

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001102	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/25/2014
NAME OF PROVIDER OR SUPPLIER VISION SURGICAL CENTER AT SPRINGHILL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 302 W 14TH ST STE 100 B JEFFERSONVILLE, IN 47130		
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002769</p> <p>Survey Date: 2/24/2014 through 2/25/2014</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 03/07/14</p>	S000000			

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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S000116	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</p> <p>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on document review and staff interview, the Governing Board failed to ensure the surgery center's CRNA was granted privileges by the Medical Staff.</p> <p>Findings included:</p> <p>1. The Vision Surgical Center at Springhill, PSC Medical Staff Bylaws (last approved 12/17/2013) Article IV section</p>	S000116	The Governing Board held an addendum meeting on 02/25/14 and re-appointed the CRNA with privileges granted by the Medical Staff. A second CRNA, who was approved and granted privileges, began on 03/03/14. The report incorrectly states staff member #3 was the only CRNA at the facility since October 2013. Staff member #3 was in fact the only CRNA at the facility for the month of February 2014. A previous CRNA left the facility at the end of January. The Director of Nursing will be responsible to monitor the timeliness of re-appointments and	02/25/2014	

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	<p>4.9.1 states, "Qualified AHPs who have a contractual relationship with the Center to provide specific patient care services must qualify for and be granted privileges to perform specified patient care services within the Center."</p> <p>2. Staff member #3 credential files contained a memorandum dated December 4th, 2012 signed by the surgery center's Medical Director indicating staff member #3, CRNA, was approved privileges for Vision Surgical Center for one-year period, from October 2012 to October 2013. The staff member's credential files did not have evidence that he/she was granted privileges by the Medical Staff after the initial privileges expired October 2013.</p> <p>3. A memorandum dated March 8th, 2013 by Centralized Application Processing Service (CAPS) states, "CAPS has been processing your application for facility privileges. Since we have</p>		approval of privileges Monitoring will occur over the next 4 Governing Board meetings and on-going as needed.				

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	<p>not received all verification letters after three attempts, and/or you have not provided all required documentation, your incomplete CAPS portion of the application process has been forwarded to the facilities to which you applied (those who approved your pre-application)."</p> <p>4. On 2/24/2014, staff member #3, CRNA, was the anesthesia provider for surgery procedures without privileges that were granted by the Medical Staff and approved by the Governing Board.</p> <p>5. At 11:00 AM on 2/25/2014, staff member #1 confirmed CRNA, staff member #3, has not been granted privileges by the Medical Staff to provide anesthesia care since October 2013. The staff member indicated the surgery center only had the one CRNA to provide anesthesia care since October 2013.</p>						

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S000182	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (O)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(O) Annual implementation of internal and external disaster preparedness plans with documentation of outcome.</p> <p>Based on document review and staff interview, the Governing Board failed to ensure the surgery center conducted an external disaster drill.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Disaster Preparedness Plan and supporting documents were reviewed and did not evidence that Vision Surgical Center participated in an external disaster drill. At 1:45 PM on 2/25/2014, staff member #1 indicated Vision Surgical Center has not participated in an external disaster drill. 	S000182	<p>The Director of Nursing has been participating in the District 5 ASC subcommittee meetings since 2010, the District 9 Hospital Preparedness Committee meetings since 2013 and has participated, with other facility staff, in Lighthouse Readiness Group disaster preparedness table top exercises since September 2012 and workplace violence training since June 2013. The facility also participated in the ISDH ASC Disaster Preparedness survey conducted in early 2013. The Director of Nursing has also been in contact and worked with the Clark County Emergency Management Officer who was given a copy of the facility disaster plan.</p> <p>The District 9 Hospital Preparedness Committee is planning a district drill on May 30, 2014 at Lighthouse Readiness Group and our facility will be participating. The DON will continue to participate in the D9 Hospital Committee meetings</p>	05/30/2014			

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S000400	<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 observation and staff interview, the facility failed to ensure patient care equipment/items were stored in a clean area for 1 utility room observed, failed to appropriately clean between cases, failed to follow facility policy on terminal cleaning and specify in terminal cleaning policy that clean items are to be cleaned first as reflected in cleaning between cases and failed to follow hand hygiene policy.</p> <p>Findings include:</p> <p>1. During tour of the pre/post operative area beginning at 1:40 p.m. and accompanied by staff member #1 the following was observed: (A) The O2 cylinders for patient use were stored in the soiled utility room within feet of the hopper.</p> <p>2. Staff member #1 indicated during the</p>	S000400	<p>leading up to the drill. The DON will be responsible for planning and conducting an annual external disaster drill and will monitor on an on-going basis.</p> <p>A contractor has been contacted and will be at the facility on 03/21/14 to relocate the portable oxygen tanks. He will also render the hopper in the utility room un-serviceable. The utility room will remain as an area to clean soiled instruments. The policy related to terminal cleaning, "Cleaning Plan for Surgical Areas" was revised on 03/12/14. Staff was rein-serviced on terminal cleaning, cleaning of the OR between cases, and on following manufacturer's instructions when using cleaning chemical on 03/13/14. Nursing staff was rein-serviced on Hand Hygiene on 03/13/14. Anesthesia staff was rein-serviced on Hand Hygiene on 03/13/14 & 03/19/14. The DON will monitor completion of the work on the utility room. The Clinical Director/Infection Control Officer will monitor all cleaning activities in the OR between cases and terminal cleaning 3 x week for 3 weeks,</p>	03/21/2014			

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	<p>observation that the hopper is utilized and that at times some instruments are brought into the room after surgery for cleaning.</p> <p>3. Label instructions for Cavicide indicate the product must be sprayed on the surface wetting areas to be disinfected and must remain visibly wet for 3 minutes to be effective against TB, Staph,etc.</p> <p>4. Facility policy titled "Cleaning of Operating Rooms Between Cases" last reviewed/revised 11/30/11 states under procedure: "1. Vision Surgical Center will used (known error) approved cleaning solutions and follow manufacturer's instructions for use. 2. Cleaning starts at the top and proceeds to the bottom beginning with the cleanest area and moving to the "dirtiest" areas last. 3. Horizontal surfaces are to be wiped using Cavicide....."</p> <p>5. Facility policy titled "Cleaning Plan for Surgical Areas" last reviewed/revised 5/10/12 states: "7. Terminal cleaning at the end of the day's surgery schedule includes but is not limited to: a. Wipe down all furniture and equipment used in all areas....." The policy did not reflect that items should</p>		<p>weekly x 3, then monthly for 3 months and on-going as needed. The DON and the QAPI officer will monitor hand hygiene weekly x 4 weeks, monthly x 3 and on-going as needed.</p>				

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	<p>be cleaned from cleanest to dirtiest areas.</p> <p>6. Facility policy titled "Hand Hygiene" last reviewed/revised 1/4/11 states "A hand wash should be performed: ".....2. Before and after every patient contact....."</p> <p>7. During observation in the operating room beginning at 1:14 p.m. on 2/24/14 staff member #3 was observed administering I.V. medication to patient #30 without performing hand hygiene after the contact.</p> <p>8. During observation of cleaning between patients in the operating room (OR) beginning at 1:32 p.m. on 2/24/14, the following was observed: (A) The staff did not spray all surfaces, including but not limited to, the stand holding the instrument sets. (B) Staff sprayed the Cavicide on surfaces without covering all areas of the surface, waited less than 2 minutes and wiped the surface off with a dry cloth.</p> <p>9. During observation of terminal cleaning of the OR on 2/25/14, the following was observed: (A) Staff members started with cleaning dirty items and then moved to</p>			

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S000428	<p>clean items. (i.e. cleaned the trash can prior to tables)</p> <p>(B) The equipment in the room was cleaned and then moved to the hallway which had not been cleaned/mopped. The OR was mopped and then the equipment which had been taken to the hallway was brought back into the cleaned room.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</p> <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>(i) Sanitation. Based on observation, the facility failed to ensure the Laser was maintained clean.</p> <p>Findings included:</p> <p>At 9:00 AM on 2/25/2014, the Laser Suite was inspected. The Femto Laser was observed with accumulation of dust build-up on</p>	S000428	Nursing staff was rein-serviced on cleaning of the femtolaser on 03/13/14. The femtolaser has been added to the weekly cleaning schedule. The Infection Control officer will monitor weekly x3, then monthly x3, then on-going as needed.	03/12/2014			

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S000444	<p>the top of the health care equipment.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <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 document review, staff interview, and observation, the facility failed to adhere to the surgical attire policy for 2 of 4 staff members and failed to update the surgical attire policy to reflect current practice of laundering surgical attire.</p> <p>Findings include:</p> <p>1. Facility policy titled "Surgical Attire" last reviewed/revised 12/13/10 states "After daily use or visible soiling, surgical attire will be placed in a hamper for laundering by staff." and "Attire worn outside the surgical suite and not covered by a lab coat must also be</p>	S000444	The Surgical Attire policy was revised 03/12/14. Nursing staff was rein-serviced on 3/13/14, anesthesia staff on 03/13/14 and 03/19/14 and medical staff were rein-serviced 03/17/14 thru 03/20/14. The Director of Nursing will monitor weekly x3, then monthly x 3 and on-going as needed	03/20/2014			

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	<p>changed. Lab coats will be used by personnel leaving the department as cover apparel for surgical attire and laundered by the employee."</p> <p>2. AORN recommendation states on page 52: "Jewelry including earrings, necklaces, watches, and bracelets that cannot be contained or confined within the surgical attire should not be worn. Jewelry that cannot be confined with the surgical attire should be removed before entering into the semirestricted and restricted areas.</p> <p>3. Staff member #1 indicated the following in interview beginning at 3:30 p.m. on 2/25/14: (A) The facility has a company that launders the scrub attire. (B) Staff member #3 (anesthesia provider) wears his/her jacket within the facility and it is laundered by the company with the scrub attire, however his/her jacket is not laundered on a daily basis. (C) T-shirts for M.D. #4 are not laundered by the contracted company that launders the scrub attire.</p> <p>4. During observation in the operating room beginning at 1:14 p.m. on 2/24/14, the following was observed: (A) Staff member #3 was observed</p>						

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S000802	<p>wearing a black and gray jacket over his/her scrub attire in and out of the OR. (B) Staff member #3 was wearing dangling earrings as well as a necklace which were visible outside his/her scrub attire in the operating room. (B) A gray t-shirt was observed under the scrub attire of M.D. #4 in the operating room.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(A)</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>(A) A requirement that a licensed physician with specialized training or experience in the administration of an anesthetic supervise the administration of the anesthetic to a patient and remain present in the facility during the surgical procedure, except when only a local infiltration anesthetic is administered.</p> <p>Based on observation and document review, the Medical Staff failed to ensure 3 of 6 Vision</p>	S000802	A training competency with posttest has been purchased from the American Society of Anesthesiologist website. All surgeons have been informed of	04/18/2014

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	<p>Surgical Center physicians were competent for supervising the CRNAs on any unusual problems which may affect administering of anesthesia (#4, 5, and 8).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Vision Surgical Center Anesthesia Services policy (Last revised 12/17/2013) states, "Anesthesia Services are supervised by a qualified member of the medical staff. The operating practitioner and/or the attending physician shall be responsible for communicating to the anesthesia staff member and to record in a legible fashion on the chart any unusual problems known to them which may affect administering of anesthesia." 2. The Vision Surgical Center at Springhill, PSC Medical Staff Bylaws (Last approved 12/17/2013) Article IV section 4.4 states, "Each current and applying Professional shall, at the time of 		<p>the requirement to complete the competency prior to the POC correction date and upon each re-appointment. The Director of Nursing will monitor for timeliness of completion. Monitoring will be on-going.</p>				

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	<p>Appointment and Reappointment and continuously thereafter, possess the following basic prerequisites: Appropriate physical and mental health; and personal and professional qualifications and appropriate record of professional performance, judgement, clinical, and technical skills."</p> <p>3. Three of 6 physician credential files (#4, 5, and 8) did not evidence of clinical and technical competency in Anesthesiology specialties.</p> <p>4. Staff member #4 was observed on 2/24/2014 conducting an operating procedure with the CRNA that performed the anesthesia. However, the operating practitioner (staff member #4) credential files did not evidence that he/she has the competency for supervising the CRNA on any unusual problems which may affect administering of anesthesia.</p>			
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S000824	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(D)</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>(D) Safety rules to be followed. Based on document review and observation, the facility failed to conduct a time-out prior to surgery for 1 surgical observation.</p> <p>Findings include:</p> <p>1. Facility policy titled "Time Out" last reviewed/revised 7/19/12 states under procedure: "Perform "TIME OUT" immediately before starting the procedure. Time out must be conducted in the operating room just before starting the procedure. It must involve the surgeon, scrub tech, and circulator and be documented in the patient's record as such. Time out should include the following: 1. Correct side site. 2. Agreement on the procedure to be done. This agreement must match information the site/side and procedure in the patient's chart. 3. Availability of correct</p>	S000824	<p>It is the practice as well as the policy to perform a time-out prior to each surgery. The surgeon, circulating RN and scrub tech all indicated a time -out was indeed performed prior to the observed surgery and they are unsure why the surveyor did not observe it. Nursing staff was rein-serviced on the Time-Out policy on 03/13/14. Anesthesia staff was rein-serviced on 03/13/14 & 03/19/14. Medical Staff were rein-serviced 03/17/14 thru 03/20/14. The Clinical Director will monitor daily x 2 weeks, weekly x 3, then monthly times 3 and on-going as needed.</p>	03/20/2014
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NAME OF PROVIDER OR SUPPLIER VISION SURGICAL CENTER AT SPRINGHILL INC				STREET ADDRESS, CITY, STATE, ZIP CODE 302 W 14TH ST STE 100 B JEFFERSONVILLE, IN 47130			
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S000830	<p>implants and any special equipment or special requirements. 4. The time the "Time Out" is conducted will be documented on the OR record."</p> <p>2. During observation of patient #30 in the operating room beginning at 1:14 p.m. on 2/24/14 it was observed that staff did not conduct a time-out.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(i)</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>(F) The delineation of preanesthesia, intra-operative, and post-anesthesia responsibilities as follows:</p> <p>(i) The completion, within forty-eight (48) hours before surgery, of a preanesthesia evaluation for each patient by an individual qualified to administer anesthesia for all types of anesthetics other than local and updated according to center policy (when more than forty-eight (48) hours) before surgery.</p> <p>Based on observation, the anesthesia provider failed to conduct a pre-anesthesia assessment according to policy for 1 patient observation.</p>	S000830	Anesthesia staff was rein-serviced/trained on all anesthesia policies and procedures including pre-anesthesia assessment on	03/19/2014			

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Anesthesia Standard of Care" last reviewed/revised 4/4/13 states on page 3: "A history and physical examination will be available on the patient's chart at the time of the pre-anesthetic visit when possible. Such documentation shall not replace the anesthesiologist's/CRNA's responsibility for personally evaluating the patient and documenting said evaluation. 2. During observation of patient #30 beginning at 12:30 p.m. on 2/24/14, the following was observed: <ol style="list-style-type: none"> (A) Staff member #3 (anesthesia provider) visited the patient in pre-op and discussed I.V. medication. No physical assessment took place, however he/she documented under "physical exam" in the medical record that HEENT was within normal limits (WNL), the Heart was WNL and that the Lungs were clear. 		03/13/14 and 03/19/14. The Director of Nursing will monitor daily x 2 weeks, weekly x 3, then monthly x 3 and on-going as needed.				

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S000888	<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. Based on document review and staff interview, it could not be determined that the operative reports were dictated/completed immediately following surgery for 29 of 29 closed medical records reviewed.</p> <p>Findings include:</p> <p>1. The operative notes for patients #1-29 medical records lacked a date of dictation, therefore it was impossible to determine that the reports were dictated immediately following the procedure.</p>	S000888	The Operative Reports were revised on 03/12/14 to include the date of dictation. Staff were rein-serviced on 03/13/14 Medical staff was in-serviced 03/17/14 thru 03/20/14. The Director of Nursing will monitor daily x 2 weeks, weekly x 3, then monthly x 3 and on-going as needed.	03/20/2014			

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S000900	<p>2. Staff member #1 verified in interview at 3:30 p.m. on 2/25/14 that the operative reports did not contain a date of dictation. He/she felt that since the document had a patient sticker on it from the day of the procedure, that it was evidence of the date it was completed.</p> <p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(a)</p> <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: Based on document review, the facility failed to ensure orders were received and a safe transfer was in place prior to allowing patient to leave the monitored area for 1 patient transfer.</p> <p>Findings include:</p> <p>1. Facility policy titled "Discharge Criteria" last reviewed/revised 8/19/10 states: "6. The PACU nurse shall contact either the anesthesiologist or attending surgeon if there are questions as to patient's suitability for discharge.</p>	S000900	It is the practice of Vision Surgical Center to safely discharge all patients following the facilities policies and procedures. Patient #1 had elevated blood pressure postoperatively. The surgeon requested staff to notify the primary care physician (PCP). The PCP was not available and his staff did not indicate there would be a return call. My staff did not expect a return call. The patient and family were instructed to visit the PCP to have the elevated blood pressure treated. The patient was assisted to their car after receiving discharge instructions. While this was	03/12/2014			

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	<p>Patients are to remain in the unit, per policy, following return from the operating room....."</p> <p>2. Review of patient #1 medical record indicated the following:</p> <p>(A) He/she presented to the facility for surgery on 5/22/13. His/her blood pressure was elevated post operatively at 214/81, 208/78, and 207/79.</p> <p>(B) Nurse notes at 10:49 a.m. indicated the patient felt dizzy upon standing and the surgeon was notified.</p> <p>(C) Nurse notes at 11:00 a.m. indicated that a call was placed to the patients primary care physician at the request of the surgeon. The primary care physician was unavailable and the staff was informed by the primary care office that the patient's blood pressure was normally 113/55 in the office. The physician's office requested the surgery center send the patient to the emergency department (ER).</p> <p>(D) The patient was allowed to leave the monitored recovery area prior to being informed of orders related to the elevated blood pressure. Nurse notes indicated that the patient had already been taken to the car by his/her spouse and that staff went out and told the spouse/patient to go to the ER.</p>		<p>occurring the PCP called back and asked to have the patient go to the hospital This was relayed to the patient and staff called report to the hospital. Staff was rein-serviced on the Discharge Criteria policy on 03/13/14. The Director of Nursing will monitor patient discharges 3 x week for 3 weeks, then weekly x 3, then monthly x 3 and on-going as needed.</p>				

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S001146	<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 and staff interview, the facility failed to maintain the surgery center environment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in one instance.</p> <p>Findings included:</p> <p>1. Vision Surgical Center Fire Safety - Hazards (Last revised 12/17/2014) states, "Hazards the personnel shall recognize and correct, cause to be corrected, or prevent from existing are as follows: Exit Ways: Do not permit the obstruction of aisles,</p>	S001146	The carts in the exit hallway were relocated to the pre-op area. The delivery of supply boxes was relocated effective 03/12/14. This leaves the exit corridor entirely clear. Staff was in-serviced on the changes on 03/13/14. Delivery staff have been told of the changes. The Director of Nursing will monitor the exit corridor 3 x week for 3 weeks, weekly times 3, then monthly x 3 and on-going as needed.	03/13/2014	

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	<p>doorways, and fire escapes or allow their use as storage places."</p> <p>2. At 11:00 AM on 2/24/2014, the rear hallway with two marked fire exit doors was observed storing a covered clean linen storage cart in the hallway. Items that also were observed stored in the hallway were a case of toilet tissue, 8 cases of assorted can soft drinks, large assorted cases of supplies. The cases were observed stored directly on the floor. The hallway was observed storing these items for at least 4 hours: 11:00 AM to 3:00 PM.</p> <p>3. At 2:15 PM on 2/24/2014, staff member #1 indicated the surgery center was short on storage locations. Items are stored in the hallway and put away in storage when staff can get to them. The clean linen storage cart stays in the hallway all the time.</p>				

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