

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001037	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2014
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NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 REX GROSSMAN BLVD BLOOMINGTON, IN 47403
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Q000000	This visit was for a recertification survey. Facility Number: 006102 Survey Dates: 10/20/14 to 10/21/14 Surveyors: Trisha Goodwin, RN BS Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor QA: claughlin 11/12/14	Q000000		
Q000041	416.41(a) CONTRACT SERVICES 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 governing body (GB) failed to ensure that services performed under contract were included in the center's quality assessment and improvement program (QAPI) in 7 (Biohazard waste, linen services, maintenance, radiology, security, tissue transplant, transcription) of 11 instances Findings:	O000041	Q041 On 11/21/2014 a Quality Assurance Performance Improvement (QAPI)/ Medical Advisory Committee (MAC) meeting was held to discuss all contract services to include biohazard waste, linen services, maintenance, radiology, security, tissue transplant, transcription. These contract services were reviewed at the QAPI/MAC meeting and will be recommended for approval by the	12/11/2014

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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Q000162	<p>1. Review of QAPI meeting minutes dated 10/29/13, 1/31/14, 4/30/14 and 8/4/14 lacked documentation of the QAPI inclusion of the following contracted services: Biohazard waste, linen services, maintenance, radiology, security, tissue transplant, transcription.</p> <p>2. In interview on 10/21/14 at 4:00pm A1, Administrative Director, confirmed the above contracted services to not be included in the QAPI program.</p> <p>416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <p>(1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration.</p>		governing board (GB) at the 12/11/2014 GB meeting. The Administrative Director (AD) will ensure that all contract services will be evaluated for safety and effectiveness annually and as needed by the QAPI/MAC and recommended to the GB for final approval. All contract reviews and approvals will be documented in the QAPI/MAC and GB minutes.	

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	<p>(7) Documentation of properly executed informed patient consent.</p> <p>(8) Discharge diagnosis.</p> <p>Based on document review, observation, and staff interview, the facility failed to ensure medical records documented accurately the course of the patient's stay for 1 observation (patient #2) of patient care, failed to accurately document patient transfers for 2 of 3 transfers (patients #4 and #31), and failed to ensure operative notes were dictated per policy for 3 of 3 patients treated by M.D. #2 (patients #8, 9, and 21).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Facility policy titled "REVIEWING CHARTS FOR COMPLETENESS" last reviewed/revised 12/18/13 states "2. TRANSCRIPTION: The operative report is dictated (such as, the procedure report and the discharge note). The medical record will be completed when the note is dictated.....a. Transcription should be dictated within 24 hours and in chart within 7 days." Review of the medical record for patient #2 indicated that the I.V. (intravenous) was started by staff member #N9 (RN) and restarted by anesthesia provider #1 in the right hand. The record documented the wrong site 	O000162	<p>Q162 On 11/20/14, the AD emailed all medical staff members a reminder of the center's policy and CMS regulation to have all operative reports dictated within 24 hours after the surgery. The business office manager and her staff will monitor compliance daily to make sure all dictations are complete within 24 hours and in the patient's chart within 7 days of the surgery. The AD will also monitor compliance daily and report results to the QAPI/MAC, GB and record in all minutes. Q162 All anesthesia providers and staff were educated on the IV documentation on 10/22/2014. The AD revised and implemented a new pre-op assessment form that allowed for documentation of the number of IV sticks, the number of times a vein was blown with a start, the number of infiltrates and the names of staff starting the IV. All staff was in-serviced on the form changes prior to implementation. The pre-op/PACU staff will audit all charts daily at the end of the day for completeness to reach 100% compliance before staff monthly chart audits resume. The AD will ensure that monthly chart audits continue with the staff and the outside medical records consultant to monitor compliance</p>	11/20/2014

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	<p>(i.e. right vs left) and failed to indicate the number of sticks, the number of times a vein was blown with a start, the number of infiltrations, and the names of staff members attempting to start the I.V.</p> <p>3. Review of patient #4 medical record indicated the following: (A) He/she had an anedotonsillectomy on 8/12/14 and was sent via private auto to acute care hospital #1 for direct admission after the procedure. (B) The medical record indicated he/she was discharged not transferred and the record lacked evidence of a transfer form.</p> <p>4. Review of patient #31 medical record indicated the following: (A) The patient underwent a bilateral maxillary antrotomy with tissue removal, septoplasty, and bilateral inferior turbinate reduction on 9/17/13 and was sent to the physician's office for post operative complications after the procedure. (B) The medical record lacked evidence of a transfer form.</p> <p>5. Patients #8 and #9 had surgery performed by M.D. #2 on 8/28/14. The operative notes were dictated on 9/3/14.</p> <p>6. Patient #21 had surgery performed by M.D. #2 on 4/3/14. The operative note</p>		<p>with proper documentation and results will be reported quarterly and included in QAPI/MAC and GB meetings and minutes.Q162 The AD re-educated the physician involved and all staff members on the center's transfer policy, transfer forms and required documentation when transferring a patient in need of acute care on 10/22/14. The AD will monitor compliance on a daily basis by actively participating and overseeing transfers as they occur and reviewing charts for complete documentation with every occurrence. The AD will document and report results and findings quarterly in QAPI/MAC and GB meetings and minutes.</p>				

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	<p>was dictated on 4/8/14.</p> <p>7. During observation of care provided to patient #2 beginning at 12:30 p.m. on 10/20/14, the following was observed: (A) The patient was a difficult I.V. start and at least four (4) different staff members attempted to start the I.V. (B) There were > 5 attempts made with 2 blown veins prior to fluid administration and 2 infiltrates after fluid was started. (C) The I.V. was eventually started by anesthesia provider #1 in the left extremity.</p> <p>8. 4. Staff member #N10 (RN) verified there was no transfer form for patient #31 at 1:00 p.m. on 10/21/14.</p> <p>9. Staff member #N8 (RN) verified there was no transfer form for patient #4 at 2:30 p.m. on 10/21/14.</p> <p>10. Staff member #N8 (RN) verified the medical record information for patient 8, 9, and 21 beginning at 2:45 p.m. on 10/21/14.</p>				

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Q000181	<p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on document review, observation, and interview, the facility failed to ensure medications were administered in a safe manner in 2 operating rooms (ORs) and failed to include directions for storage of general medication multi dose vials in policy.</p> <p>Findings include:</p> <p>1. Facility policy titled "PHARMACY 170.2" last reviewed/revised 12/18/13 states on page 1: "c. Use multi-dose vials of saline, water and insulin until the manufacturer's expiration date on the vial or within 28 days..... d. Single use vials will be discarded after first use or end of day if the same patient on which the first dose was administered may require re-dosing. Single use vials can be used only for a single patient."</p> <p>2. During observations beginning at 12:30 p.m. on 10/20/14, the following was observed: (A) Anesthesia provider #1 was observed administering medication without using alcohol to the I.V. port</p>	Q000181	<p>Q181 The AD held an in-service staff meeting on 10/22/2014, to re-educated staff members on the center's policy and procedures for single dose and multi-dose vials. The AD emailed all anesthesia providers on 11/21/2014 to remind them of the policy on single and multi-dose vials. The AD also re-educated all staff and anesthesia providers about wiping off the IV port with an alcohol wipe prior to medication administration and cleaning the rubber stopper with an alcohol wipe prior to drawing up the medication in the staff in-service on 10/22/2014 and anesthesia provider email on 11/21/2014. The AD asked all staff to hold each other accountable when administering patient care and maintain proper infection control practices. The AD will ensure policy and procedure compliance by daily direct observation, re-educate as needed until 100% compliant and then monitor quarterly. The AD will report results and include in all QAPI/MAC, GB meetings and minutes quarterly.</p>	11/21/2014

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Q000232	<p>prior to administration and drawing up medication without cleansing the rubber stopper to the vial prior to drawing up the medication.</p> <p>(B) An opened single dose vial of Nitroglycerin was observed in the anesthesia cart in OR #4.</p> <p>(C) An opened single dose vial of Metoclopramide was observed in the anesthesia cart in OR #3.</p> <p>(D) An opened, undated multi dose vial of Labotalol was observed in the anesthesia cart in OR #4.</p> <p>3. Anesthesia provider #1 indicated in interview at 3:00 p.m. on 10/20/14 that he/she had not used the Nitroglycerin or Labotalol during procedures on 10/20/14.</p> <p>4. Staff member #N8 (RN) indicated in interview at 3:10 p.m. on 10/20/14 that OR #3 that there were no more procedures scheduled in OR #3 and the room was cleaned.</p> <p>416.50(f)(2) SAFETY [The patient has the right to -]</p> <p>(2) Receive care in a safe setting Based on document review, observation and interview, the facility failed to ensure blanket warmer temperatures were</p>	Q000232	<p>Q232 On 10/22/2014 the AD adjusted the blanket warmers to the max 130 degrees</p>	10/22/2014

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	<p>maintained according to policy for 2 of 2 blanket warmers observed and failed to label fluids per policy for 1 of 1 fluid warmer observed.</p> <p>Findings include:</p> <p>1. Facility policy titled "WARMING CABINET TEMPERATURE CONTROLS AND MONITORING" last reviewed/revised 12/18/13 states under policy on page 1: "Staff will maintain safe temperatures for irrigation fluids and blankets....." and "b. Label fluid with the date the fluid should be removed....."and on page 2: "The temperature for warming blankets cannot exceed 130 degrees. Higher temperatures have been known to cause skin burns."</p> <p>2. During facility tour beginning at 12:30 p.m. on 10/20/14, the following was observed:</p> <p>(A) A blanket warmer in the clean utility room in the preoperative area was observed with a temperature of 150 degrees.</p> <p>(B) A blanket warmer in the sub sterile room was observed with a temperature of 150 degrees.</p> <p>(C) A fluid warmer was observed in the sub sterile room and the fluids within the warmer were not labeled.</p>		<p>and posted new logs with correct parameters to follow according to policy on the front of all blanket warmers. The AD then re-educated the RN staff that fluids will be labeled with the date per policy and re-educated the staff about the policy for the blanket warmers and max temperature settings. The AD assigned a nurse assistant record temperature logs daily and to notify the AD of any variances. The nurse assistant will also check that fluids are marked with the date and report any variances to the AD. The AD will perform weekly checks on all warmers for compliance and hold all staff accountable for variances.</p>				

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Q000241	<p>3. A note on the front of the blanket warmers indicated max temperature for blankets would be 110 degrees.</p> <p>4. Staff member #N4 (RN) verified the blanket warmer temperatures in the preoperative area during time of tour.</p> <p>5. Staff member #N8 (RN) verified the blanket warmer temperature and failure to label fluids in the substerile area during time of tour.</p> <p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on observation and interview, the center failed to maintain a clean and sanitary environment throughout all areas in two (2) instances.</p> <p>Findings:</p> <p>1. During facility tour on 10/21/14 between 12:30pm and 1:15pm, in the presence of A1, Amdinistrative Director, it was observed in mechanical room #1,</p>	O000241	Q241 Housekeeping cleaned the mechanical and electrical room and boxes were placed off the floor on pallets on 10/23/2014. Housekeeping has been assigned to clean the mechanical and electrical rooms weekly. The AD assigned a nurse assistant to monitor the mechanical and electrical room cleaning weekly. The AD will monitor overall compliance monthly.	10/23/2014

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Q000261	<p>dirty floors with heavy dust in corners, boxes directly on the floor with insects, webbing and egg like debris atop the boxes. In the electrical room, a large amount of dead bugs was noted piled along wall edges and in corners.</p> <p>2. In interview on 10/21/14 at 1:00pm, A1 indicated housekeeping was not assigned to clean this area and was unaware of whose responsibility it was to do so.</p> <p>416.52(a)(1) ADMISSION ASSESSMENT Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy.</p> <p>Based on document review and interview, the facility failed to ensure a history and physical (H&P) exam was performed for 1 of 3 patients undergoing a hip injection (patient #13).</p> <p>Findings include:</p> <p>1. Review of patient #13 medical record indicated the following:</p>	Q000261	<p>Q261 The physician involved was educated on how to completely fill out the H&P form. The AD re-educated all physicians (via email) and staff that it is a CMS requirement and center policy that all H&P's are to be complete, no older than 30 days and updated with any changes or no changes the day of surgery. The medical records clerk will monitor compliance daily and report incomplete H&P's to the AD. The AD will monitor overall compliance and report compliance</p>	11/20/2014

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Q000264	<p>(A) He/she had a hip injection procedure performed on 8/1/14.</p> <p>(B) The H&P form was faxed to the facility on 7/1/14, however the systemic review section and the physical examination section of the form were left blank.</p> <p>2. Staff member #N8 (RN) verified the above beginning at 2:45 p.m. on 10/21/14.</p> <p>416.52(b) POST-SURGICAL ASSESSMENT (1) The patient's post-surgical condition must be assessed and documented in the medical record by a physician, other qualified practitioner, or a registered nurse with, at a minimum, post-operative care experience in accordance with applicable State health and safety laws, standards of practice, and ASC policy. (2) Post-surgical needs must be addressed and included in the discharge notes. Based on document review, the facility failed to appropriately meet post surgical patient needs and arrange for appropriate transfer for 2 of 3 patients transferred from the facility.</p> <p>Findings include;</p>	O000264	<p>quarterly to the QAPI/MAC and make recommendations if needed to the GB.</p> <p>Q264 On 10/22/14 the AD re-educated the physician involved and all staff that per the center's policy and a CMS requirement, a physician, qualified practitioner or RN with minimum post-operative care must evaluate and document the patient's condition prior</p>	12/11/2014

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	<p>1. Review of patient #4 medical record indicated the following:</p> <p>(A) The patient (3 year old) underwent an adenotonsillectomy on 8/12/14 by M.D. #1.</p> <p>(B) Nurses notes indicated that the patient was difficult to arouse and had low O2 sats. Notes indicated the sats were in the 80's and that oxygen was administered at 8-10 liters per minute. Notes at 12:45 p.m. indicated that nursing questioned M.D. #1 if an ambulance with oxygen was needed and he/she indicated that no ambulance was needed. Notes at 1303 hours indicated the child was discharged from facility to go to acute care hospital #1 for direct admission via private auto with family.</p> <p>(C) A discharge summary from acute care hospital #1 indicated the patients O2 sat was in the 60's upon arrival there.</p> <p>2. Review of patient #31 medical record indicated the following:</p> <p>(A) The patient underwent a bilateral maxillary antrotomy with tissue removal, septoplasty, and bilateral inferior turbinate reduction on 9/17/13 by M.D. #1.</p> <p>(B) Nurses notes indicated the patient had increased nasal bleeding and vomited "bright red tinged emesis." M.D. #1 was notified x 4 of the patients increased bleeding and nausea. Note at 1545 hours</p>		<p>to discharge. If a patient is in need of acute care requiring a transfer to the hospital the center will adhere to the transfer policy and document appropriately and completely to include all correct forms. The AD and PACU RN's will monitor daily for compliance and report noncompliance to the QAPI/MAC and GB. At the GB meeting on 10/29/14 it was discussed that we had a state and Medicare survey and we were awaiting the results. The transfer policy was discussed at this meeting. The transfer policy was then reviewed at the QAPI/MAC meeting on 11/21/14 and was found to be safe and effective and will be recommended for approval by the GB at the 12/11/14 GB meeting.</p>	

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S000000	indicated that M.D. #1 called the facility and requested that the patient be sent to his/her office for evaluation by a physician assistant. Notes at 1615 hours indicated the patient vomited an additional 200 ml "bright red emesis." Notes at 1620 hours indicated that the patient was released with family to go to the office of M.D. #1.						
	This survey was for a State licensure survey. Facility Number: 006102 Survey Dates: 10/20/14 to 10/21/14 Surveyors: Trisha Goodwin, RN BS Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor QA: cloughlin 11/12/14	S000000					
S000106	410 IAC 15-2.4-1						

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S000122	<p>GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Review the bylaws at least triennially. Based on document review and interview, the facility failed to ensure that the governing body (GB) of the center reviewed the GB bylaws at least triennially.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the document titled Operating Agreement and amendments there of indicated the last review/approval to have been 9/1998. 2. Review of GB meeting minutes dated 10/7/13,12/18/13, 4/7/14, and 7/14/14 lacked documentation of GB review of GB Operating Agreement/bylaws. 3. In interview on 10/21/14 at 3:00pm A1, administrative director, indicated GB review of their bylaws/Operating Agreement could not be found in any meeting minutes and no further documentation was provided prior to exit. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND</p>	S000106	<p>S106 According to state regulations, the operating agreement, medical staff bylaws and rules and regulations, and Governing Body rules, regulations and responsibilities should be reviewed by the governing board (GB) at least triennially. The quality assurance performance improvement (QAPI)/ Medical Advisory Committee (MAC) reviewed the operating agreement, medical staff bylaws and rules and regulations, Governing Body rules, regulations and responsibilities on 11/21/14 and will recommend annual reviews and approval to the GB on 12/11/14. The AD will ensure that the operating agreement, medical staff bylaws and rules and regulations, Governing Body rules, regulations and responsibilities are presented to the QAPI/MAC/GB for review and approval annually. All reviews and approvals will be documented in the QAPI/MAC/GB meeting minutes.</p>	12/11/2014

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	<p>DUTIES 410 IAC 15-2.4-1 (b)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body.</p> <p>Based on document review and interview, the governing body (GB) failed to ensure triennial review by the medical staff (MS) of the MS bylaws or rules and regulations within the past three years.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the two (2) documents titled Medical Staff Bylaws and Medical Staff Rules indicated the most recent review date by the MS as 7/11/11 for each. Review of documents titled Minutes for Medical Advisory/QAPI Committee and QAPI Medical advisory Committee Minutes dated 7/12/13, 4/30/14, and 8/4/14 lacked documentation of MS review of their bylaws or rules. In interview on 10/21/14 at 3:00pm A1, Administrative Director, indicated 7/11/11 to be the most recent review date found in MS documentation and no further documentation was provided prior to exit. 	S000122	S122 According to state regulations, medical staff bylaws and rules and regulations should be reviewed by the GB at least triennially. The QAPI/MAC reviewed the Medical Staff Bylaws and rules and regulations on 11/21/14 and will recommend annual reviews and approval to the GB on 12/11/14. The AD will ensure that the medical staff bylaws and rules and regulations are presented to the QAPI/MAC/GB for review and approved annually. All reviews and approvals will be documented in the QAPI/MAC/GB meeting minutes by the AD.	12/11/2014

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S000153	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review and interview, the facility failed to ensure agency personnel received facility orientation for 1 of 1 agency file reviewed (staff member #N1).</p> <p>Findings include:</p> <p>1. Facility policy titled "HUMAN RESOURCES 100 Competency Assessment System" last reviewed/revised 12/18/13 states: "3. Orientation: Orientation will be provided to all new employees and contracted related employees.....5. Documentation:.....d. Orientation documents....."</p> <p>2. Staff member #N1 (RN) personnel file lacked evidence of orientation to the facility.</p>	S000153	S153When the center uses an agency nurse the Administrative Director (AD) will orient that person to the facility to include all protocols, policy and procedures, reference manuals and resources. The AD will be responsible for all orientation documentation to be completed and in their file.	10/22/2014

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S000224	<p>3. Staff member #A1 (RN Administrator) indicated in interview at at 12:15 p.m. on 10/20/14 that the facility had utilized only one (1) agency staff member (#N1) in previous year and that the personnel file for him/her did not contain evidence of orientation.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(2)</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>(2) Ensure that the services performed under a contract are provided in a safe and effective manner and are included in the center's quality assessment and improvement program.</p> <p>Based on document review and interview, the governing body (GB) failed to ensure that services performed under contract are included in the center's quality assessment and improvement program (QAPI) in 7 of 11 instances (biohazard waste, linen services, maintenance, radiology, security, tissue transplant, transcription).</p> <p>Findings:</p>	S000224	<p>S 224 On 11/21/14 a QAPI/MAC meeting was held to discuss all contract services to include bio-hazard waste, linen services, maintenance, radiology, security, tissue transplant, transcription. These services were reviewed at the QAPI/MAC meeting and will be recommended for approval by the GB at the GB meeting on 12/11/2014. Annually, the AD will ensure that all contract services will be reviewed and evaluated for safety and effectiveness</p>	12/11/2014

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S000228	<p>1. Review of QAPI meeting minutes dated 10/29/13, 1/31/14, 4/30/14 and 8/4/14 lacked documentation of the QAPI inclusion of the following contracted services: Biohazard waste, linen services, maintenance, radiology, security, tissue transplant, transcription.</p> <p>2. In interview on 10/21/14 at 4:00pm A1, Administrative Director, confirmed the above contracted services to not be included in the QAPI program.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</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>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p>		by the QAPI/MAC and be recommended to the GB for approval and that all approvals will be documented in the QAPI/MAC, GB minutes.	

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S000320	<p>Based on document review and interview, the governing body of the center failed to ensure that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at at least one appropriate hospital in one (MD 2) of 11 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of 11 medical staff (MS), MD 1-11, credential files lacked documentation of admitting privileges for MD 2 to an appropriate hospital. In interview on 10/21/14 at 12:00pm A1, Administrative Director, indicated admitting privileges for MD2 were not available at this time and no further documentation was provided prior to exit. <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control.</p>	S000228	<p>S 228 IU Health Bloomington Hospital credentials Southern Indiana Surgery Center, (SISC) physicians. IU Health's credentialing office will change the hospital letter that states Active Staff Category to Admitting Privileges to an appropriate hospital. The AD will follow up with the credentialing office to verify all the letters are placed in the physicians files beginning 12/1/2014. The AD will manually check and verify that all the files are compliant by 12/11/14, then monitor at initial and re-appointments and as needed for continued compliance.</p>	12/11/2014

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S000630	<p>(C) Medication errors. (D) Response to patient emergencies. Based on document review and interview, the quality assessment and improvement program (QAPI) of the center failed to include all functions in three (3) instances (discharge, transfer, and medication errors).</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of QAPI meeting minutes and reports dated 10/29/13, 1/31/14, 4/30/14, and 8/4/14 lacked documentation of the following being evaluated by the program: discharge, transfer, and medication errors. In interview on 10/21/14 at 4:00pm A1, Administrative Director, indicated the above had not been included for evaluation by the QAPI program and no further documentation was provided prior to exit. <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <ol style="list-style-type: none"> identify the patient; support the diagnosis; justify the treatment; and document accurately the course of 	S000320	<p>S320 Policies, forms, and occurrences for discharge, transfer and medication errors were reviewed at the MAC meeting on 11/21/2014. The AD will ensure it is always discussed and documented at all quarterly QAPI/MAC meetings and presented to the GB for review and approval. All review and approvals will be documented in all meeting minutes by the AD. The 11/21/14 QAPI/MAC meeting recommendations will be presented for approval at the next GB meeting 12/11/14.</p>	12/11/2014			

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	<p>the patient's stay in the center and the results.</p> <p>Based on observation and document review, the facility failed to ensure medical records documented accurately the course of the patient's stay for 1 observation of patient care (patient #2).</p> <p>Findings include:</p> <ol style="list-style-type: none"> During observation of care provided to patient #2 beginning at 12:30 p.m. on 10/20/14, the following was observed: <ul style="list-style-type: none"> (A) The patient was a difficult I.V. (intravenous) start and at least four (4) different staff members attempted to start the I.V. (B) There were > 5 attempts made with 2 blown veins prior to fluid administration and 2 infiltrates after fluid was started. (C) The I.V. was eventually started by anesthesia provider #1 in the left upper extremity. Review of the medical record for patient #2 indicated that the I.V. was started by staff member #N9 (RN) and restarted by anesthesia provider #1 in the right hand. The record documented the wrong site (i.e. right vs left) and failed to indicate the number of sticks, the number of times a vein was blown with a start, the number of infiltrations, and the names of staff members attempting to start the 	S000630	<p>S630 Anesthesia providers and staff were educated on IV documentation on 10/22/14. The AD revised and implemented the pre-op assessment form on 11/20/2014 that allowed documentation of the number of IV sticks, number of times a vein was blown with a start, number of infiltrations and names of staff starting the IV. All staff received an in-service on the form changes prior to implementation. The pre-op/pacu staff will audit all charts daily at the end of the day for completeness to reach 100% compliance as reviewed by the AD before the staff resumes monthly chart audits. The AD will ensure monthly chart audits continue by the staff and the outside medical records consultant for compliance with proper documentation. The AD will present results and findings to the QAPI/MAC and GB. All reviews and findings will be documented in the QAPI/MAC and GB minutes</p>	11/20/2014

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S000672	<p>I.V.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(13) A copy of the transfer form, if the patient is referred to a hospital or other facility.</p> <p>Based on document review and interview, the facility failed to ensure a transfer form was completed for 2 of 3 patient transfers (patients #4 and #31).</p> <p>Findings include:</p> <p>1. Facility policy titled "TRANSFERS" last reviewed/revised 12/18/13 states: "PURPOSE: In the event a patient needs continuance of specialized care, adequate arrangements must be made..... 6. The patient transfer record will be used to document the patient's status and the receiving facility communication....."</p> <p>2. Review of patient #4 medical record indicated the following: (A) He/she had post operative complications and transferred to acute</p>	S000672	S672 The AD re-educated the physician involved and all staff members on the center's transfer policy, transfer forms, and required documentation when transferring a patient in need of acute care on 10/22/14. The AD will monitor compliance on a daily basis by actively participating and overseeing transfers as they occur while reviewing charts for complete documentation for every occurrence. The AD will report all results and findings to the QAPI/MAC and GB. All findings and recommendations will be documented in the QAPI/MAC and GB meeting minutes.	10/22/2014

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S000772	<p>care facility #1 on 8/12/14. (B) The record lacked a transfer form.</p> <p>3. Review of patient #31 medical record indicated the following: (A) He/she had post operative complications and transferred to the office of M.D. #1 on 9/17/13. (B) The record lacked a transfer form.</p> <p>4. Staff member #N10 (RN) verified there was no transfer form for patient #31 at 1:00 p.m. on 10/21/14.</p> <p>5. Staff member #N8 (RN) verified there was no transfer form for patient #4 at 2:30 p.m. on 10/21/14.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be</p>						

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	<p>performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review and interview, the facility failed to ensure a history and physical (H&P) exam was performed for 1 of 3 patients undergoing a hip injection (patient #13).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of patient #13 medical record indicated the following: <ol style="list-style-type: none"> He/she had a hip injection procedure performed on 8/1/14. The H&P form was faxed to the facility on 7/1/14, however the systemic review section and the physical examination section of the form were left blank. Staff member #N8 (RN) verified the above beginning at 2:45 p.m. on 10/21/14. 	S000772	<p>S772</p> <p>The physician involved was educated on how to completely fill out an H&P form by the AD on 11/20/14 and the staff on 10/22/14. The AD re-educated all the physicians via email on 11/20/14 that it is the center's policy and CMS requirement that all H&P's are to be complete, no older than 30 days and updated with any change or no change the day of the surgery. The medical records clerk has been assigned to monitor compliance daily before placing the H&P's in the chart, prior to surgery and report any incomplete H&P's to the AD. The AD will follow up with the physician if an H&P isn't filled out completely, over 30 days old and not updated with or without any changes the day of surgery. The AD will monitor overall compliance and report</p>	11/20/2014

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S000788	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(R)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(R) A requirement that a physician shall be available to the center during the period any patient is present in the center.</p> <p>Based on document review, the facility failed to ensure a physician was available on the premises to treat post operative complications for 1 of 3 patient transfers (patient #31).</p> <p>Findings include:</p> <p>1. Review of patient #31's medical record indicated the following:</p> <p>(A) The patient underwent a bilateral maxillary antrotomy with tissue removal, septoplasty, and bilateral inferior turbinate reduction on 9/17/13 by M.D. #1.</p> <p>(B) Nurse notes indicated the patient had increased nasal bleeding and vomited "bright red tinged emesis." M.D. #1 was</p>	S000788	<p>findings quarterly to the QAPI/MAC and GB. All findings, recommendations, and approvals will be documented in the QAPI/MAC, GB meeting minutes by the AD.</p> <p>S788 On 10/22/14 the AD re-educated the physician involved and all staff that per the center's policy and CMS requirement, a physician, qualified practitioner, or RN with minimum post-operative care must be present and evaluate and document the patient's condition prior to discharge. If a patient is in need of acute care requiring a transfer to the hospital, the center will adhere to the transfer policy and document appropriately and completely to include all correct forms. The AD and PACU RN's will monitor daily for compliance and report noncompliance to the QAPI/MAC and GB. At the GB meeting on 10/29/14 it was discussed that we had a state and Medicare</p>	12/11/2014			

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S000888	<p>notified x 4 of the patient's increased bleeding and nausea. At the request of M.D. #1, the patient was sent to his/her office. The physician was not available on the premises to examine and treat the patient's post operative complication.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review and interview, the facility failed to ensure operative notes were dictated immediately following surgery for 3 of 3 patients treated by M.D. #2 (patients #8,</p>	S000888	<p>survey and we are awaiting results. The transfer policy was discussed at this meeting. The transfer policy was then reviewed at the MAC meeting on 11/21/14 and was found to be safe and effective and will be recommended for approval by the GB at the GB meeting on 12/11/14.</p> <p>S888 On 11/20/14, the AD emailed all medical staff members a reminder of the center's policy and CMS requirement to have all operative reports dictated within 24hrs</p>	11/20/2014

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S000900	<p>9, and 21).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "REVIEWING CHARTS FOR COMPLETENESS" last reviewed/revised 12/18/13 states "2. TRANSCRIPTION: The operative report is dictated (such as, the procedure report and the discharge note). The medical record will be completed when the note is dictated.....a. Transcription should be dictated within 24 hours and in chart within 7 days." 2. Patients #8 and #9 had surgery performed by M.D. #2 on 8/28/14. The operative notes were dictated on 9/3/14. 3. Patient #21 had surgery performed by M.D. #2 on 4/3/14. The operative note was dictated on 4/8/14. 4. Staff member #N8 (RN) verified the medical record information beginning at 2:45 p.m. on 10/21/14. <p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(a)</p>		<p>after the surgery. The business office manager and her staff will monitor compliance daily and make sure all dictations are complete within 24hrs after the surgery and in the patients chart within 7 days. The AD will monitor compliance daily and report results to the QAPI/MAC, GB and record in all minutes.</p>				

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	<p>(a) All patient care services must meet the needs of the patient, within the scope of the service offered, in accordance with acceptable standards of practice. Patient care services must be under the direction of a qualified person or persons. Patient care services must require the following:</p> <p>Based on document review, the facility failed to appropriately meet post surgical patient needs and arrange for appropriate transfer for 2 of 3 patients transferred from the facility (patients #4 and #31).</p> <p>Findings include:</p> <p>1. Review of patient #4 medical record indicated the following:</p> <p>(A) The patient (3 year old) underwent an adenotonsillectomy on 8/12/14 by M.D. #1.</p> <p>(B) Nurse notes indicated that the patient was difficult to arouse and had low O2 sats. Notes indicated the sats were in the 80s and that oxygen was administered at 8-10 liters per minute. Notes at 12:45 p.m. indicated that nursing questioned M.D. #1 if an ambulance with oxygen was needed and he/she indicated that no ambulance was needed. Notes at 1303 hours indicated the child was discharged from facility to go to acute care hospital #1 for direct admission via private auto with family.</p> <p>(C) A discharge summary from acute</p>	S000900	S900 On 10/22/14 the AD re-educated the physician involved and all staff that per the center's policy and CMS requirement, a physician, qualified practitioner, or RN with minimum post-operative care must be present and evaluate and document the patients condition prior to discharge. If a patient is in need of acute care requiring a transfer to the hospital, the center will adhere to the transfer policy and document appropriately and completely to include all correct forms. The AD and PACU RN's will monitor daily for compliance and report noncompliance to the QAPI/MAC and GB. At the GB meeting on 10/29/14 it was discussed that we had a state and Medicare survey and we are awaiting results. The transfer policy was discussed at this meeting. The transfer policy was then reviewed at the QAPI/MAC meeting on 11/21/14 and was found to be safe and effective and will be recommended for approval by the GB at the GB meeting on 12/11/14.	12/11/2014

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S001010	<p>care hospital #1 indicated the patient's O2 sat was in the 60s upon arrival there.</p> <p>2. Review of patient #31 medical record indicated the following:</p> <p>(A) The patient underwent a bilateral maxillary antrotomy with tissue removal, septoplasty, and bilateral inferior turbinate reduction on 9/17/13 by M.D. #1.</p> <p>(B) Nurse notes indicated the patient had increased nasal bleeding and vomited "bright red tinged emesis." M.D. #1 was notified x 4 of the patient's increased bleeding and nausea. Notes at 1545 hours indicated that M.D. #1 called the facility and requested that the patient be sent to his/her office for evaluation by a physician assistant. Notes at 1615 hours indicated the patient vomited an additional 200 ml "bright red emesis." Notes at 1620 hours indicated that the patient was released with family to go to the office of M.D. #1.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the</p>			

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	<p>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>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, interview and document review, the facility failed to ensure medications were administered in a safe manner in 2 operating rooms (ORs) and failed to include directions for storage of general medication multi dose vials in policy.</p> <p>Findings include:</p> <p>1. Facility policy titled "PHARMACY 170.2" last reviewed/revised 12/18/13 states on page 1: "c. Use multi-dose vials of saline, water and insulin until the manufacturer's expiration date on the vial or within 28 days..... d. Single use vials will be discarded after first use or end of day if the same patient on which the first dose was administered may require re-dosing. Single use vials can be used only for a single patient."</p> <p>2. During observations beginning at 12:30 p.m. on 10/20/14, the following was observed:</p> <p>(A) Anesthesia provider #1 was</p>	S001010	S1010 The AD re-educated the staff on 10/22/2014 on policy and procedures for single dose and multi-dose vials. The AD will ensure policy and procedures are being followed daily by direct observation. The AD re-educated the anesthesia providers on 11/21/2014 on policy and procedures for single dose and multi-dose vials and on cleaning the IV port prior to administration and cleaning the rubber stopper prior to drawing up medications. The nurse, team leaders and the AD will monitor compliance daily. Compliance will be discussed and included in the QAPI/MAC, GB meetings and minutes by the AD.	11/21/2014

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S001100	<p>observed administering medication without using alcohol to the I.V. port prior to administration and drawing up medication without cleansing the rubber stopper to the vial prior to drawing up the medication.</p> <p>(B) An opened single dose vial of Nitroglycerin was observed in the anesthesia cart in OR #4.</p> <p>(C) An opened single dose vial of Metoclopramide was observed in the anesthesia cart in OR #3.</p> <p>(D) An opened, undated multi dose vial of Labotalol was observed in the anesthesia cart in OR #4.</p> <p>3. Anesthesia provider #1 indicated in interview at 3:00 p.m. on 10/20/14 that he/she had not used the Nitroglycerin or Labotalol during procedures on 10/20/14.</p> <p>4. Staff member #N8 (RN) indicated in interview at 3:10 p.m. on 10/20/14 that there were no more procedures scheduled in OR #3 and the room was cleaned.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(a)(1)</p>				

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	<p>(a) The center shall be constructed, arranged, and maintained to ensure the safety of the patient and to provide facilities for services authorized under the center license as follows:</p> <p>(1) The plant operations and maintenance service, equipment maintenance, and environmental services must be as follows:</p> <p>(A) Staffed to meet the scope of the services provided.</p> <p>(B) Under the direction of a person or persons qualified by education, training, or experience according to center policy, approved by the governing body.</p> <p>Based on document review and interview, the facility failed to ensure that plant operations and maintenance service was under the direction of a qualified person(s) and approved by the governing body (GB).</p> <p>Findings:</p> <p>1. In interview on 10/21/14 at 1:45pm A1, Administrative Director, indicated a contracted company to be in charge of general maintenance and all equipment maintenance to be by various contracted entities. A1 further indicated the current general maintenance to be under arrangement by a new contract as of 10/1/14. A1 indicated the new contract</p>	S001100	<p>S1100</p> <p>The contract with the center's general maintenance company that was signed on 10/1/14 was reviewed and evaluated for safety and effectiveness at the QAPI/MAC meeting on 11/21/14 and will be recommended to the GB for annual approval 12/11/14. The AD will ensure it is annually reviewed and evaluated and approved by the QAPI/MAC and GB. All approvals will be documented in all minutes by the AD.</p>	12/11/2014	

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S001146	<p>and maintenance arrangement had not yet been approved by the GB and documentation of approval for prior maintenance oversight could not be found.</p> <p>2. Review of facility documents lacked evidence of maintenance being under the direction of a qualified person or who was directly responsible for physical plant maintenance.</p> <p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</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>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation, and interview, the facility failed to ensure blanket warmer temperatures were maintained according to policy for 2 of 2 blanket warmers observed and failed to label fluids per policy for 1 of 1 fluid warmer observed.</p> <p>Findings include:</p>	S001146	S1146 The AD adjusted the blanket warmers to 130 degrees and posted new logs with correct parameters to follow according to policy on the front of all blanket warmers indicating max temperature for the blankets to be 130 degrees. The AD educated the staff that all fluids will be labeled with the date. A nurse assistant has been assigned to record temperature logs daily and	10/22/2014

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	<p>1. Facility policy titled "WARMING CABINET TEMPERATURE CONTROLS AND MONITORING" last reviewed/revised 12/18/13 states under policy on page 1: "Staff will maintain safe temperatures for irrigation fluids and blankets....." and "b. Label fluid with the date the fluid should be removed....."and on page 2: "The temperature for warming blankets cannot exceed 130 degrees. Higher temperatures have been known to cause skin burns."</p> <p>2. During facility tour beginning at 12:30 p.m. on 10/20/14, the following was observed: (A) A blanket warmer in the clean utility room in the preoperative area was observed with a temperature of 150 degrees. (B) A blanket warmer in the sub sterile room was observed with a temperature of 150 degrees. (C) A fluid warmer was observed in the sub sterile room and the fluids within the warmer were not labeled.</p> <p>3. A note on the front of the blanket warmers indicated max temperature for blankets would be 110 degrees.</p> <p>4. Staff member #N4 (RN) verified the blanket warmer temperatures in the</p>		will notify the AD of any variances. The nurse assistant has been assigned to check that fluids are marked with the date and report any variances to the AD. The AD will perform weekly checks on all warmers for compliance and hold all staff accountable for variances reported or found.	

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S001172	<p>preoperative area during time of tour.</p> <p>5. Staff member #N8 (RN) verified the blanket warmer temperature and failure to label fluids in the substerile area during time of tour.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: Based on observation and interview, the center failed to maintain a clean and orderly building throughout all areas in two (2) instances.</p> <p>Findings:</p> <p>1. During facility tour on 10/21/14 between 12:30pm and 1:15pm, in the</p>	S001172	S1172 Housekeeping has been assigned and has cleaned the mechanical and electrical rooms on 10/23/2014. Boxes were placed on pallets off the floor. Housekeeping has been assigned to clean the mechanical and electrical rooms weekly and a log will be kept. A nurse assistant has been assigned by the AD to monitor the weekly cleaning of	10/23/2014

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	<p>presence of A1, Aministrative Director, it was observed in mechanincal room #1, dirty floors with heavy dust in corners, boxes directly on the floor with insects, webbing and egg like debris atop the boxes. In the electrical room, a large amount of dead bugs was noted piled along wall edges and in corners.</p> <p>2. In interview on 10/21/14 at 1:00pm, A1 indicated housekeeping was not assigned to clean this area and was unaware of whose responsibility it was to do so.</p>		<p>the mechanical and electrical rooms. The nurse assistant will report back to the AD any variances. The AD will monitor overall compliance and include results in the quarterly QAPI/MAC and GB meetings and minutes.</p>		