procedures will no longer be scheduled when Dr. Beck is not in the facility. Corey Potts and Dr. Beck have been advised that Dr. Beck has to be in the center at all times when pain management procedures are being performed regardless of whether IV anesthesia is being administered. Dr. Beck will also comply with: <u>Policy 721</u> A history and physical will be present on each patient's medical record, <u>preferably</u> performed no longer than <i>seven (7) days</i> from the scheduled surgery date, and at most, within a 30 day period of the scheduled surgery date. The physician history and physical (H&P) will include a review of systems, any known allergies, previous surgeries, medications and dosages, and a medical history taken from the patient. If the history and physical is done 24 hours or more prior to the scheduled surgery date, the physician must update the history and physical when the patient enters the facility. An update checkbox will be available at the end of the report. The physician</p>	10/13/2011	

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O0103	[The ASC must provide a functional and sanitary environment for the provision of surgical services.] The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities. Based on document review and interview, the facility failed to have a policy in place to comply with State notifiable disease	O0103	will write in any update information if applicable and sign and date the box for the date of surgery. A patient H&P performed by physician <u>other</u> than the attending surgeon will be reviewed by the attending surgeon pre-operatively as well as any lab or other diagnostic result(s). Documentation of the attending physician's agreement with the evaluation will be made on the patient's medical record prior to the patient's transport to the operating room. <u>Prevention:</u> The Pain Clinic will be closed on days when Dr. Beck is out of town. Pain procedures will not be allowed to proceed if Dr. Beck leaves the building but can resume when he returns. The scheduling software has been programmed to not allow procedures to be scheduled if Dr. Beck is not scheduled to be present. <u>Responsible Individuals:</u> Tracy Maglis, RN Coordinator and Melissa Johnson, Operation Manager and Stephanie Adams, Office Administrator. <u>Date of Correction:</u> October 13, 2011 To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 9, 2011 Re: Plan of Correction ID	11/01/2011	

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Q0121	<p>reporting requirements.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of policies revealed there was no policy in place that included the communicable diseases to be reported to the State. Staff member #4 verified the above at 4:45 p.m. on 10/12/11. <p>Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.</p> <p>Based on document review and interview, the medical staff failed to make recommendations to the governing board for 4 of 6 (MD#2, 3, 4, 5) medical staff reappointments for a period not to exceed 2 years.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of physician credential files on 10-11-11 and 10-12-11 indicated the 	00121	<p>Prefix Tag Q 103 Corrective Action: Policy 309 Reporting of Communicable Diseases has been revised to include a detailed list of each communicable disease for the state of Indiana. The Governing Body reviewed the revision and approved the revised Policy 309 on November 1, 2011 during the quarterly business meeting. The revised policy was added to the current Policy and Procedure manual. Prevention: The Indiana State Department of Health website will be checked quarterly to insure that the listing of communicable disease is current and correct. Responsible Individuals: Tracy Maglis, RN, RN Coordinator Date of Correction: November 1, 2011</p> <p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 9, 2011 Re: Plan of Correction ID Prefix Tag Q 121 Corrective Action: All facility approved physicians' credentialing files were reviewed by the Governing Body on November 1, 2011. Physicians with current reappointment packets but have not practiced in the facility for 2 years were removed from active status. The remaining physician</p>	11/01/2011	

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O0181	<p>medical staff failed to ensure 4 of 6 (MD's #2, 3, 4, and 5) medical staff recommendations for reappointment were acted upon at least every two years.</p> <p>2. Review of physician credential files on 10-11-11 and 10-12-11 indicated the following:</p> <p>a.) MD#2 was reappointed 9-30-09 b.) MD#3 was reappointed 9-30-09 c.) MD#4 was reappointed 7-2-09 d.) MD#5 was reappointed 3-11-08</p> <p>3. Review of Medical Staff Bylaws on 10-12-11 indicated the following under Appointments and Privileges: Appointments shall be made by the Governing Body upon recommendations by the Medical Staff. All appointments shall be made for a 2-year period.</p> <p>4. Interview with B#2 on 10-12-11 at 1300 hours confirmed 4 of 6 physician reappointments (MD's #2, 3, 4, and 5) have not been acted upon by the medical staff every two years as required by the medical staff bylaws.</p> <p>Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on observation, the facility failed to ensure single dose vials were destroyed after use and failed to ensure medications were not accessible to patients for one (1)</p>	O0181	<p>files were reviewed and appointments to the staff were made based on the date of their last reapplication packet. Forms affirming active status were completed based on date from last reapplication form, signed by board members and added to each physician's file. <u>Prevention:</u> The spreadsheet with physician credentialing information was revised to include physician reappointment date column. This spreadsheet is checked on a routine bases. Primary Source reappointment reminders will be utilized to check the accuracy of the spreadsheet information. <u>Responsible Individuals:</u> Melissa Johnson, Operation Manager <u>Date of Correction:</u> November 1, 2011</p> <p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 9, 2011 Re: Plan of Correction ID Prefix Tag Q 181 Corrective</p>	11/11/2011	

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O0241	<p>exam room observed.</p> <p>Findings include:</p> <p>1. During tour of the exam room within the preoperative area beginning at 11:15 a.m. on 10/12/11, the following was observed:</p> <p>(A) An opened single dose vial of Sensorcaine in an unlocked drawer.</p> <p>(B) Eight (8) 100 ml bottles of Sodium Chloride, twenty five (25) 30 ml vials of Sodium Chloride, one (1) bottle of Kenalog, and one (1) tube of Clotrimazole was observed in an unlocked bedside table.</p> <p>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 and document review, the facility failed to ensure disinfectant solutions were mixed according to manufacturers guidelines for terminal cleaning and failed to provide a sanitary environment for 1 of 2 operating rooms (OR).</p>	O0241	<p><u>Action:</u> All medications and sharps will be removed from areas where office patients are seen. These supplies will be placed in a caddy that is brought out to the nurse's station at the beginning of the office schedule. The caddy will stay in the nurse's station and the doctor will come to the station to obtain needed supplies. This caddy is then locked in the Operation Manager office at the end of the day.</p> <p><u>Prevention:</u> The office exam rooms are inspected after each patient visit to ensure nothing has been accidentally left in the room and that single dose vials are destroyed after use. Dr. Beck has been instructed that due to patient safety issues we cannot store any medications or supplies that patients could harm themselves with in patient exam rooms. <u>Responsible Individuals:</u> Melissa Johnson, Operation Manager <u>Date of Correction:</u> November 11, 2011</p> <p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 9, 2011 Re: Plan of Correction ID Prefix Tag Q 241 <u>Corrective Action:</u> The housekeeper has been advised that the cleaning concentration that was being used is inadequate to achieve the disinfection standard. He has</p>	12/01/2011	

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	<p>Findings include:</p> <p>1. During observation of the terminal cleaning beginning at 3:35 p.m. on 10/11/11, the following was observed: (A) Staff member #H1 mixed H2 Orange2 Concentrate 3 ounces with 3 gallon of water to clean the floors and 5 ounces of solution to 64 ounces of water to clean surfaces.</p> <p>2. During observation of cleaning between cases in OR #2 beginning at 12:25 p.m. on 10/12/11, the following was observed: (A) The pad on the OR table had multiple tears rendering it impossible to disinfect between cases.</p> <p>3. Label directions for the H2 Orange2 Concentrate state "To insure that all bacteria and viral agents, except HIV- are killed as stated, use 10 oz. of H2 Orange2 Solution concentrate 117 manual and dispenser dilution (10 parts to 118 parts) of cold water. For HBV, use concentration of 10 oz. per gallon (10 parts per 118 parts)"</p>		<p>been made aware that the concentration needs to be 10 ounces of H2Orange to 1 gallon of water. There are cards, with directions for usage as a floor disinfectant and surface disinfectant, posted in the housekeeping closet. The Operation Manager or Clinical Manager will randomly observe the housekeeper while preparing the mop bucket and the manual cleaning bucket on a monthly schedule. The dilution ratio will be observed to ensure the correct concentration is being used to reach the manufacturer's recommendations. The observations will be recorded and reported in the QA/PI meeting and reported quarterly to the Governing Body. The monthly concentration observations have been added to the QA/PI worksheet. The Amsco 3085 table has new body and foot pad sections. These pads were replaced due to cracking. <u>Prevention:</u> During routine cleaning and end of the day cleaning special attention will be paid to the table pads to ensure the integrity of the pad surfaces. If any compromises in the pad integrity is noted either Tracy Maglis or Melissa Johnson will be contacted to purchase a replacement. <u>Responsible Individuals:</u> Melissa Johnson, Operation Manager, Tracy Maglis, RN, Clinical Manager and Eddie Harris, Housekeeping <u>Date</u></p>		

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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 004101</p> <p>Survey Dates: 10-11/12-11</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 11/01/11</p>	S0000	<p><u>of Correction:</u> Dec. 1, 2011</p> <p>This is a copy of the letter that was sent to the Indiana State Department of Health notifying the change of ASC operating hours. November 9, 2011 Dear Ms. Hamel: The Princeton Surgery Center is officially notifying the Indiana State Department Of Health that the hours of operation have been changed. The new Business hours for the Princeton Surgery Center are: Monday 6:30 am – 1:00 pm Tuesday 6:30 am – 1:00 pm Wednesday 6:30 am – 5:00 pm Thursday 6:30 am – 1:00 pm Friday 6:30 am – 1:00 pm The new business hours have been posted on the main entrance doors. Thank You, Melissa Johnson Princeton Surgery Center Operation Manager 2030 Sherman Dr. Princeton, IN 47670 812-385-1111</p>		

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S0116	<p>410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</p> <p>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on document review and interview, the governing board failed to ensure 4 of 6 (MD#2, 3, 4, 5) medical staff reappointments were acted upon at least biennially.</p> <p>Findings include:</p> <p>1. Review of physician credential files on 10-11-11 and 10-12-11 indicated the governing board failed to ensure 4 of 6 (MD's #2, 3, 4, and 5) medical staff reappointments were acted upon at least biennially.</p> <p>2. Review of physician credential files on 10-11-11 and 10-12-11 indicated the</p>	S0116	<p>To: Indiana State Department of Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 9, 2011</p> <p>Re: Plan of Correction</p> <p>ID Prefix Tag S 116</p> <p><u>Corrective Action:</u> All facility</p>	11/01/2011	

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	<p>following:</p> <p>a.) MD#2 was reappointed 9-30-09</p> <p>b.) MD#3 was reappointed 9-30-09</p> <p>c.) MD#4 was reappointed 7-2-09</p> <p>d.) MD#5 was reappointed 3-11-08</p> <p>3. Review of Medical Staff Bylaws on 10-12-11 indicated the following under Appointments and Privileges: Appointments shall be made by the Governing Body upon recommendations by the Medical Staff. All appointments shall be made for a 2-year period.</p> <p>4. Interview with B#2 on 10-12-11 at 1300 hours confirmed 4 of 6 physician reappointments (MD's #2, 3, 4, and 5) have not been acted upon by the governing board biennially as required by the medical staff bylaws.</p>		<p>approved physicians' credentialing files were reviewed by the Governing Body on November 1, 2011. Physicians with current reappointment packets but have not practiced in the facility for 2 years were removed from active status. The remaining physician files were reviewed and appointments to the staff were made based on the date of their last reapplication packet. These appointment periods are for 2 years. Based on date from last reapplication forms affirming active status were completed, signed and added to each physician's file.</p> <p><u>Prevention:</u> The spreadsheet with physician credentialing information was revised to include physician reappointment date column. This spreadsheet is checked on a routine bases. Primary Source reappointment reminders will be utilized to check the accuracy of the spreadsheet information.</p> <p><u>Responsible Individuals:</u> Melissa Johnson, Operation Manager</p> <p><u>Date of Correction:</u> November 1, 2011</p>		

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S0162	<p>410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(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.</p> <p>Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence according to facility policy for 3 of 3 (B#3, 4 and 5) facility staff members.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility policy #144 on 10-12-11, titled CPR and ACLS Training, indicated the following: All employees of the Center will be trained in CardioPulmonary Resuscitation (CPR), based on the frequency required by the American Heart Association or American Red Cross. 2. Review of the personnel files for 3 of 3 staff members (B#3, 4, and 5) lacked evidence of CPR competency as required by facility policy. 3. Interview with B#2 on 10-12-11 at 1300 hours confirmed 3 of 3 employees 	S0162	<p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 11, 2011 Re: Plan of Correction ID Prefix Tag S 162 Corrective Action: Policy 144 has been revised stating that all employees of the center with direct patient contact will be trained in CPR. The new policy will go to the governing body on 12-6-11 for approval. The revised policy will be placed in the Policy and Procedure Manual. The employee that is in need of CPR is scheduled for training at Gibson General Hospital in Jan. 2012. The employee flow spreadsheet has been revised to separate the patient care employees and those with no patient care contact. Prevention: The policy has been revised to reflect only employees with direct patient contact will require CPR rather than all employees. The employee flow sheet is reviewed on a monthly basis to ensure current standings for all</p>	12/06/2011			

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S0310	<p>(B#3, 4, and 5) do not have current CPR competency as required by facility policy.</p> <p>410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the ASC failed to assure the contracted services of Radiology, Transcription, and Security are included in the facility Quality Assurance of Performance Improvement (QAPI) program.</p> <p>Findings include:</p> <p>1. Review of facility documents on 10-11-11 lacked evidence that the contracted services of radiology, transcription, and security are included in the facility Quality Assurance of Performance Improvement (QAPI) program to ensure they are provided in a safe and effective manner.</p> <p>2. Interview with B#1 on 10-11-11 at 1515 hours confirmed the contracted services of radiology, transcription, and security are not included in the facility</p>	S0310	<p>employees. <u>Responsible Individuals:</u> Tracy Maglis, RN, RN Coordinator and Melissa Johnson, Operation Manager <u>Date of Correction:</u> December 6, 2012</p> <p>To: Indiana State Department of Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 10, 2011</p> <p>Re: Plan of Correction</p> <p>ID Prefix Tag S 310</p> <p><u>Corrective Action:</u> QA studies on Transcription, Radiology, and Security began on November 1, 2011 and will run for a time period of three months. Results will be reported to the Governing Body at completion and then annually thereafter.</p>	11/01/2011

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	QAPI program.		<p><u>Prevention:</u> On November 1, 2011 The Surgery Center began utilizing the ASC QA/QI revised worksheet provided by the Indiana state surveyors during their inspection on October 12, 2011. Radiology, Transcription, and Security have been added to the list of contracted services to be monitored under our QA/QI program. This worksheet will give the Center a guideline to follow to maintain compliance with State requirements.</p> <p><u>Responsible Individuals:</u> Tracy Maglis RN, RN Coordinator</p> <p><u>Date of Correction:</u> QA studies on Transcription, Radiology, and Security began on November 1, 2011 and will run for three months. Results will be reported to the Governing Body at completion and then annually thereafter.</p>		

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

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	<p>that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually.</p> <p>(e) Any serious reportable listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the center between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)</p> <p>Based on document review and interview, the facility failed to include adverse events, reportable to the Indiana State Department of Health (ISDH) in the</p>	S0334	To: Indiana State Department of	11/14/2011

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	<p>facility Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 10-11-11 lacked evidence that adverse events, reportable to the ISDH, were included in the facility QAPI program. 2. Interview with B#1 on 10-11-11 at 1515 hours confirmed adverse events, reportable to the ISDH, are not included in the facility QAPI program. 		<p>Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 14, 2011</p> <p>Re: Plan of Correction</p> <p>ID Prefix Tag S 334</p> <p><u>Corrective Action:</u> Adverse Medical Error Events Reportable to the State is currently on the agenda for each Governing Body meeting and is reflected in these meeting minutes. Review of meeting minutes shows no reportable event at the Center. Adverse Medical Error Events Reportable to the State has <i>now</i> been added to the agenda for our staff QA/QI program. In the event of a reportable medical error determined by the Center's QA/QI program, the Center will report the occurrence to the ISDH as defined in the Indiana State regulations.</p> <p><u>Prevention:</u> On November 1, 2011 The Surgery Center began utilizing the ASC QA/QI revised worksheet provided by the Indiana state surveyors during their inspection on October 12, 2011. Adverse medical error events reportable to the State have been added to the list of QA/QI monitors to be included in</p>		

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S0400	<p>410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and document review, the facility failed to ensure disinfectant solutions were mixed according to manufacturers guidelines for terminal cleaning and failed to provide a sanitary environment for 1 of 2 operating rooms (OR).</p> <p>Findings include:</p> <p>1. During observation of the terminal cleaning beginning at 3:35 p.m. on 10/11/11, the following was observed:</p>	S0400	<p>our facility's QA/QI program. This worksheet will give the Center a guideline to follow to maintain compliance with State requirements. Also, the Operations Director reports annually to the State these occurrences through the Center's State Specific Outcomes Report to Indiana.</p> <p><u>Responsible Individuals:</u> Tracy Maglis RN Clinical Coordinator and Melissa Johnson, Operations Director</p> <p><u>Date of Correction:</u> November 14, 2011</p> <p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 9, 2011 Re: Plan of Correction ID Prefix Tag S 400 <u>Corrective Action:</u> The housekeeper has been advised that the cleaning concentration that was being used is inadequate to achieve the disinfection standard. He has been made aware that the concentration needs to be 10 ounces of H2Orange to 1 gallon of water. There are cards, with directions for usage as a floor disinfectant and surface</p>	12/01/2011

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	<p>(A) Staff member #H1 mixed H2 Orange2 Concentrate 3 ounces with 3 gallon of water to clean the floors and 5 ounces of solution to 64 ounces of water to clean surfaces.</p> <p>2. During observation of cleaning between cases in OR #2 beginning at 12:25 p.m. on 10/12/11, the following was observed: (A) The pad on the OR table had multiple tears rendering it impossible to disinfect between cases.</p> <p>3. Label directions for the H2 Orange2 Concentrate state "To insure that all bacteria and viral agents, except HIV- are killed as stated, use 10 oz. of H2 Orange2 Solution concentrate 117 manual and dispenser dilution (10 parts to 118 parts) of cold water. For HBV, use concentration of 10 oz. per gallon (10 parts per 118 parts)"</p>		<p>disinfectant, posted in the housekeeping closet. The Operation Manager or Clinical Manager will randomly observe the housekeeper while preparing the mop bucket and the manual cleaning bucket on a monthly schedule. The dilution ratio will be observed to ensure the correct concentration is being used to reach the manufacturer's recommendations. The observations will be recorded and reported in the QA/PU meeting and reported quarterly to the Governing Body. The monthly concentration observations have been added to the QA/PI worksheet. The Amsco 3085 table has new body and foot pad sections. These pads were replaced due to cracking. <u>Prevention:</u> During routine cleaning and end of the day cleaning special attention will be paid to the table pads to ensure the integrity of the pad surfaces. If any compromises in the pad integrity is noted either Tracy Maglis or Melissa Johnson will be contacted to purchase a replacement. <u>Responsible Individuals:</u> Melissa Johnson, Operation Manager, Tracy Maglis, RN, Clinical Coordinator and Eddie Harris, Housekeeping <u>Date of Correction:</u> December 1, 2011</p>		

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S0616	<p>410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on document review and staff interview, the facility failed to ensure the integrity of the medical record was maintained and the record entries were secure for 19 of 19 medical records.</p> <p>Findings include:</p> <p>1. Review of patients #N3-N5 and N7-N22 (all discharged >30 days) electronic medical records indicated the following: (A) The operative reports and the physician dashboard section of the records were not locked and could be altered.</p> <p>2. Review of patients #N4, N8, N10, N15, and N17 (all discharged > 30 days) electronic medical records indicated the following: (A) The history and physical (H&P) was</p>	S0616	<p>To: Indiana State Department of Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 14, 2011</p> <p>Re: Plan of Correction</p> <p>ID Prefix Tag S 616</p> <p><u>Corrective Action:</u> Z-chart provides services for our facility's electronic medical records. Brian Hamrin, Z-chart software specialist, was contacted concerning this problem on October 13, 2011 after our State inspection. On November 14, 2011, Brian notified our facility</p>	11/14/2011	

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	<p>not locked and could be altered.</p> <p>3. Staff member #1 indicated in interview at 4:45 p.m. on 10/12/11 indicated that the above portion of the medical records were an attached document to the record and not a file that could not be altered.</p>		<p>that a change had been made in the Z-chart program database that would enable the <i>entire</i> Z-chart medical record to be locked after pressing the locked button in the medical record. This change allows the sections of the medical record that were not previously locking (physician dashboard and attached documents) to be locked. Also, all documents saved to the attached documents section of Z-chart will be scanned or PDF documents. This allows no changes to be made in this area as well.</p> <p><u>Prevention:</u> All staff members have been notified to save only scanned or PDF word documents to the attached documents section of Z-chart. This change as well as Brian's software update will now ensure the integrity of the medical record.</p> <p><u>Responsible Individuals:</u> Tracy Maglis RN Clinical Coordinator and Brian Hamrin, Z-chart software specialist</p> <p><u>Date of Correction:</u> November 14, 2011</p>		

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S0620	<p>410 IAC 15-2.5-3(c)(5)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(5) Plain paper facsimile orders, reports, and documents are acceptable for inclusion in the medical record if allowed by the center policies.</p> <p>Based on document review and interview, the facility failed to develop a policy to ensure facsimile documents are on plain paper.</p> <p>Findings include:</p> <p>1. Review of facility policies/procedures on 10-11-11 and 10-12-11 lacked evidence that the facility had developed a policy to ensure facsimile documents are on plain paper.</p> <p>2. Interview with B#2 on 10-12-11 at 1300 hours confirmed the facility has not developed a policy to ensure facsimile documents are on plain paper.</p>	S0620	<p>To: Indiana State Department of Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 11, 2011</p> <p>Re: Plan of Correction</p> <p>ID Prefix Tag S 620</p> <p><u>Corrective Action:</u> Policy 1018 page 1 Reasonable Safeguards – Facsimile and E-Mail Transmissions has been revised. The revision states: “All faxes received by the Surgery Center must be submitted on plain paper”. The governing body reviewed and approved the revised policy on Nov. 1, 2011. The revised policy has been updated in the Policy and</p>	11/01/2011	

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S0622	<p>410 IAC 15-2.5-3(c)(6)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(6) The center shall have a system of coding and indexing medical records which allows for timely retrieval of records by diagnosis and procedure, physician, and condition on discharge, in order to support continuous quality assessment and improvement activities. Based on document review and interview, the facility failed to implement a system which allows for timely retrieval of records by condition on discharge.</p> <p>Findings include:</p> <p>1. Review of the facility surgical log of patients on 10-12-11 lacked evidence that the condition on discharge was included.</p>	S0622	<p>Procedure Manuel.</p> <p><u>Prevention:</u> All staff members have been advised of the policy revision and they have also been instructed to not accept any fax unless on plain paper.</p> <p><u>Responsible Individuals:</u> Melissa Johnson, Operation Manager and Stephanie Adams, Office Administrator</p> <p><u>Date of Correction:</u> November 1, 2011</p> <p>To: Indiana State Department of Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 11, 2011</p> <p>Re: Plan of Correction</p>	11/11/2011

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S0706	<p>2. Interview with B#1 on 10-12-11 at 1320 hours confirmed the log of patients receiving treatment at the ASC does not include their condition on discharge and patient records cannot be retrieved by the condition on discharge.</p> <p>410 IAC 15-2.5-4(a)(2)</p> <p>The medical staff shall do the following:</p> <p>(2) Examine credentials of candidates for appointment and reappointment to the medical staff by using sources in accordance with center policy and applicable state and federal law.</p> <p>Based on document review and interview,</p>	S0706	<p>ID Prefix Tag S 622</p> <p><u>Corrective Action:</u> The Surgery Center O.R. case log has been updated to now include a column for Condition at Discharge. All patients seen in the center will now have their condition at the time of discharge documented in the log book.</p> <p><u>Prevention:</u> The log book is completed at the end of each day's procedures. The centers' log book is an electronic spreadsheet and is reviewed weekly by the nursing staff. If information is missing a blank column will notify the nurse to complete the condition of discharge</p> <p><u>Responsible Individuals:</u> Tracy Maglis, RN, RN Coordinator and Daphne Smith, RN</p> <p><u>Date of Correction:</u> November 11, 2011</p> <p>To: Indiana State Department of</p>	01/01/2012	

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S0708	<p>the medical staff failed to ensure 6 of 6 physicians (MD's #1-6) had annual peer reviews completed as required by the medical staff bylaws.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of physician credential files on 10-11-11 and 10-12-11 lacked evidence the medical staff had conducted annual peer review/performance reviews for 6 of 6 physicians (MD's #1-6) as required by the medical staff bylaws. 2. Review of the medical staff bylaws on 10-11-11 indicated the following under Appointments and Privileges: Peer reviews will be conducted annually. 3. Interview with B#2 on 10-12-11 at 1300 hours confirmed the medical staff bylaws require annual peer review for physicians; B#2 confirms 6 of 6 physician (MD's # 1-6) credential files lack evidence of annual peer review/performance review. <p>410 IAC 15-2.5-4(a)(3)</p> <p>The medical staff shall do the following:</p> <p>(3) Make recommendations to the governing body on the appointment or reappointment of the applicant for a period not to exceed two (2) years. Based on document review and interview,</p>	S0708	<p>Health From: The Princeton Surgery Center Date: November 11, 2011 Re: Plan of Correction ID Prefix Tag S 706 Corrective Action: The Governing Body was advised on November 1, 2011, during the quarterly business meeting, that there had not been peer reviews performed for the staff physicians. The board was advised that this function must be under taken by fellow physicians. The board is contacting Gibson General Hospital to assist them in the evaluation process. Prevention: The physician credentialing spreadsheet has been revised with a column added for annual peer reviews. This spreadsheet is monitored on a weekly base to prevent any physician lapsing in a peer review. Responsible Individuals: Dr. Wagih A. Satar, CEO and Melissa Johnson, Operation Manager Date of Correction: Jan. 01, 2012</p>	11/01/2011	

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	<p>the medical staff failed to make recommendations to the governing board for 4 of 6 (MD#2, 3, 4, 5) medical staff reappointments for a period not to exceed 2 years.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of physician credential files on 10-11-11 and 10-12-11 indicated the medical staff failed to ensure 4 of 6 (MD's #2, 3, 4, and 5) medical staff recommendations for reappointment were acted upon at least every two years. Review of physician credential files on 10-11-11 and 10-12-11 indicated the following: <ol style="list-style-type: none"> MD#2 was reappointed 9-30-09 MD#3 was reappointed 9-30-09 MD#4 was reappointed 7-2-09 MD#5 was reappointed 3-11-08 Review of Medical Staff Bylaws on 10-12-11 indicated the following under Appointments and Privileges: Appointments shall be made by the Governing Body upon recommendations by the Medical Staff. All appointments shall be made for a 2-year period. Interview with B#2 on 10-12-11 at 1300 hours confirmed 4 of 6 physician reappointments (MD's #2, 3, 4, and 5) have not been acted upon by the medical staff every two years as required by the medical staff bylaws. 		<p>To: Indiana State Department of Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 9, 2011</p> <p>Re: Plan of Correction</p> <p>ID Prefix Tag S 708</p> <p><u>Corrective Action:</u> All facility approved physicians' credentialing files were reviewed by the Governing Body on November 1, 2011. Physicians with current reappointment packets but have not practiced in the facility for 2 years were removed from active status. The remaining physician files were reviewed and appointments to the staff were made based on the date of their last reapplication packet. Forms affirming active status were completed based on date from last reapplication form, signed by board members and added to each physician's file.</p> <p><u>Prevention:</u> The spreadsheet with physician credentialing information was revised to include physician reappointment date column. This spreadsheet is checked on a routine bases.</p>		

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S0728	<p>410 IAC 15-2.5-4(b)</p> <p>(b) The medical staff shall adopt and enforce bylaws to carry out its responsibilities. These bylaws and rules must be as follows: Based on document review and interview, the medical staff failed to ensure ACLS certification for 4 of 6 (MD's #1, 2, 4, and 5) physicians according to facility policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of physician credential files on 10-11-11 and 10-12-11 lacked evidence that 4 of 6 (MD's #1, 2, 4, and 5) physicians had current ACLS certification as required by facility policy. Review of facility policy, #215, titled Quality Improvement-Medical Staff Credentialing, indicates the following as requirements: Current ACLS certification for practitioners supervising or administering conscious sedation. Interview with B#2 on 10-12-11 at 1300 hours confirmed MD's #1, 2, 4, and 	S0728	<p>Primary Source reappointment reminders will be utilized to check the accuracy of the spreadsheet information.</p> <p><u>Responsible Individuals:</u> Melissa Johnson, Operation Manager</p> <p><u>Date of Correction:</u> November 1, 2011</p> <p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 11, 2011 Re: Plan of Correction ID Prefix Tag S 728 Corrective Action: The Medical Staff Bylaws will be revised removing the ACLS requirement for physicians to have current ACLS certification. Policy 215 Quality Improvement – Medical Staff Credentialing pages 1, 3, 4 and 5 will have the requirement of current ACLS certification removed. This measure will go before the Governing Body during the next business meeting for approval. <u>Prevention:</u> There is no preventative action to take place due to the fact that requirements are being deleted rather than added. <u>Responsible Individuals:</u> Dr. Wagih A. Satar, CEO and Melissa Johnson, Operation Manager <u>Date of Correction:</u></p>	12/11/2011

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S0786	<p>5 supervise/administer conscious sedation and do not have current ACLS certification as required by facility policy.</p> <p>410 IAC 15-2.5-4(b)(3)(Q)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(Q) A requirement for a center that permits patient care responsibilities by practitioners other than physicians, to have established policies and procedures, approved by the governing body, for overseeing and evaluating the nonphysician practitioners.</p> <p>Based on staff interview and document review the facility failed to ensure physician oversight of nonphysician practitioners for every pain management procedure provided.</p> <p>Findings include:</p> <p>1. Staff member #2 indicated the following in interview beginning at 3:10 p.m. on 10/12/11:</p> <p>(A) AH #2 performs pain management procedures with the oversight of M.D. #3.</p> <p>(B) M.D. #3 may not always be in the facility during the pain management procedures.</p>	S0786	<p>December 11, 2011</p> <p>To: Indiana State Department of Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 9, 2011</p> <p>Re: Plan of Correction</p> <p>ID Prefix Tag S 786</p> <p><u>Corrective Action:</u> Pain Management procedures will no longer be scheduled when Dr.</p>	10/13/2011	

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	<p>2. Patients #1, 2, and 3 had no physician oversight of procedure performed on 8/31/11.</p> <p>3. Review of schedules for 8/31/11 indicated that AH #2 performed three (3) pain management procedures and M.D. #3 was documented as out of town 8/28/1-8/31/11.</p>		<p>Beck is not in the facility. Corey Potts and Dr. Beck have been advised that Dr. Beck has to be in the center at all times when pain management procedures are being performed regardless of whether IV anesthesia is being administered. Dr. Beck will also comply with: <u>Policy 721</u> A history and physical will be present on each patient's medical record, <u>preferably</u> performed no longer than <i>seven (7) days</i> from the scheduled surgery date, and at most, within a 30 day period of the scheduled surgery date. The physician history and physical (H&P) will include a review of systems, any known allergies, previous surgeries, medications and dosages, and a medical history taken from the patient.</p> <p>If the history and physical is done 24 hours or more prior to the scheduled surgery date, the physician must update the history and physical when the patient enters the facility. An update checkbox will be available at the end of the report. The physician will write in any update information if applicable and sign and date the box for the date of surgery.</p> <p>A patient H&P performed by physician <u>other</u> than the attending surgeon will be reviewed by the attending surgeon pre-operatively as well as any lab or other</p>		

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			<p>diagnostic result(s). Documentation of the attending physician's agreement with the evaluation will be made on the patient's medical record prior to the patient's transport to the operating room.</p> <p><u>Prevention:</u> The Pain Clinic will be closed on days when Dr. Beck is out of town. Pain procedures will not be allowed to proceed if Dr. Beck leaves the building but can resume when he returns. The scheduling software has been programmed to not allow procedures to be scheduled if Dr. Beck is not scheduled to be present.</p> <p><u>Responsible Individuals:</u> Tracy Maglis, RN Coordinator and Melissa Johnson, Operation Manager and Stephanie Adams, Office Administrator.</p> <p><u>Date of Correction:</u> October 13, 2011</p>		

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S1026	<p>410 IAC 15-2.5-6(3)(E)(i)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(i) Drug cabinets must be accessible only to authorized personnel.</p> <p>Based on document review, the facility failed to ensure medications, syringes and needles were accessible only to authorized personnel for one (1) exam room toured.</p> <p>Findings include:</p> <p>1. During tour of the exam room within the preoperative area beginning at 11:15 a.m. on 10/12/11, the following was observed:</p> <p>(A) One (1) vial of Sensorcaine, eight (8) 100 ml bottles of Sodium Chloride, twenty five (25) 30 ml vials of Sodium Chloride, one (1) bottle of Kenalog, and one (1) tube of Clotrimazole was observed in an unlocked bedside table.</p> <p>(B) > 20 (1cc) syringes and >40 needles</p>	S1026	<p>To: Indiana State Department of Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 9, 2011</p> <p>Re: Plan of Correction</p> <p>ID Prefix Tag S 1026</p> <p><u>Corrective Action:</u> All medications and sharps have been removed from areas where office patients are seen. These supplies are</p>	11/14/2011	

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S1198	<p>were observed in unlocked drawers under the exam table.</p> <p>410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the facility failed to coordinate emergency and disaster preparedness with a an</p>	S1198	<p>stored in a caddy that is brought out to the nurse's station at the beginning of the office schedule. The caddy will stay in the nurse's station and the doctor will come to the station to obtain needed supplies. This caddy is then locked in the Operation Manager office at the end of the day.</p> <p><u>Prevention:</u> The office exam rooms are inspected after each patient visit to ensure nothing has been accidentally left in the room and that single dose vials are destroyed after use. Dr. Beck has been instructed that due to patient safety issues we cannot store any medications or supplies that patients could harm themselves with in patient exam rooms.</p> <p><u>Responsible Individuals:</u> Melissa Johnson, Operation Manager</p> <p><u>Date of Correction:</u> November 14, 2011</p>	11/09/2011	

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	<p>appropriate community, state, or federal agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility documents lacked evidence that the facility emergency and disaster preparedness program is coordinated with an appropriate community, state, or federal agency. 2. Interview with B#2 on 10-12-11 at 1300 hours confirmed the ASC emergency and disaster preparedness is not coordinated with any community, state, or federal agency. 		<p>To: Indiana State Department of Health</p> <p>From: The Princeton Surgery Center</p> <p>Date: November 9, 2011</p> <p>Re: Plan of Correction</p> <p>ID Prefix Tag S 1198</p> <p><u>Corrective Action:</u> Terry Hedges with the local Emergency Management Association was contacted to register the Princeton Surgery Center with the local agency. Terry requested that the center contact Susan Woods with Gibson General Hospital to provide information regarding the center. Susan informed the center that there is a District 10 hospital emergency management planning committee. This committee meets at various times throughout the year and has invited the center to participate. The next meeting is scheduled for Jan. 2012 at Gibson General Hospital. Susan has added the center to the listing of facilities to participate in the annual disaster preparedness drill. She has also enrolled the center to participate in the upcoming emergency evacuation training drill scheduled for April 2012. Susan will be visiting the center after the first of</p>		

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S1210	<p>410 IAC 15-2.5-8(c)(1)</p> <p>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:</p> <p>(1) Radiology services must be supervised by a radiologist or radiation oncologist.</p> <p>Based on document review and interview, the facility failed to ensure the facility's radiology services provided on-site at the center are supervised by a radiologist or</p>	S1210	<p>the year to look over the space available and supplies that we have on the premises. The center will also be attending the Local Emergency Preparedness Committee meetings where members from all county wide services are present to review and update information.</p> <p><u>Prevention:</u> The center is now registered with the emergency services providers for Gibson County and District 10. These agencies will be notifying the center of all meetings and drills scheduled. There are attendance schedules maintained for all of the functions</p> <p><u>Responsible Individuals:</u> Melissa Johnson, Operation Manager</p> <p><u>Date of Correction:</u> November 9, 2011</p> <p>To: Indiana State Department of Health From: The Princeton Surgery Center Date: November 16, 2011 Re: Plan of Correction ID Prefix Tag S 1210 Corrective</p>	01/01/2012	

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NAME OF PROVIDER OR SUPPLIER THE SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2030 SHERMAN DR PRINCETON, IN47670		
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	radiation oncologist. Findings include: 1. Review of facility documents lacked evidence that the radiology services at the center are supervised by a radiologist or radiation oncologist. 2. Interview with B#2 on 10-12-11 at 0900 hours confirmed the facility does not have a radiologist or radiation oncologist supervising the radiology services provided by the center.		<u>Action:</u> Contract a Radiologist or Radiation Oncologist to provide oversight for our radiology program and make a supervisory visit to the Center annually. Dr. Benjamin Wendell, a board certified radiologist, has been asked to contract with the Center for this service. <u>Prevention:</u> On November 1, 2011 The Surgery Center began utilizing the ASC QA/QI revised worksheet provided by the Indiana state surveyors during their inspection on October 12, 2011. The Radiologist/Radiation Oncologist has been added to the list of contracted services to be monitored under our QA/QI program. This worksheet will give the Center a guideline to follow to maintain compliance with State requirements. <u>Responsible Individuals:</u> Tracy Maglis RN Clinical Coordinator and Melissa Johnson, Operations Director <u>Date of Correction:</u> January 1, 2012		