

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001174	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
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NAME OF PROVIDER OR SUPPLIER METRO SPECIALTY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MISSOURI AVE, BLDG 18 JEFFERSONVILLE, IN 47130
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S000000	This was a standard licensure survey. Facility Number: 012244 Survey Dates: 9/23/14 to 9/24/14 Surveyors: Trisha Goodwin, RN BS Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor Marcia Anness, RN Public Health Nurse Surveyor QA: cloughlin 10/10/14	S000000		
S000048	410 IAC 15-2.3-1 ISSUANCE OF LICENSE 410 IAC 15-2.3-1 (d) (d) All changes in ownership, name, and address must be reported in writing to the division. Reapplication must be filed when a change of fifty percent (50%) or greater ownership occurs. Based on document review and interview, the facility failed to report, in writing, changes in ownership to the division.	S000048	S-0048 Administrator submitted most recent Exhibit A during survey that shows ownership. Most recent Exhibit A is also attached. Administrator is now	09/24/2014

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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S000110	<p>Findings:</p> <ol style="list-style-type: none"> Review of documents titled Exhibit A to Operating Agreement dated January 1, 2014 and April 1, 2014 indicated 16 owner members on the 1/1/14 list and 17 owner members on the 4/1/14 list. In interview on 9/23/14 at 11:00am, employee A1, Administrator, indicated the facility had a change in ownership by adding a new owner and that this was not reported to the State. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review, it could not be determined that the governing body (GB) reviewed quality assessment and improvement (QAPI) reports in any quarter of 12 months reviewed.</p>	S000110	<p>aware that changes need to be submitted at the time of change and will follow protocol of reporting to state. No ownership changes have been made since the survey. Administrator is responsible.</p> <p>S-0110: Administrator submitted meeting notes during survey. See Exhibit B for agenda of 5/14/13 quality council. Exhibit B was presented at 5/14/13 board meeting and a 5/14 quality council meeting as well that was held</p>	09/24/2014

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S000156	<p>Findings:</p> <ol style="list-style-type: none"> Review of documents titled Members Meeting dated 5/14/13, 9/9/13, 1/7/14 and 5/7/14 lacked documentation of GB review of QAPI reports. Review of documents titled Agenda - Quality Council Quarterly Reporting dated May 2014 and 9/9/14 lacked documentation of reports being presented to the GB. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on policy review, personnel file review and interview, the facility failed to ensure that performance appraisals were</p>	S000156	<p>prior to the board meeting. Subsequent meetings on 9/9/13, 11/7/14 followed the same format. Correction is to always make documentation of separate meetings held for quality council and board meetings and not let the detailed agenda suffice. Further, all going quality council meetings will contain Exhibit C-our updated QAPI plan (with the addition of housekeeping) that will monitored monthly but reported quarterly. Next quality meeting and board meeting in January 2015 will reflect above documented process. Administrator is responsible for tasks described above.</p> <p>S0156: Purchasing agent job description added to staff P3 file. Completed by Clinical Manager</p>	09/26/2014			

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	<p>completed on 4 of 7 staff (P3, N2, N4, N5).</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of policy and procedure, "Annual Performance Appraisal" approved on 1/7/14 in the Members Meeting indicated: <ol style="list-style-type: none"> Policy read "All employees have a right to have their performance evaluated on a yearly basis." Review of one direct/support care non-credentialed staff, P3, radiology technician, included a document titled Job Description - Radiology Technician, the most recent performance evaluation dated 7/24/13 for Job Title: Purchasing Agent and no other documentation of performance evaluation. In interview on 9/24/14 at 4:35 pm, employee A2, Nurse Manager/Administrator designee, indicated the facility policy & procedure (P&P) for evaluations to be that employees will have an annual evaluation. Review of staff personnel files for staff member #s N2(CM), N4(RN) and N5(RN) had performance appraisals due prior to 9/23/14. These performance appraisals were not present. At 4:30 PM on 9/24/14, staff member 		(CM) who has responsibility for this. Annual eval for rad tech completed and placed in file (9/26/14). Completed all staff evals, reviewed with staff by CM and placed in files. (9/26/14). The rad tech and materials/purchasing manager are the same employee and will be evaluated by both job descriptions. Clinical manager is responsible for follow up.	

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S000230	<p>#N2(CM) verified that staff members #s N2, N4, N5 have not received an annual performance appraisal.</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> <p>Based on document review and interview, it could not be determined that the governing body (GB) provided for periodic utilization review (UR) by a committee composed of physicians having no financial interest in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the document titled Exhibit A to Operating Agreement, April 1, 2014 indicated 14 physicians with financial interest to the facility. Review of the document titled Utilization Review/Peer Review 	S000230	S230: Process is currently in place where our anesthesiologist provide peer review and ongoing, daily review of operations and utilization review. Admin has designated three leaders to formalize process and governing board shall approve designation at next meeting 1/6/15. Names of anesthesiologists designated as "Periodic Reviewers": Dr. Carla Guess, Dr. Danna Whittenburg and Dr. Rob Keifer. The named periodic reviewers have no financial interest in Metro Specialty. Administrator is responsible for follow up.	10/01/2014			

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S000310	<p>indicated three of six (3/6) participants with financial interest in the facility.</p> <p>3. In interview on 9/24/14 at 2:00 pm, employee A2 indicated not all UR meeting minutes were available, verified the above and provided no further documentation prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the center failed to include all services in the quality assessment and performance improvement program (QAPI) in any instance.</p> <p>Findings:</p> <p>1. Review of documents titled Agenda - Quality Council Quarterly Reporting dated 5/2014 and 9/2014 and the document spreadsheet dated September 2014 provided as indication of quality monitors and standards indicated no inclusion of the contracted and/or</p>	S000310	S310: This was never mentioned in a survey at Metro by surveyors. Nonetheless, we have added 'tissue storage' to our QAPI template. Please see Exhibit C. This will be approved officially and reported to the board at our next meeting January 6, 2015. Admin is responsible for follow up.	10/24/2014			

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S000400	<p>provided service of tissue transplant.</p> <p>2. In interview on 9/24/14 at 1:30 pm, A2 confirmed the above, informed no further documentation for QAPI was available at this time and stated the service of tissue transplant had not been included in 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>Based on policy review and observation, the facility failed to ensure that surgical skin prep was done using sterile technique in 1 of 1 OR cases.</p> <p>Findings:</p> <p>1. Review of policy and procedure, "Preparation of Skin in the OR" approved 1/7/14 in the Members Meeting indicated:</p> <p style="padding-left: 40px;">a. Under the " Procedure", step I stated " Don sterile gloves"</p> <p>2. Observation on 9/24/14 of patient #27's skin prep in the OR found that staff member #N7 did not don gloves while prepping skin prior to surgery.</p>	S000400	S-400" Clinical manager (CM) reviewed P and P for surgical prep with OR personnel in staff meeting on 9/25/2014. CM will conduct periodic observation of staff to ensure future compliance. CM responsible for follow up.	09/25/2014			

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S000624	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(7)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(7) The center shall ensure the confidentiality of patient records. The center must develop, implement, and maintain the following:</p> <p>(A) A procedure for releasing information or copies of records only to authorized individuals, in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records. Based on document review, observation and interview, the facility failed to implement policy and procedure (P&P) to ensure the confidentiality of patient records in any instance.</p> <p>Findings:</p> <p>1. Review of facility P&P titled Medical Records, last approved 1/7/14, indicated: The medical records shall be maintained in a locked filing cabinet within the facility.</p>	S000624	S624: Admin has received quote for \$6205.71 replacement of existing chart storage system to make it more secure, fire and water proof and locking. 10/24/14. Chart storage system will be re-quoted for better pricing. 11/24/14 Chart storage system will be installed. 12/24/14 Quote attached in Exhibit D Administrator responsible for follow up.	10/24/2014

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S000658	<p>2. During facility tour on 9/24/14 between 12:30 pm and 1:30 pm in the presence of A2, it was observed in an area to the side of the reception desk, without closure to the waiting area and only one locking door on the staff side hallway, metal sliding file shelves with patient medical records (MR), indicated by A1 to be the facility MR storage area. The shelves had no locking mechanism nor enclosure for fire protection.</p> <p>3. In interview on 9/24/14 at 1:30 pm, employee A1 indicated this area could be accessible by persons in the facility after hours or at a time the front desk were unattended.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(6)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(6) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on policy review, medical record review and interview, the facility failed to</p>	S000658	S658: Anesthesia consents will be changed to include check box	09/24/2014	

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S000676	<p>ensure that informed consent was completed on 22 of 27 medical records.</p> <p>Findings:</p> <p>1. Review of policy and procedure, "Anesthesia Services" approved 1/7/14 by the Members Meeting indicated:</p> <p style="padding-left: 40px;">a. Under "Pre-Anesthesia Evaluation and Care" step D stated" The anesthesiologist or his designate will obtain an anesthesia consent from the patient which must include a description of proposed anesthesia."</p> <p>2. Medical record review indicated the following:</p> <p style="padding-left: 40px;">a. Medical record #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 13, 16, 17, 18, 19, 21, 22, 24, 25, 26, 27 and 28 did not designate the proposed anesthesia.</p> <p>3. At 5:30 PM on 9/24/14, staff member #2(NM) verified that anesthesia consents on the above medical records did not designate which technique was discussed with the patient for their procedure.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or</p>		<p>for anesthesia designation and change reviewed with anesthesia. 9/25/14 New form developed for more simplified compliance 10/24/14 New form will be implemented with CM responsible for follow up through periodic review See Exhibit G for new form (attached)</p>				

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	<p>legally reproduced medical records must be maintained by the center for a period of seven (7) years in accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure.</p> <p>Based on document review, observation and interview, the facility failed to maintain medical records (MR) in accordance with the center policy.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of facility P&P titled Medical Records, last approved 1/7/14, indicated: The medical records shall be maintained in a locked filing cabinet within the facility. The P&P further indicated: ...all efforts shall be made to protect the records from fire, water, or other sources of damage. During facility tour on 9/24/14 between 12:30 pm and 1:30 pm in the presence of A2, it was observed in an area to the side of the reception desk, without closure to the waiting area and only one locking door on the staff side hallway, metal sliding file shelves with patient medical records (MR), indicated by A1 to be the facility MR storage area. The shelves had no locking mechanism 	S000676	<p>S0676: Admin has received quote for \$6205.71 replacement of existing chart storage system to make it more secure, fire and water proof and locking. 10/24/14. Chart storage system will be re-quoted for better pricing. 11/24/14 Chart storage system will be installed. 12/24/14 Quote attached in Exhibit D Admin responsible for follow up.</p>	12/24/2014			

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S000704	<p>nor enclosure for fire protection.</p> <p>3. In interview on 9/24/14 at 1:30 pm, employee A1 confirmed the storage lacked a protective closure and indicated this area could be accessible by persons in the facility after hours or at a time the front desk were unattended. A1 further indicated the cleaning staff who were regularly in the facility after hours, each signed HIPAA agreements and provided documentation of such.</p> <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 of the facility failed to conduct outcome-oriented performance evaluation of its members in 11 of 11 credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 11 credential files, eight (8) physician and three (3) allied health, indicated lack of documentation of</p>	S000704	S704: See attached document Exhibit E for new performance appraisal process to be used for re-credentialing. Administrator in charge of follow up through periodic review of files.	10/24/2014			

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S000710	<p>performance evaluations for any of the eleven reviewed.</p> <p>2. Review of documents titled Peer Review Committee Meeting dated 5/6/14 and 9/4/14 lacked documentation of out-come oriented performance evaluations. No other documents were made available for review.</p> <p>3. In interview on 9/23/14 at 1:00 pm, employee A1, Administrator, indicated the facility conducted no performance evaluations of the medical staff (MS), but instead used Peer Review.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the</p>			

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	<p>individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p> <p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p>						

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S000756	<p>(G) Other items specified by the center and medical staff.</p> <p>Based on documentation and interview, the facility failed to include appropriate documentation for each member of the medical staff (MS) for three of three (3/3) allied health (AH) members (AH 1, AH 2 and AH 3).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the credential file for AH 1 lacked documentation of a signed statement to abide by the rules of the center, and current health status. 2. Review of the credential file for AH 2 lacked documentation of appointment to the MS, experience, approved privileges, a signed statement to abide by the rules of the center, and current health status. 3. Review of the credential file for AH 3 lacked documentation of appointment to the MS, experience, approved privileges, a signed statement to abide by the rules of the center, and current health status. 4. In interview on 9/24/14 at 4:00 pm, employee A3 confirmed the above and no further documentation was provided prior to exit. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND</p>	S000710	S710: See Exhibit F for new process adapted as reflected in new application form wherein allied health and all medical staff are required to have DOP, abide by, health statement, etc as specified in S710. Administrator is responsible for follow up through periodic review.	10/24/2014			

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	<p>SURGICAL 410 IAC 15-2.5-4(b)(3)(J)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(J) A requirement that each physician's services, , dentist's services, and podiatrist's services are to be reviewed and analyzed at specified intervals at regular meetings, including, but not limited to, the following:</p> <p>(i) Appropriateness of diagnoses and treatments rendered related to a standard of care and anticipated or expected results. (ii) Performance evaluation based on clinical performance indicated in part by the results or outcome of surgical intervention. (iii) Scope and frequency of procedures.</p> <p>Based on document review and interview, the medical staff (MS) failed to ensure requirement that each MS members services were reviewed and analyzed at specified intervals and included appropriateness of diagnosis, performance evaluations based on clinical results and scope and frequency of procedures in any instance.</p> <p>Findings:</p> <p>1. Review of the document titled</p>	S000756	S0756: See Exhibit E for new process/form wherein clinical outcomes are used in new performance evaluation process for medical staff. Will be used for re-credentialing by Admin.	10/24/2014			

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S000826	<p>Medical Staff Bylaws lacked evidence of provision for specified periodic clinical outcome based evaluations of the MS.</p> <p>2. Review of documents provided as evidence of MS performance evaluations, titled Peer Review Committee Meeting, dates 5/6/14 and 9/4/14 indicated in each review that 48 physician charts, 47 nurse anesthetists, and 44 anesthesiologist charts were audited. The documents failed to include indication of physician service type or MS member, appropriateness of diagnoses, performance results or outcome of surgical interventions, or scope and frequency of procedures.</p> <p>3. In interview on 9/23/14 at 1:00 pm, employee A1, Administrator, indicated the facility conducted no performance evaluations of the medical staff (MS), but instead used Peer Review.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(E) Safety training required of</p>			

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S000850	<p>personnel. Based on document review and interview, the medical staff (MS) of the center failed to write policies and procedures (P&P) for safety training required of operating room (OR) personnel.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the document titled Medical Staff Bylaws failed to include safety training required of MS personnel. 2. In interview on 9/23/14 at 12:45 pm, employee A1, administrator, indicated that there were no separate MS rules only bylaws and policies and procedures (P&P) and that the clinical P&P served as rules of the MS. 3. Review of P&P failed to indicate a P&P for safety training required of MS. 4. In interview on 9/23/14 at 2:00 pm, employee A2, Nurse Manager, indicated the facility had no P&P for safety training required of OR personnel and no further documentation was provided prior to exit. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4 (d)</p> <p>(d) Surgical services must be organized according to scope of the</p>	S000826	S826: CM will add medical staff training to medical bylaws per board approval at next meeting 1/6/2015. CM modified existing policy and procedure on annual safety training to include 'medical staff' (10/24/14). CM was asked for safety training of 'medical staff' only during survey. Existing policy for safety training for 'OR personnel' was never requested at time of survey. See Exhibit H for OSHA guidelines that currently exist and have been in place that will be expanded to include 'medical staff' with board approval 1/6/2015. Administrator is responsible for follow up at 1/6/2015 meeting.	10/24/2014			

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	<p>services offered, to meet the needs of the patient, in accordance with acceptable standards of practice and safety. Requirements for surgical services include:</p> <p>Based on policy review and observation, the facility failed to ensure that surgical attire and cleaning of operating room followed standards in 1 of 1 case observed.</p> <p>Findings:</p> <p>1. Review of policy and procedure, "Surgical Attire for Surgery Restricted Area" approved on 1/7/14 by the Members Meeting indicated:</p> <p style="padding-left: 20px;">a. Under "Policy":</p> <p style="padding-left: 40px;">- 4. Personnel will cover head and facial hair with a clean, low lint surgical head cover or hood that confines all hair.</p> <p style="padding-left: 40px;">-5. All persons entering the restricted areas of the surgical suite should confine or remove all jewelry and watches.</p> <p style="padding-left: 40px;">-7. Closed toe shoes and clean shoe covers or O.R. dedicated shoes are to be worn.</p> <p>2. Review of policy and procedure, "Cleaning of Operating Room (Routine Clean) approved on 1/7/14 by the Members Meeting indicated></p> <p style="padding-left: 20px;">a. Under "Procedure" the step for cleaning the O.R. room indicates that</p>	S000850	S850: CM reviewed surgical attire policy with all OR personnel on 9/25/14. Visual reminders of policy were hanged in staff changing areas. PPE was evaluated for appropriateness. CM responsible for follow up and continued compliance through periodic observation. 2) Policy for cleaning OR between cases reviewed with OR personnel by CM (9/24/14). Clinical manager is responsible for follow up.	09/25/2014

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S001148	<p>trash and biohazard trash is removed from the room prior to cleaning with disinfectants.</p> <p>3. Observation on 9/24/14 in O.R., #2 form patient #27 found the following:</p> <p>a. Staff members #7(RN),9(CST) and 10(1st Assist) had earrings not covered by a bouffant cap.</p> <p>b. Staff members #8(Equipment rep), 10(1st Assist) and 12(MD) had beards not fully covered by surgical mask.</p> <p>c. Staff member #8(Equipment rep) did not have shoe covers over his/her street shoes.</p> <p>d. After the procedure, the O.R. had suction canisters with biohazard material in room while room cleaning was in process. During this time the CRNA was preparing medications(drawing up drugs) for the next case.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(A)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being pf patients are</p>			
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	<p>assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals must be available, along with training or instruction, or both, of the appropriate center personnel, in the maintenance and operation of fixed and movable equipment.</p> <p>Based on document review and interview, the facility failed to provide for periodic inspection and preventive maintenance (PM) of the physical plant and equipment by qualified personnel.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the document titled Members Meeting, dated 5/7/14, indicated in the section subtitled Administrator Approvals: The Board approved for the Administrator to be in charge of building maintenance. 2. Review of A1 employee file lacked documentation of training and/or instruction in maintenance of equipment. 3. In interview on 9/24/14 at 3:40 pm, employee A2, acting Administrator, indicated A1, Administrator, to be in charge of facility maintenance and performs the periodic inspections of the back-up generator. 	S001148	S-1148: See Exhibit I. This is the template we use to document facility maintenance and a complete form for 2014 was given to the surveyors during the survey and subsequently lost. We will continue to document facility maintenance on this template as we have done the since inception of our organization as it serves as both a calendar for inspection and proof thereof. See Exhibit J for approval to manage building and equipment and verification of training. Administrator is responsible for this task.	09/24/2014			

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S001166	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii)</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>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on observation and interview, the facility failed to ensure preventative maintenance (PM) of all patient care equipment in two (2) instances.</p> <p>Findings:</p> <p>1. During facility tour on 9/24/14 between 12:30 pm and 1:30 pm, in the presence of A2, in the orthopaedic storage room, two (2) Anthrex AR 1600M shoulder booms were noted</p>	S001166	S1166: CM began development of "Patient equipment maintenance plan" on 9/25/14. Plan will be completed and submitted for approval along with policy at board meeting 1/6/15.	09/25/2014

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	without PM stickers. PM documentation was requested of A2 at that time. 2. In interview on 9/24/14 at approximately 1:20 pm, A2 indicated PM was not done on those pieces of equipment. A2 further indicated that PM was provided only for equipment that plugged into the wall/had an electrical source and non-electrical stretchers. No further documentation was provided prior to exit.				