

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001046	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER NORTH MERIDIAN SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 13225 N MERIDIAN STREET CARMEL, IN 46032
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S 000 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 007125</p> <p>Survey Date: 3/31/2015 through 4/2/2015</p> <p>QA: cjl 04/16/15</p>	S 000		
S 110 Bldg. 00	<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 documentation review and staff interview, the governing</p>	S 110	S-0110 The First and Second Quarter Governing Board/ Medical Staff Meetings for 2014	05/06/2015

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>body failed to review quarterly reports of management operations including quality assessment and improvement program for 2 of 4 quarters.</p> <p>Findings included:</p> <ol style="list-style-type: none"> By-laws of the Governing Board/Medical Staff of North Meridian Street Surgicenter & Associates, LLC (last reviewed 10/1/2014) indicated there shall be the following standing committees: Governing Board/Medical Staff; Credentials; Quality Assurance; Utilization; Tissue and Infection Control. Each committee shall meet at least quarterly. Each quarter, management operations will be addressed including: credentialing, quality assurance, utilization review, tissue and infection control. Staff member #1 (Director) provided the Governing Board/Medical Staff quarterly minutes for 2014. The meeting 		<p>occurred under the leadership of NMSC's previous Director. The current Director assumed his role at the beginning of July 2014. The missing minutes were not recovered or available from the previous Director's files. Going forward, the current Director will to uphold the By-Laws approved by the Governing Board/ Medical Staff of North Meridian Street Surgicenter & Associates, LLC requiring quarterly meetings. (Example – Governing Board Meeting Minutes from 08/04/14, 11/17/14, and 01/26/15 which were presented to the surveyors). The current Director has combined the Governing Board/ Medical Staff, Credentials, Quality Assurance, Utilization Review, and Tissue and Infection Control Meetings into one quarterly meeting and documents accordingly. The first quarter Board meeting is scheduled for May 6, 2015. The Director is responsible for assuring these meetings and minutes are done and permanently maintained quarterly.</p>		

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S 300 Bldg. 00	<p>minutes provided evidenced the meetings were held on 8/4/14 and 11/17/14. Therefore, minutes from the first and second quarter were not provided.</p> <p>3. At 1:15 PM on 4/1/2015, staff member #1 (Director) indicated he/she could not locate Governing Board meeting minutes for the first and second quarter of 2014.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on documentation review and staff interview, the facility</p>	S 300	S-0300 The First and Second Quarter Governing Board/ Medical Staff Meetings for 2014 occurred under the leadership of	05/06/2015

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	<p>failed to ensure all four quarterly meetings were held for the Quality Assurance Committee as defined by the Quality Assessment & Performance Improvement program (QAPI).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. North Meridian Surgery Center Quality Assessment & Performance Improvement program (last reviewed 10/1/2014) stated, "The Quality Improvement Committee will meet at least quarterly." 2. Staff member #1 (Director) provided the Governing Board/Medical Staff quarterly minutes for 2014. The meeting minutes provided noted meetings held only on 2 quarters: 8/4/2014 and 11/17/2014. 3. At 1:15 PM on 4/1/2015, staff member #1 (Director) indicated he/she confirmed the only documented QAPI minutes that 		<p>NMSC's previous Director. The current Director assumed his role at the beginning of July 2014. The missing minutes were not recovered or available from the previous Director's files. Going forward, the current Director will uphold the By-Laws approved by the Governing Board/ Medical Staff of North Meridian Street Surgicenter & Associates, LLC requiring quarterly meetings. (Example – Governing Board Meeting Minutes including QAPI Minutes, from 08/04/14, 11/17/14, and 01/26/15 which were presented to the surveyors). The current Director has combined the Governing Board/ Medical Staff, Credentials, Quality Assurance, Utilization Review, and Tissue and Infection Control Meetings into one quarterly meeting and documents accordingly. The first quarter Board meeting is scheduled for May 6, 2015. The Director is responsible for assuring these meetings and minutes are done and permanently maintained quarterly.</p>		

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S 310 Bldg. 00	<p>were able to be located were for the third and fourth quarter of 2014.</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.</p> <p>Based on document review and interview, the center failed to follow its policy/procedure and ensure that the services performed under contract were evaluated and approved by the Quality Assurance committee for 40 contracted services.</p> <p>Findings included:</p> <p>1. The Quality Assessment & Performance Improvement</p>	S 310	<p>S-0310 At the time of the survey, the Director presented the surveyors with an Annual QA Summary of Contracted Services and Definitions of Acceptable Service of those Contracted Services. However, the Annual QA Summary was not evaluated by the Governing Body/ Medical Staff/ Quality Assurance Committee. After further review NMSC's Policy 1.07, the Director understands that this QA Process of the Contracted Vendors needs to be ongoing. The Director has reviewed/ evaluated the Contracted Vendor List and will present to the Governing Body during the next Governing Board/</p>	05/06/2015

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	<p>Program (last Reviewed 10/1/14) indicated all vendors associated directly or indirectly with patient care will be evaluated routinely through the Quality Assurance committee. The Contracted Services Evaluation - QA Summary report shall be evaluated annually by the Governing Body/Medical Staff/Quality Assurance Committee.</p> <p>2. Staff member #1 (Director) provided the Governing Board/Medical Staff/Quality Assurance quarterly minutes for 2014. The Governing Board/Medical Staff/Quality Assurance documents provided only had two meetings held in 2014: 8/4/14 and 11/17/14. The Contracted Services Evaluation - QA Summary report of 40 contractor vendors were not reviewed and approved in 2014.</p> <p>3. At 1:15 PM on 4/1/2015, staff member #1 (Director) confirmed that the Contracted Services</p>		<p>Medical Staff Meeting on May 6, 2015. The Director has developed an ongoing evaluation for each Contracted Vendor. The Director is responsible for making sure this evaluation process is done routinely. Because there are so many contracted services, they will be divided up so that each service is evaluated at least annually. (Attachment A – Northside Anesthesia Services Contract Evaluation 2015.04.30).</p>		

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S 400 Bldg. 00	<p>Evaluation - QA Summary report was not reviewed and approved in 2014.</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 documentation review and staff interview, the facility failed to ensure the temperature of the Operating Rooms are maintained according to AORN (Association of periOperative Nurses) guidelines.</p> <p>Findings included:</p> <p>1. North Meridian Surgery Center adopted AORN guidelines on operating rooms temperature and humidity ranges. AORN recommends Operating Rooms acceptable temperature range to be between 68 to 73 degrees</p>			S 400	<p>S-0400 NMSC Policy 10.01 – Environmental Control Policy was updated and implemented. (Attachment B - Updated Policy 10.01 – Environmental Control). It will be discussed at the next Governing Board/ Medical Staff Meeting on May 6, 2015, and during the next Employee Staff Meeting on May 12, 2015. Immediately, each of the thermostats in the OR are being monitored daily and adjusted accordingly to AORN Recommendations. Temperature and Humidity will continue to be monitored and recorded daily utilizing a Temperature and Humidity Log. The Director is responsible for educating the staff & physicians to the AORN Recommendations and for making sure this is done on a daily basis and reported to the</p>		05/06/2015

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S 414 Bldg. 00	<p>Fahrenheit.</p> <p>2. North Meridian Surgery Center Temperature/Humidity Logs were reviewed for January through March of 2015. The three operating rooms maintained a temperature reading of 61 degrees Fahrenheit in each room.</p> <p>3. At 11:00 AM on 4/2/2015, staff member # 1 (Director) confirmed the operating room's temperature is not maintained to the levels defined by the AORN guidelines.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible</p>		board on a quarterly basis.				

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	<p>for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on documentation review and staff interview, the governing body failed to ensure Infection Control meetings are held quarterly for 1 of 4 quarters.</p> <p>Findings included:</p> <ol style="list-style-type: none"> By-laws of the Governing Board/Medical Staff of North Meridian Street Surgicenter & Associates, LLC (Last reviewed 10/1/2014) indicated there shall be the following standing committees: Governing Board/Medical Staff; Credentials; Quality Assurance; Utilization; Tissue and Infection Control. Each committee shall meet at least quarterly. Staff member #1 (Director) 	S 414	<p>S-0414 As explained to the surveyors at the time of the survey, NMSC's previous Director held separate Infection Control Meetings. (Attachment C – 2014 First Quarter Infection Control Meeting Minutes). NMSC's current Director has combined the Governing Board/ Medical Staff, Credentials, Quality Assurance, Utilization Review, and Tissue and Infection Control Meetings into one quarterly meeting and documents accordingly. However, due to his inexperience of being in his role for only one month, Quarter 2 Infection Control Meeting Minutes were not included at the quarterly Governing Board/ Medical Staff Meeting held on 08/04/14. The ISDH Deficiency Report references that the Director indicated he/ she could not locate Infection Control Meeting Minutes for the Third Quarter of 2014, but it was actually the Second Quarter Meeting Minutes that were unable to be located. Going forward, the Director will uphold</p>	05/06/2015

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S 444 Bldg. 00	<p>provided the Infection Control minutes for 2014. The meeting minutes provided evidenced that meetings were held on 2/19/14, 8/4/14 and 11/17/14. The first quarter meeting minutes were Infection Control only, while the third and fourth quarter Infection Control agenda was addressed within the Governing Board/Medical Staff meetings.</p> <p>3. At 1:15 PM on 4/1/2015, staff member #1 (Director) indicated he/she could not locate Infection Control meeting minutes for the third quarter of 2014. The staff member indicated the previous director had separate meeting minutes for the Infection Control Team; however, the Governing Board combined several meetings into one meeting in the third and fourth quarter.</p>		<p>the By-Laws approved by the Governing Board/ Medical Staff of North Meridian Street Surgicenter & Associates, LLC requiring quarterly meetings. The next Governing Board/ Medical Staff Meeting will be on May 6, 2015. (Example – Governing Board Meeting Minutes including Infection Control from 11/17/14 (Q3), and 01/26/15 (Q4) which were presented to the surveyors).</p>		
	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)				

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	<p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks.</p> <p>Findings included:</p> <p>1. While observing in the pre-op area at 7:30 AM on 04/01/15, a male staff member was observed walking to the lounge with a surgical mask hanging around his neck. Another male staff member was observed coming out of the surgical area, going to the nurses' station, and talking with patients with his surgical mask hanging round his neck, then returning to the surgical area. At 10:15, the same male staff member, with a surgical mask around his neck, came out to the consultation area to talk with a patient. At 10:30 AM, two female staff members were observed at the nurses' station with their surgical masks around</p>	S 444	<p>S-0444 Policy 5.06 – Dress Code Requirements and infection control principles related to will be reviewed at the next Governing Board/ Medical Staff Meeting on May 6, 2015, and during the next Employee Staff Meeting on May 12, 2015. Medical Staff and Clinical Staff were immediately reminded at time of survey that face masks are for single use only and of the importance of changing face masks between operative procedures or more frequently when necessary. The Director is responsible for monitoring compliance on a daily basis and implementing corrective action for noncompliance.</p>	05/06/2015			

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S 010 Bldg. 00	<p>their necks.</p> <p>2. The facility policy "Dress Requirements", last reviewed 10/14, indicated, "7. Face masks are changed between operative procedures, and more frequently when necessary."</p> <p>3. At 9:00 AM on 04/01/15, staff member #1, the facility director, confirmed the facility followed AORN recommendations which indicated surgical masks were to be changed between cases and not worn around the neck or stored in pockets.</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 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, policy review, and interview, the facility failed to follow their policy and nationally recognized guidelines regarding multi-dose vials for two of two open vials of insulin</p>	S 010	S-1010 Policy 8.01 – Pharmacy Services will be reviewed at the next Governing Board/ Medical Staff Meeting on May 6th and during the next Employee Staff Meeting on May 12, 2015.	05/06/2015			

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	<p>observed.</p> <p>Findings included:</p> <p>1. During the tour of the surgical area at 9:25 AM on 04/01/15, accompanied by staff member #1, the facility director, the following items were observed in the medication refrigerator in the surgical core:</p> <p>a. A ten milliliter vial of Humalog insulin with an open date of 12/18/13.</p> <p>b. A ten milliliter vial of Humulin R insulin with an open date of 12/04/14.</p> <p>c. No other vials of insulin were available for use.</p> <p>2. The facility policy, "Pharmacy Services", last revised 10/01/14, indicated, "The Center utilizes the most current CDC/AORN Perioperative Standards and Recommended Practices regarding Safe Injection Practices. ...Drugs and medications requiring refrigerated storage shall be stored in a temperature controlled refrigerator with temperature recorded daily. ...The Pharmacist shall make a quarterly inspection of the Drug Storage Cabinet and Emergency Drug Containers using the Inspection checklist. A record of such quarterly inspections shall be reported to the Governing Body and maintained in the Center to verify that:</p>		<p>Medical Staff and Clinical Staff have been reminded that per CDC's Safe Injection Practices a multi-dose medication vial needs to be disposed of 28 days after opening, unless specified otherwise by the manufacturer, or sooner if sterility is questioned and compromised. Humalog and Humulin R have been added to the monthly medication outdate checks to be monitored by the Pharmacy Consultant during her quarterly audit. The outdated medication has been removed from the facility and replacement reordered. The Director is responsible for compliance and will assure that every medication in the facility is checked for outdates on a monthly basis and that proper labeling is done according to Safe Injection Practices.</p>				

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S 146 Bldg. 00	<p>...All drugs are properly stored. No outdated or otherwise unusable drugs are stored in the Center. ...Vials: ...Dispose of opened multi-dose medication vials 28 days after opening, unless specified otherwise by the manufacturer, or sooner if sterility is questioned or compromised."</p> <p>3. At 9:30 AM on 04/01/15, staff member #1 indicated a facility nurse was responsible for checking medications monthly and confirmed the pharmacy consultant performed quarterly checks and did not find or remove the outdated vials.</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 observation, interview, manufacturer's recommendations, and review of nationally</p>	S 146	S-1146 On April 2, 2015, at 1300 NMSC's Chief Engineer cleaned and straightened Boiler Room and removed bare wire	05/06/2015			

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	<p>recognized guidelines, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in four (3) instances: Boiler Room; Main Electrical Room; and Electrical Room and failed to ensure patient safety by monitoring the blanket warmers and following manufacturer guidelines for temperature regulation.</p> <p>Findings included:</p> <ol style="list-style-type: none"> At 9:30 AM on 4/1/2015, the boiler room closet was inspected. A bare single wire was observed alligator clipped to the high voltage heavy duty electrical box metal door while the other end of the wire was connected to an utility light. The utility light was observed clamped to flexible metal conduit. The light was mounted over equipment within the room. At 9:40 AM on 4/1/2015, staff 		<p>and utility light that were in question during the time of the survey. Chief Engineer also cleaned and straightened Main Electrical/ Fire Alarm Room and small Electrical Room. Chief Engineer removed the boxes that were in question during the time of the survey. Visual observation of these services was witnessed by Director. The Director is responsible for current and future compliance. Policy 5.39 – Blanket Warming Cabinets was created and implemented. It will be presented to the Governing Board/ Medical Staff Meeting on May 6, 2015, for approval. (Attachment D - Policy 5.39 – Blanket Warming Cabinets). The blanket warming cabinets are now being monitored daily for temperature according to the AORN Recommendations not to exceed 130 degrees F. Per Policy 5.39, a thermometer or digital display is being utilized to monitor temperature of the blanket warming cabinets and recorded daily on a Temperature Log. (Attachment E - Blanket Warming Cabinet Temperature Log). The Director is responsible for assuring compliance.</p>		

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	<p>member #2 (maintenance man) indicated the light was in the room for some repairs the service men were doing. The staff member confirmed the way the light was mounted to the electric box was a safety hazard.</p> <p>3. At 9:45 AM on 4/1/2015, the Main Electrical/Fire Alarm Room was toured. The room was heavily cluttered with assorted boxes of supplies, maintenance equipment, etc. Cardboard boxes were observed leaning against high voltage electrical boxes. The electrical boxes had a warning on them to keep clear in front of the electrical boxes to prevent against the possibility of an electrical arc.</p> <p>4. At 10:00 AM on 4/1/2015, the small Electrical room was observed heavily cluttered with loose paper on the floor, boxes of supplies, etc.</p> <p>5. During the tour of the pre/post area at 7:30 AM on 04/01/15 with staff member #1, the facility director, a Blickman warming cabinet containing blankets was observed with the temperature registering</p>			

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	<p>160 degrees F. (Fahrenheit). Staff member #1 indicated the temperature of the warmer was not monitored and recorded and was set according to manufacturer recommendations.</p> <p>6. During the tour of the surgical area at 7:55 AM on 04/01/15 with staff member #1, a warming cabinet containing blankets was observed. No manufacturer's name could be found on the unit and staff member #1 indicated it was a very old unit. A dial knob on the bottom of the unit was set at 200, but an actual temperature read-out could not be determined.</p> <p>7. At 9:00 AM on 04/02/15, staff member #1 indicated the facility did not have any policies or procedures regarding blanket warming, including monitoring or specific temperature requirements. He/she indicated no manual could be found for the older unit, but one was found for the Blickman unit. He/she confirmed the facility did follow AORN (Association of periOperative Registered Nurses) guidelines.</p> <p>8. Review of the User Manual for the Blickman Warming Cabinet indicated, "These Cabinets have been designed to heat: Liquids in vented containers. Liquids in non-vented containers to a</p>			

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S 168 Bldg. 00	<p>temperature of 150 degrees F./65 degrees C. (Celsius) Maximum. Metal objects. Muslin or cotton sheets and wool blankets. ...Recommended Settings: Blickman does not recommend any operating temperature set point. For appropriate heating temperatures, please contact the manufacturer of the goods being heated."</p> <p>9. AORN recommendations indicated the temperature of blanket or linen warming cabinets should not exceed 130 degrees F. and should be checked at regular intervals and documented on a log or electronically.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</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>				

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	<p>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on documentation review and staff interview, the facility failed to ensure patient wheelchairs had a preventive maintenance inspection performed on them.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Staff member #1 (Director) provided the preventive maintenance documents for review. The wheelchairs used for patient transport in the facility did not have documented evidence of having a preventive maintenance inspection performed on them. At 11:05 AM on 4/2/2015, staff member #1 (Director) confirmed the facility did not have any documented evidence that there was preventive maintenance inspections performed on the center's wheelchairs. 	S 168	<p>S-1168 On April 30, 2015, NMSC's 3 wheelchairs were added to the Weekly Preventative Maintenance Inspection Checklist. The Instrument / Supply Coordinator performed these inspections and documented appropriately on the attached form. (Attachment F – Weekly Preventative Maintenance Inspection Checklist). Preventative Maintenance Inspections will be reviewed and during the next Employee Staff Meeting on May 12, 2015. The Director is responsible for assuring compliance.</p>	04/30/2015	

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S 188 Bldg. 00	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on documentation review and staff interview, the facility failed to audibly or overhead announce a fire drill for 2 of 4 quarters of fire drills in 2014.</p> <p>Findings included:</p> <p>1. North Meridian Surgery Center Emergency Operations policy (Last reviewed 10/1/2014) stated, "In order to assure that all employees are prepared to deal with an emergency, a fire drill shall be conducted on a quarterly basis.</p>	S 188	<p>S-1188 Past Fire Drills have utilized an overhead announcement alerting staff to location of the fire; however this wasn't adequately documented on our Fire Drill Evaluation report. On April 8, 2015, NMSC's Fire Drill Evaluation Report was modified to include Question #4. "Was an overhead announcement made?" (Attachment G – Updated Fire Drill Evaluation Report)</p>	04/08/2015			

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	<p>This drill will include sounding the fire alarm.</p> <p>2. The 2000 Life Safety Code regulations, chapters 20/21.7.1.2 indicate drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required under varied conditions. This requires drills to be either audible or public announced as in overhead system.</p> <p>3. The Fire Drill Evacuation Reports were reviewed for 2014. The reports evidenced fire drills were held quarterly; however, the reports document if the fire alarms are sounded. Two of the four quarterly Fire Drill Evacuation Reports evidenced that the fire alarms were not sounded nor announced over an overhead page.</p> <p>4. At 11:15 AM on 4/1/2015, staff member #1 (Director) confirmed the surgery center documentation provided did not evidence a</p>			

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	sounded fire alarm nor an overhead fire drill announcement for 2 of 4 quarterly fire drills conducted in 2014.				