

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001114	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/06/2012
NAME OF PROVIDER OR SUPPLIER  SOUTH CENTRAL SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5002 E SR 44 FRANKLIN, IN 46131		
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 003073</p> <p>Survey Date: 9/4/12 through 9/6/12</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 09/12/12</p>	S0000			

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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S0110	<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 facility failed to conduct quarterly meetings of the Credentialing Staff and failed to conduct quarterly Quality Assurance Committees as defined in the Medical Staff Bylaws</p> <p>Findings included:</p> <p>1. Medical Staff Bylaws Article X, Committees of the Staff, last reviewed October 19th 2011, states, "There shall be the following standing committees of the medical staff; Credentials, Quality Assurance, Utilization Review, Tissue, Infection Control. Each</p>	S0110	<p>On October 24, 2012 the Governing Board will review the frequency of credentialing committee meetings. The Governing Board will remind the credentialing committee this committee is required to meet quarterly and to report their findings to the Governing Board at its quarterly meetings. The General Staff will select a chairperson and the President will select a person to sit on the Quality Assurance Committee. The Governing Board will review with the Quality Assurance Committee what responsibilities they have and The Quality Assurance Committee will be reporting their findings at the quarterly Governing Board meeting. The Quality Improvement Committee will begin each meeting minutes with a list of members present at each meeting. The Director of Nursing will monitor the meetings and</p>	10/24/2012	

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	<p>committee shall meet quarterly."</p> <p>2. The Credentialing Committee minutes were reviewed for 2011 and 2012: 2/9/11, 4/7/11, 10/19/11, 3/1/12, and 7/25/12. The credentialing committee did not meet 3rd quarter of 2011 and the 2nd quarter of 2012.</p> <p>3. At 1:45 PM on 9/4/2012, staff member #2 confirmed the two missing quarters of the Credentialing Committee were missing and not available to be reviewed.</p> <p>4. Medical Staff Bylaws Article X section 10.2 states, "The Quality Assurance Committee shall consist of a chairperson and one other member appointed by the President."</p> <p>5. The Quality Improvement Committee previously met 7/18/12, 5/16/12, 2/15/12, and 8/24/11. All 4 committees lacked the members who attended the meeting.</p>		report to the Governing Board when the Credentialing Committee and the Quality Assurance Committee have met.				

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	6. At 2:15 PM on 9/4/2012, staff member #2 confirmed the Quality Assurance committee meetings lacked the members who attended those meetings.			
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S0122	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND 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 documentation and staff interview, it could not be determined the governing board had reviewed and approved the medical staff bylaws in the past three years.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>On 9/4/2012 at 12:00 PM, staff member #2 was requested to provide documentation including when the governing board last reviewed and approved the medical staff bylaws.</li> <li>The Governing Board meeting minutes for years 2009, 2010, 2011, and 2012 and the Administrative Policy and Procedure manual were reviewed. The October 19, 2011</li> </ol>	S0122	<p>The Director of Nursing will review the Policy and Procedure Book. The Director of Nursing will confirm that all pages of the Medical Staff Bylaws and Rules. The Director of Nursing will also confirm that all Policies and Procedures are included in the Policy and Procedure Book. The Director will present the Policy and Procedure Book at the Governing Board for approval. It will then be noted in the front of the Policy and Procedure Book the Date that it was approved. The Director of Nursing will monitor the Policy and Procedure book each year and have the Policy and Procedure Book reviewed for approval every three years. All new policies will be reviewed and approved by the Governing Board and placed in the Policy and Procedure Book by the Director of Nursing. The Quality Assurance and Improvement Committee will develop a Quality Improvement checklist. This will be monitored by the Director of Nursing. The Director of Nursing will report the</p>	10/24/2012	

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	<p>South Central Surgery Center Board and Medical Staff meeting minutes identified the Policy and Procedure book was reviewed and approved. However, the review of the Medical Staff bylaws, pages 16-27 were missing from the Policy and Procedure manual. Further review of the policy and procedure manual indicated the following policies were missing from the manual: Radiology Equipment Policy, Emergency Call System policy, Certificate Renewals Quality Improvement policy, and patient Bill of Rights policy. The face sheet for the Policy and Procedure manual was handwritten and signed by the administrator, staff member #2. The last date recorded on the cover-sheet was 12/30/08 and signed by the administrator.</p> <p>3. At 2:35 PM on 9/4/2012, staff member #2 indicated he/she has policies that were approved and are located in his/her office. The staff member confirmed the policy and</p>		findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report the findings to the Governing Board.		

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	procedure manual is unorganized and it would be hard to ensure anyone the manual was current with all of the correct policies and procedures.			

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S0153	<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 policy review, personnel file review, and interview, the facility failed to ensure 3 of 7 staff members received job specific orientation (#A10, A13, and A15).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Employee Orientation", last reviewed 10/19/11, indicated, "...A. The orientation of new employees shall take place within the first week of employment beginning with the first day. The orientation checklists that are a part of this Policy are intended to assure the completeness of this process. These Checklists are to be included in the personnel file of the employee."</li> <li>The employee file for staff members #A10, a registered nurse hired 03/03/11, indicated an "Orientation Skills Checklist" signed by the employee, but</li> </ol>	S0153	<p>All present employees files have been reviewed the ones without orientation skill sheets not completed will be coming in to work with the Director of Nursing. Each employee will have to do a skills check that is observed by the Director of Nursing. The Director of Nursing will mark each skill completed on the orientation list. Then both the employee and the Director of Nursing will sign and date the orientation list. The list will then be placed in the employees file. The Director of Nursing will be the one to review files to confirm that all new employees have the orientation skills check list completed with in the 1st week of employment. The Quality Assurance and Improvement Committee will develop a form to track that all new employees files have all the appropriate information in them the first week of employment. The Director of Nursing will maintain this report findings to Quality Assurance and</p>	10/17/2012	

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	<p>not completed at all or signed by a preceptor or supervisor.</p> <p>3. The employee files for staff members #A13, a surgery tech hired 07/07/10, and staff member #A15, a registered nurse hired 09/23/10, lacked documentation of job specific orientation or any orientation checklists.</p> <p>4. At 11:00 AM on 09/06/12, staff member #A2 confirmed the employee file findings.</p>		Improvement Committee. The Quality Assurance and Improvement Committee will report the findings to the Governing Board.		

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S0162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on policy review, employee file review, and interview, the facility failed to ensure CPR (cardiopulmonary resuscitation) competency for all health care workers providing direct patient care in 3 of 7 files reviewed (#A10, A13, and A15) and failed to ensure ACLS (advanced cardiac life support) in 2 of 4 RNs (Registered Nurses) files reviewed (#A10 and A15).</p> <p>Findings included:</p> <p>1. The facility policy "CPR", last reviewed 10/19/11, indicated, "All medical personnel employed by the Surgery Center must possess current HCLS/CPR Certification as approved by the American Heart Association or by the American Red Cross. ...A copy of the CPR card will be attached to the</p>	S0162	The two Registered Nurses will be providing the Director of Nursing with a copy of their CPR and ACLS certification. The Surgical Tech has also been require to bring in a copy of CPR certification. The Director of Nursing will review employee files annually to make sure all staff files are updated. The Quality Assurance and Improvement Committee will develop a check list to follow this. The Director of Nursing will maintain this and report findings to the Quality Assurance and Improvement Committee. The Quality and Improvement Committee will report their findings to the Governing Board.	10/17/2012	

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	<p>employee's file folder."</p> <p>2. The facility policy "Policy and Procedure for External Disasters", last reviewed 10/19/11, indicated, "...Nurses are ACLS and CPR certified."</p> <p>3. The files for staff members #A10, an RN hired 03/03/11, A13, a surgical tech hired 07/07/10, and A15, an RN hired 09/23/10, lacked documentation of a current CPR card or competency verification.</p> <p>4. The files for staff members #A10, an RN hired 03/03/11 and A15, an RN hired 09/23/10, lacked documentation of a current ACLS card or competency verification.</p> <p>5. At 11:00 AM on 09/06/12, staff member #A2 confirmed the lack of CPR and ACLS competency in the files, but indicated all staff were certified as required.</p>				

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S0164	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program.</p> <p>Based on policy review, employee medical file review, and interview, the facility failed to ensure all of their employees had documentation of post offer physicals in 3 of 7 employee medical files reviewed (A10, A13, and, A14).</p> <p>Findings included:</p> <p>1. The facility policy "Employment Application and Record", last reviewed 10/19/11, indicated, "...3. The personnel health record shall contain: a. Results of employee physical examination, b. Results of diagnostic tests, c. Hepatitis Vaccination record, d. Tuberculosis testing, e. Any other testing deemed appropriate by physician with the physicals."</p> <p>2. The medical file for staff member #A10, with a hire date of 03/03/10,</p>	S0164	<p>The three employees #A13,#A14, #A2, will redo their physical exam. This will be conducted by our Medical Director. The form will be signed and dated by the employee and the Medical Director. These will be placed in their files by the Director of Nursing. The Director of Nursing will make sure that all new employees have completed their physical exams by the Medical Director and that they are signed by both the employee and the Medical Director. The Quality Assurance and Improvement Committee will develop a Quality Assurance form. The Quality Assurance will be maintained by the Director of Nursing and report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report the findings to the Governing Board.</p>	10/17/2012			

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	<p>indicated a physical exam form with the employee history portion completed, but with no actual exam or physician signature.</p> <p>3. The medical file for staff member #A13, with a hire date of 07/07/10, lacked any documentation of a physical exam form or history questionnaire.</p> <p>4. The medical file for staff member #A14, with a hire date of 05/17/06, indicated a physical exam form with the employee history portion completed, but no physician signature.</p> <p>5. At 11:00 AM on 09/06/12, staff member #A2 confirmed the employee medical record findings.</p>				

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S0310	<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 staff interview, the facility failed to ensure 2 services provided in-house (housekeeping, radiology) and 6 services provided by contractors (trash service, fire system, protection services and pest) as part of its comprehensive quality assessment and improvement (QA&amp;I) program.</p> <p>Findings included:</p> <p>1. The 2011 and 2012 Quarterly QA Reports and Quality Improvement Committee minutes were reviewed. Two services provided in-house (housekeeping, radiology) and 6 services provided by contractors (RTS, CFSS, KPS, JC, AA and T) as part of its comprehensive quality assessment and improvement (QA&amp;I) program. The facility documentation provided for review did not evidence the 8 services</p>	S0310	<p>A Quality Assurance and Improvement program will be developed or updated for the 8 services we have already started by the Director of Nursing. This will be maintained by the Director of Nursing. This will be maintained on a monthly basis by the Director of Nursing. The Quality Assurance and Improvement Committee will develop a Quality Assurance form to track this. The Director of Nursing will maintain this and report the findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report their findings to the Governing Board.</p>	10/24/2012			

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	<p>were evaluated by the Quality Assurance Process.</p> <p>2. At 9:00 AM on 9/6/2012, staff member #2 confirmed the 8 services were not evaluated by the Quality Assurance Process.</p>				

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S0328	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and staff interview, the facility failed to ensure 3 services (pharmacy, infection control, laundry/linen) were properly evaluated and monitored by the Quality Assurance Process.</p> <p>Findings included:</p> <p>1. The 2012 Quarterly QA Reports were reviewed. The criteria for the QA process of the pharmacy service was to send reminder letter to pharmacy about QA. The QA criteria for linen was to wash laundry in sanitary cycle. The QA criteria for infection control was to</p>	S0328	The Quality Assurance and Improvement program for Laundry includes Laundry additives used. Universal precautions examination of linen and how they are handled. The Quality Assurance and Improvement Committee will be reviewed and updated. The Quality Assurance for Laundry will bill be maintained on a monthly basis by the Director of Nursing and reported to the Governing Board at their quarterly meeting by the Quality Assurance and Improvement Committee. The Pharmacy Quality Assurance includes that the pharmacist is making quarterly visits to check our medications for outdates and the storage of medication. The Quality Assurance form will be reviewed and updated. The infection control Quality Assurance will also be reviewed and updated by the Quality	10/24/2012			

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	<p>send reports to doctors. The criteria for the three services was not an effective way to measure the performances of the three services.</p> <p>2. At 9:00 AM on 9/6/2012, staff member #2 confirmed pharmacy, infection control, and laundry/linen services are not being effectively evaluated by the Quality Assurance Process.</p>		<p>Assurance and Improvement Committee. These Quality Assurance forms will be maintained by the Director of Nursing on a monthly basis. The Director of Nursing will report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to the Governing Board.</p>		

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S0400	<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 interview, the facility failed to provide a safe patient environment by ensuring areas were inspected and free of outdated patient supplies.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. During the tour of the pre/post op area at 11:25 AM on 09/05/12, accompanied by staff members #A2 and A9, the following observations were made:             <ol style="list-style-type: none"> <li>A. An open, but not dated, bottle of control solution for the glucometer. Manufacturer's directions were to discard 90 days after opening.</li> <li>B. Three of three 22 gauge intravenous needles expired 02/2012 and two of two 20 gauge intravenous needles expired 07/2006 in the IV start kit at the nurses' station.</li> <li>C. In the bottom of the warming cabinet:                 <ol style="list-style-type: none"> <li>1. One of one 500 milliliter 0.9% normal saline for irrigation expired June 2012.</li> <li>2. One of one 500 milliliter sterile water for irrigation expired May 2009.</li> <li>3. Five of five 250 milliliter 5% Dextrose</li> </ol> </li> </ol> </li> </ol>	S0400	<p>The staff will be checking all supplies in all areas. Any found to be outdated will be removed from the stock and disposed of in the proper manner. The Director of Nursing will have someone on the staff going thru supplies in their areas each month to check for outdated or damaged medication or supplies. The staff will have a review on dating all items opened, glucose strips, medication, cidex OPA strips. The Quality Assurance and Improvement Committee will develop new Quality Assurances for each area. These will be maintained by the Director of Nursing on a monthly basis. The Director of Nursing will report the findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report the findings to the Governing Board at their quarterly meetings.</p>	10/10/2012			

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	<p>for injection, 3 expired 08/09 and 2 expired 04/10.</p> <p>D. On top of the crash cart, a trach kit expired 02/2012 and a box of ten defibrillator pads expired 11/2004.</p> <p>E. In the drawers of the crash cart:</p> <ol style="list-style-type: none"> <li>1. Three of three 18 gauge BD Insyte needles expired 07/2006.</li> <li>2. Three of three 20 gauge BD Insyte needles expired 06/2006.</li> <li>3. Two of two 16 gauge BD Insyte needles expired 05/2003.</li> <li>4. Lab tubes in a baggie, 2 of 2 blue top expired 05/2008, 2 of 2 yellow top expired 04/2008, and 1 of 1 purple top expired 06/2008.</li> <li>5. A 22 French latex catheter expired 09/2004.</li> </ol> <p>2. During the tour of the surgical area at 12:30 PM on 09/05/12, accompanied by staff member #A2, the following observations were made in OR 1:</p> <ol style="list-style-type: none"> <li>A. One of one Foley catheter tray expired 04/2007.</li> <li>B. One of one package of Iodophor scrub expired 03/05.</li> <li>C. Five of five open bottles of Providone Iodine solution, 2 expired 11/04, 1 expired 08/04, and 2 expired 10/05.</li> </ol> <p>3. During the tour of the clean supply room at 12:45 PM on 09/05/12, accompanied by staff member #A2, the</p>			

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	<p>following observations were made:</p> <p>A. A box of 22 French catheters with an expiration date of 04/2005.</p> <p>B. A box of 14 French catheters with an expiration date of 11/2006.</p> <p>C. Another box of 22 French catheters with an expiration date of 09/2004.</p> <p>D. A box of Spinecon Spinal needles with an expiration date of 05/2006.</p> <p>4. At 12:50 PM on 09/05/12, accompanied by staff member #A2, an open, but not dated, container of Cidex test strips was observed in the decontamination area. The label indicated the strips were to be discarded 90 days after opening.</p> <p>5. At 1:00 PM on 09/05/12, staff member #A2 indicated the supplies were to be checked monthly and outdates discarded.</p>				

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S0414	<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 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>Review of committee rosters and minutes and interview, the facility failed to ensure the infection control committee included representation from the medical staff.</p> <p>Findings included:</p> <p>1. Review of the infection control meeting minutes indicated the committee was comprised of staff members #A2, the director of nursing and person in charge</p>	S0414	<p>the General Staff will choose the Infection Control Committee. The Infection Control Committee will include the Infection Control Person, one Medical Staff person and one Nursing Staff person. These selected people will be directed all reports of their meetings will be given to the Governing Board at their quarterly meetings. The Quality Assurance and Improvement Committee will develop a Quality Assurance form to track this. The Director of</p>	10/24/2012

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	<p>of the infection control program, #A9, a licensed practical nurse, and #A12, a surgical tech.</p> <p>2. At 11:00 AM on 09/06/12, staff member #A2 indicated the infection control committee was comprised of those 3 staff members and confirmed a member of the medical staff was not on the committee. He/she indicated the meetings were held informally in the break room and the medical director, staff member #A1, was in the room at least half of the time.</p>		<p>Nursing will maintain this Quality Assurance and report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to Governing Board at the quarterly meetings.</p>		

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S0422	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk. Based on employee file review, manufacturer's directions, and interview, the facility failed to ensure the staff TB tests were read within 48 to 72 hours as required in 7 of 7 employee medical files reviewed (A2, A9, A10, A12, A13, A14, and A15).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of the medical files for staff members A2, A9, A10, A12, A13, A14, and A15 indicated the last TB tests were placed on 05/16/12 and read on 05/18/12, but no times were documented either for the placement or the reading of the tests, making it impossible to determine adherence to the specified requirement.</li> <li>2. The manufacturer's directions for Tubersol, the solution used for the TB testing, indicated the tests were to be read between 48 and 72 hours for accuracy.</li> <li>3. At 11:00 AM on 09/06/12, staff</li> </ol>	S0422	<p>The PPD forms have been revised to include date and time when the test has been given and read. To insure that it is done with in the time frame of 48 to 72 hours. The Quality Assurance and Improvement committee will develop a form to track this. The Director of Nursing will maintain the Quality Assurance on a quarterly basis. The Director of Nursing will report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to the Governing Board at the quarterly meeting.</p>	10/04/2012			

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	member A2 confirmed the findings and agreed that the times should be documented to ensure the tests were read between 48 and 72 hours.				

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S0442	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on policy review, employee medical file review, and interview, the facility failed to ensure all of their employees had documentation of immunization status in 6 of 7 employee medical files reviewed (A2, A9, A10, A13, A14, and A15).</p> <p>Findings included:</p> <p>1. The facility policy "Employment Application and Record", last reviewed 10/19/11, indicated, "...3. The personnel health record shall contain: a. Results of employee physical examination, b. Results of diagnostic tests, c. Hepatitis Vaccination record, d. Tuberculosis testing, e. Any other testing deemed</p>	S0442	All employees have been ask to bring in a copy of their immunization record. If the employee is unable to produce a copy. A blood titer will be done at the expense of the surgery center. Either a copy of the immunization record or a report of the titer will be placed in the employees file. All new employees will be required to have a copy of immunization record or a titer in their file. The Quality Assurance and Improvement Committee will add this to the Quality Assurance for employee files and requirements. This will be maintained by the Director of Nursing report findings to the Quality Assurance and Improvement Committee. The Infection Control and The Quality	10/17/2012			

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	<p>appropriate by physician with the physicals."</p> <p>2. The medical file for staff member A2, with a hire date of 12/18/01, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of the diseases. The file indicated self reporting of "No" for Varicella disease or immunization.</p> <p>3. The medical file for staff member A9, with a hire date of 12/18/01, failed to indicate any documentation of the Rubella, Rubeola, or Varicella status other than the self-reported history of the diseases.</p> <p>4. The medical file for staff member A10, with a hire date of 03/03/11, failed to indicate any documentation of the Rubella, Rubeola, or Varicella status other than the self-reported history of the diseases.</p> <p>5. The medical file for staff member A13, with a hire date of 07/07/10, failed to indicate any documentation of the Rubella, Rubeola, or Varicella status other than "No" for history of the diseases or immunizations.</p> <p>6. The medical file for staff member A14, with a hire date of 05/17/06, failed</p>		Assurance and Improvement Committees will report findings to the Governing Board at the quarterly meeting.				

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	<p>to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of the diseases. The file indicated self reporting of "No" for Varicella disease or immunization.</p> <p>7. The medical file for staff member A15, with a hire date of 09/23/10, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of the diseases. The file indicated self reporting of "No" for Varicella disease or immunization.</p> <p>8. At 3:45 PM on 09/05/12, staff member A2 confirmed the medical file findings and indicated he/she thought the self reporting was acceptable and they had never required verification of immunization. He/she indicated there were no policies in place regarding staff members in a nonimmune status working in the facility.</p>			

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S0446	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(x)</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>(x) A program of linen management.</p> <p>Based on documentation review and staff interview, the facility failed to ensure an effective linen management program that addresses handling and transporting processes of clean and soiled linen.</p> <p>Findings included:</p> <p>1. South Central Surgery Center Linen Policy and Procedure, last reviewed 10/19/11, states, "All soiled linen will be handled with universal precautions. Linen carts will be covered at all times. Sanitation cycle will be used for every load of laundry. All clean laundry will be kept separate from soiled laundry. Each item of</p>	S0446	<p>Laundry detergent or an agent that will reduce microbial contamination in the wash cycle will be purchased. and used in each laundry cycle. The Temp on the water heater is set at 135 degrees. Bleach will used in each cycle. Sanitize cycle will be used with each load. A linen management in house policy will be written by the Director of Nursing and the Infection Control Committee. A training session for all staff will be conducted and the attendance will be noted in their file. The policy will be placed in the Policy and Procedure Book and will be reviewed and approved by the Governing Board at their quarterly meeting. The Quality Assurance and Improvement Committee will develop a form to track that detergent or an agent that will reduce microbial contamination in the wash cycle will be used. Also that all employees will attained a</p>	10/23/2012	

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	<p>laundry will be checked for stains, holes, and snags. QA will be kept on the above each month. Report any problems to the Director of Nursing."</p> <p>2. The detergent that was being used for the front loading washer was Tide with Downy fabric softener. The detergent does not describe what organisms the detergent can kill.</p> <p>3. Kenmore Elite HE Front-loading Automatic Washer owner's manual states, "Sanitary Cycle also helps eliminate 99.999% of 3 common infectious bacteria." The owner's manual does not specify what the bacteria the sanitary cycle will eliminate and only requires no more than 1/3 cup of liquid bleach in #5 dispenser. The washer indicates the operator to set the water heater to 120 F.</p> <p>4. CDC Guidelines for Laundry in Health Care Facilities states, "Chlorine bleach becomes activated</p>		<p>training session on in house linen management. The Director of Nursing will maintain the Quality Assurance and report findings to the Infection Control Committee and the Quality Assurance and Improvement Committee. Each of these committees will report findings to the Governing Board at the quarterly meetings.</p>	

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	<p>at water temperatures of 135 to 145 F. Several studies have demonstrated that lower water temperatures can reduce microbial contamination when cycling the washer, the wash detergent, and the amount of laundry additive are carefully monitored and controlled. Low temperature laundry cycles rely heavily on the presence of chlorine-or oxygen activated bleach to reduce the levels of microbial contamination."</p> <p>5. At 11:30 AM on 9/6/2012, staff member #2 indicated he/she hopes the detergent and the bleach added to the washer was effective against pathogens. The staff member indicated he/she never tested or monitored the effectiveness of the washer. The staff member indicated the water heater was set on 126 F and all wash cycles are on the sanitary cycle. The staff member indicated the policy in the Administrative Policy and Procedure manual was referencing the commercial laundry/linen</p>			

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NAME OF PROVIDER OR SUPPLIER  SOUTH CENTRAL SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5002 E SR 44 FRANKLIN, IN 46131
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	service the facility used to have. The staff member indicated the facility does not have a Linen Management Program that addresses the in-house laundry/linen service.			

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S0494	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(2)(i)(2)(B)</p> <p>(B) If laundry is processed in the center:</p> <p>(i) a laundry processing room must be provided;</p> <p>(ii) clean linen storage and mending must be separated from soiled linen storage; and</p> <p>(iii) employee hand washing facilities shall be available in each room where clean or soiled linen is processed and handled.</p> <p>Based on observation, document review, and staff interview, the facility failed to ensure the clean and soiled laundry/linen are being processed in a separate room from other items, failed to provide separation of clean and dirty linen and failed to provide handwashing facilities for the processing of the laundry/linen.</p> <p>Findings included:</p> <p>1. At 1:30 PM on 9/5/2012, the receiving room was inspected. The room was observed storing assorted equipment, paint, housekeeping</p>	S0494	<p>Laundry Processing Room. Eight years ago we ask our Federal Surveyor to take a tour of our facility and show us where we could place a laundry processing room. The surveyor indicated the general supply room. Indicated where we should place the washer and where to place the dryer. Both were placed in the area the surveyor indicated. We then ask for guidelines which we were given and have been following. Such as the washer would need a sanitize cycle which it has and is used for every cycle. In the last eight years this is the first time we have been cited on the area of our laundry processing room. Every year the Surveyor is taken a tour and shown this room. The surgery center has not had any infections in our facility. November 30,</p>	11/30/2012

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	<p>supplies, etc. The room was observed storing a covered cart of linen. In the room, there was a brown laundry basket stored on a wooden pallet. The laundry basket contained soiled linen. Next to the laundry basket was a housekeeping cart that had a gallon of bleach on it with soiled white assorted linen on it also. Against the wall, there was a front loaded washer and dryer sitting side-by-side. On top of the washer was a gallon container of 'Tide' liquid detergent that contained 'Downy' fabric softener. Adjacent to the dryer was a 5-foot steel table. The room did not have a hand washing sink. The room did not have a separation of soiled and clean linen during the processing of washing, drying, and folding of the laundry/linen.</p> <p>2. At 2:45 PM on 9/5/2012, staff member #2 indicated the laundry would be washed and dried in the same room. The dried laundry would be folded on the table position next to the dryer. The staff</p>		<p>2012. Laundry Policy updated All soiled linen will be placed in a covered linen hamper by staff wearing gloves. All soiled linen will be taken to the soiled utility room in a covered linen hamper. In the soiled utility room the staff will wear gloves, goggles and gown if needed. The staff will than sort and pre-treat linen at the hopper or the sink. The soiled linen will be placed in a covered linen cart. The soiled linen will than be placed in the washer. The sanitize cycle along with bleach, laundry detergent and fabric softner will be started. The staff will then remove gloves goggles and gown and wash hands. Washer to dryer. The staff will wash hands and apply clean gloves. The wet linen will be placed in a clean linen cart and taken to the dryer. The wet linen will be placed in the dryer. The staff will than remove their gloves and wash their hands. Dryer to linen closet. The staff will wash their hands. Then fold clean linen on the clean folding table. The folded linen will be placed in the covered linen cart. The covered linen cart will be taken to the linen closet where the clean linen will be placed. The laundry policy will be reviewed annually with the staff to ensure that the policy is being done properly. A quality assessment will be developed by the QA committee. This will be maintained by the Director of Nursing and the reports will be</p>				

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	member indicated the facility elected to wash and dry all their linen in-house because the cost of sending out the laundry was getting too expensive.		given to the QA committee and the Infection Control Committee. These two committees will report to the Governing Board quarterly		

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S0646	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(3)</p> <p>All entries in the medical record must be as follows:</p> <p>(3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure all operative reports/discharge summaries were authenticated and dated according to policy for 23 of 23 patients undergoing procedures at the facility (#P1- 11, P13- 20, and P22- 25).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Policy and Procedure for Identification of Authors and Authentication of Medical Record Entries", last reviewed 10/19/11, indicated, "...B. Every entry, including transcribed reports, is dated and authenticated by the author."</li> <li>The medical record for patient #P1, who underwent a procedure on 04/06/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</li> <li>The medical record for patient #P2,</li> </ol>	S0646	All medical personnel have been informed to place the date by their signatures on the op-note-discharge summary. The Quality Assurance and Improvement Committee will form a Quality Assurance to track this. The Director of Nursing will maintain this track monthly then report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to The Governing Board at quarterly meeting.	10/10/2012	

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	<p>who underwent a procedure on 04/04/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>4. The medical record for patient #P3, who underwent a procedure on 06/20/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>5. The medical record for patient #P4, who underwent a procedure on 04/13/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>6. The medical record for patient #P5, who underwent a procedure on 04/20/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>7. The medical record for patient #P6, who underwent a procedure on 05/03/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>8. The medical record for patient #P7, who underwent a procedure on 01/13/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p>				

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	<p>9. The medical record for patient #P8, who underwent a procedure on 01/11/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>10. The medical record for patient #P9, who underwent a procedure on 01/23/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>11. The medical record for patient #P10, who underwent a procedure on 01/12/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>12. The medical record for patient #P11, who underwent a procedure on 03/01/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>13. The medical record for patient #P13, who underwent a procedure on 02/03/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>14. The medical record for patient #P14, who underwent a procedure on 02/08/12, indicated an operative report/discharge</p>						

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	summary dictated/transcribed and signed by the physician, but not dated.  15. The medical record for patient #P15, who underwent a procedure on 02/09/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.  16. The medical record for patient #P16, who underwent a procedure on 02/17/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.  17. The medical record for patient #P17, who underwent a procedure on 02/15/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.  18. The medical record for patient #P18, who underwent a procedure on 03/30/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.  19. The medical record for patient #P19, who underwent a procedure on 04/12/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.  20. The medical record for patient #P20,				

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	<p>who underwent a procedure on 06/08/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>21. The medical record for patient #P22, who underwent a procedure on 05/18/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>22. The medical record for patient #P23, who underwent a procedure on 06/28/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>23. The medical record for patient #P24, who underwent a procedure on 04/24/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>24. The medical record for patient #P25, who underwent a procedure on 05/21/12, indicated an operative report/discharge summary dictated/transcribed and signed by the physician, but not dated.</p> <p>25. At 3:45 PM on 09/05/12, staff member #A2 confirmed the medical record findings.</p>						

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S0710	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p>						

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	<p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on documentation review and staff interview, it could not be determined that 7 of 7 physicians had approved delineation of privileges with the surgery center and 3 of 7 physicians had documentation of privileges to perform surgical procedures in a hospital within the county or joining county the surgery center lies in (#1, 3, 4, 5, 6, 7, and 8).</p>	S0710	All Medical Staff has been ask to fill out reappointment applications also to send a copy of DEA certificate. Sign list of surgeries they would like privileges for at South Central Surgery Center. A letter from an adjacent county hospital they have privileges with indicating that they have privileges at that hospital. These above items will be reviewed along with a copy of their medical license and their most recent malpractice insurance by the Credentialing Committee. The Credentialing Committee will sign and date once they have	10/17/2012	

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	<p>Findings included:</p> <ol style="list-style-type: none"> <li>1. The credential meeting minutes for 2010, 2011, and 2012 were reviewed. The minutes do not identify delineation of privileges for each physician that were approved by the committee.</li> <li>2. Staff member #1 credential file noted there was no signed delineation of privileges that the physician was granted to perform in the surgery center.</li> <li>3. Staff member #3 credential file noted there was no signed delineation of privileges that the physician was granted to perform in the surgery center. The physician's credential file did not evidence privileges to perform surgical procedures in a hospital within or joining county South Central Surgery Center lies in.</li> <li>4. Staff member #4 credential file noted there was no signed delineation of privileges that the</li> </ol>		<p>reviewed and approved for each person. The Credentialing Committee will then present this information to the Governing Board and they will review and approve each application. All information will be kept in each persons file. The Quality and Assurance Improvement Committee will form a Quality Assurance to track this. The Director of Nursing will maintain this on an annual basis. The Director of Nursing will report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to the Governing Board at quarterly meetings.</p>		

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	<p>physician was granted to perform in the surgery center. The physician's credential file did not evidence privileges to perform surgical procedures in a hospital within or joining county South Central Surgery Center lies in. The physician's hospital privileges were for Hancock Hospital (not a joining county); however, staff member #1 contacted Johnson County Hospital and had his/her delineation of privileges faxed to the facility. The hospital privileges were not available for the credential committee to assist in making a sound decision on approving membership to the surgery center medical staff.</p> <p>5. Staff member #5 credential file noted there was no signed delineation of privileges that the physician was granted to perform in the surgery center.</p> <p>6. Staff member #6 credential file noted there was no signed delineation of privileges that the</p>			

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	<p>physician was granted to perform in the surgery center.</p> <p>7. Staff member #7 credential file noted there was no signed delineation of privileges that the physician was granted to perform in the surgery center.</p> <p>8. Staff member #8 credential file noted there was no signed delineation of privileges that the physician was granted to perform in the surgery center. The physician's credential file did not evidence privileges to perform surgical procedures in a hospital within or joining county South Central Surgery Center lies in.</p> <p>9. At 9:45 AM on 9/6/2012, staff member #2 indicated he/she maintains the physician's credential files. The staff member confirmed the files are unorganized and he/she needs to improve on maintaining the files. The staff member confirm it would be hard to determine from the meeting minutes and files what</p>						

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	the delineation of privileges each physician has.				

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S0780	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure 2 of 2 patients who stayed at the facility for 23 hours had discharge orders written by the physician (#P16 and P25).</p> <p>Findings included:</p> <p>1. The facility policy "Medical Record Completeness", last reviewed 10/19/11, indicated, "Accurate and complete written medical records shall be maintained for all patients. A complete medical record consists of the following information. ...11. Signed discharge orders."</p> <p>2. The facility policy "Discharge", last reviewed 10/19/11, indicated, "Patients will be discharged once their condition</p>	S0780	All nursing staff and Medical staff have been instructed to include discharge orders for all patients including 23 hour stay. These must be dated and timed on the appropriate date. The Quality Assurance and Improvement Committee will develop a Quality Assurance for this to be tracked. The Director of Nursing will maintain this on a monthly basis. The Director of Nursing will report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to Governing Board at quarterly meeting.	10/01/2012			

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	<p>satisfies the discharge criteria. This will be determined by the surgeon &amp;/or anesthesiologist/CRNA, who will then write an order for discharge, sign and implement."</p> <p>3. The medical record for patient #P16, who underwent a procedure the morning of 02/17/12, indicated post-op medication orders written by the anesthesiologist on 02/17/12 at 1640. The patient remained overnight and went home the morning of 02/18/12, but the record lacked a written discharge order. The Anesthesia Evaluation form had the box checked "Approved for Discharge", but the post anesthesia evaluation was signed by the anesthesiologist and dated "0745 on 02/17/12" which was 10 minutes after the pre-anesthesia evaluation.</p> <p>4. The medical record for patient #P25, who underwent a procedure the morning of 05/21/12, indicated post-op medication orders written by the anesthesiologist on 05/21/12 at 1525. The patient remained overnight and went home the morning of 05/22/12, but the record lacked a written discharge order. The Anesthesia Evaluation form had the box checked "Approved for Discharge", and was signed, but was not an actual order.</p> <p>5. At 3:45 PM on 09/05/12, staff member</p>			

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	#A2 confirmed the medical record findings and indicated the box checked on the Anesthesia Evaluation form was not an actual order.				

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S0930	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)(5)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following:</p> <p>(5) A provision that all nursing personnel meet annual inservice requirements as established by center and federal and state requirements. Based on policy review, personnel file review, and interview, the facility failed to ensure all staff received annual inservicing according to policy for 7 of 7 files reviewed (#A2, A9, A10, A12, A13, A14, and A15).</p> <p>Findings included:</p> <p>1. The facility policy "Continuing Education Service Training", last reviewed 10/19/11, indicated, "...2. In-Service Training, The Director shall prepare an annual schedule of regular in-service training for Center employees. The program should be comprehensive and address all important aspects of the Center operation and patient care and shall annually include as a minimum: Subject: Continuing Education/In-Service Training a. Emergency Operations b. Cardio-pulmonary resuscitation techniques c. Use of emergency</p>	S0930	The Director of Nursing will begin placing minutes of the staff meetings in each employee file that attends when education training is done. The Quality Assurance and Improvement Committee will include this with the Quality Assurance for employee files. The Director of Nursing will maintain this on a monthly basis and report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to the Governing Board at quarterly meeting.	10/17/2012

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	<p>equipment d. Infection control and aseptic technique e. Quality assurance f. Universal precautions- disease transmission g. Hazardous Material B. A record of both in-service training and formal continuing education shall be maintained for all employees and kept in each employee's personnel file, using the forms on the succeeding pages."</p> <p>2. The employee files for staff members #A2, A9, A10, A12, A13, A14, and A15, all hired longer than one year ago, lacked documentation of annual in-servicing, including infection control, fire safety, and responding to emergencies.</p> <p>3. At 10:10 AM on 09/06/12, staff member #A2 indicated the annual topics were covered during the monthly staff meetings and fire drills, but confirmed there was no documentation of training in the employee files as specified by the policy. He/she also confirmed there was not documentation of actual training material covered and any learning verification such as post-tests.</p>				

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S1010	<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 regarding multi-dose vials for 1 of 1 open vials observed.</p> <p>Findings included:</p> <p>1. During the tour of the facility at 11:25 AM on 09/05/12, accompanied by staff member #A2, an open, but not dated, 10 milliliter multidose vial of Morphine Sulphate with a manufacturer's expiration date of 10/2012 was observed in the locked narcotic cabinet at the nurses' station.</p> <p>2. The facility policy "Medication Control and Accountability", last reviewed 10/19/11, indicated, "...4. Multiple use medications shall be discarded within thirty days after initial use."</p>	S1010	<p>All medication opened including multi-dose vials will be discarded after 30 days. All medication will have dates written on them the day they were opened. In-services will be held to review all these policies with all medical employees it will be documented in their files that they attended. The Quality Assurance and Improvement Committee will develop a Quality Assurance for to track this. The Director of Nursing will maintain this. The Director of Nursing will report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to the Governing Board at quarterly meetings.</p>	10/17/2012	

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	3. At 11:25 AM on 09/05/12, staff member #A2 indicated the manufacturer's expiration date was followed when using a multidose vial of medication.			

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S1146	<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, document review and staff interview, the facility failed to ensure drinking alcohol was not easily available to staff during hours of operation and failed to ensure a safe environment in the event of an anesthetic emergency by having a fully stocked malignant hyperthermia kit per standard of practice.</p> <p>Findings included:</p> <p>1. At 9:00 AM on 9/6/2012, the counter cabinet located above the sink in the employee break-room was observed with a half empty 1.5 liter of bacardi rum, completely</p>	S1146	All alcohol in the building is now locked in a cabinet in the employee break room. The key is kept by the medical Director. A policy on drinking alcohol during working hours is being written by the Safety Committee. It will be placed in the Policy and Procedure Book and be taken to the Governing Board for approval at the quarterly meeting by the Director of Nursing. The medical Director is working with the CEO of Johnson Memorial Hospital to write an agreement for medication we should require any additional doses in case of emergency. The expired supplies have been removed from the crash cart and new ones will be placed. The Quality Assurance and Improvement Committee will develop a Quality Assurance to track the drinking policy, the agreement with the hospital. The expired supplies will be included	10/19/2012
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	<p>empty 1.5 liter of burgundy red wine and a half empty 750 liter of burgundy wine.</p> <p>2. At 10:30 AM on 9/6/2012, staff member #2 indicated he/she did not know there was alcohol stored in the break room's kitchen cabinet unsecured. The staff member indicated the facility does not have a policy on drinking alcohol in the work place. The staff member indicated he/she asked around and no one said they knew the alcohol was in the employee's break room. One employee told staff member #2 the alcohol could be from the facility's opening party in 2002.</p> <p>3. The facility policy "Malignant Hypothermia" (should be hyperthermia), last reviewed 10/19/11, indicated, "Standard protocol for patients with suspected malignant hypothermia is as follows: 1. Arrangements will be made for an ambulance to transfer the patient to the hospital. 2. A physician as well as a nurse will accompany the patient during the transfer to the hospital. Initial treatment upon waiting for the ambulances arrival includes: 1.</p>		with the Quality Improvement for expired supplies. The Director of Nursing will maintain this on a monthly basis and report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to the Governing Board at quarterly meeting.		

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	<p>Discontinuation of all anesthetic gases. 2. Begin appropriate drug therapy such and Dantrium, cold IV packs, etc."</p> <p>4. During the tour of the facility at 12:05 PM on 09/05/12, accompanied by staff member #A2, the malignant hyperthermia supplies were observed in the crash cart. The standard of practice is to keep 36 vials of Dantrium on hand in case of an emergency, but the cart contained only 18 vials of Dantrium. The lab tubes and a latex catheter in the box had expired in 2008 and 2004.</p> <p>5. Review of the Drug Formulary list for the facility indicated 36 vials of Dantrium Sodium were on hand at the facility.</p> <p>6. At 12:05 PM on 09/05/12, staff member #A2 indicated the facility had an agreement with the hospital that they each would supply the other 18 vials to the facility in need. When the document was requested, staff member #A2 supplied a single typed page, titled "South Central Surgery Center, LLC Dantrium Exchange with Hospital", which stated, "South Central Surgery Center will keep Three (3) dantrium on the code cart. If would need to use them the Johnson Memorial Hospital will provide us with additional Dantrium until patient can be stabilized and transferred to their facility. We will</p>			

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	<p>also provide Johnson Memorial Hospital with Dantrium if they should need it." The page was signed by the medical director of the facility, staff member #A1, with a handwritten date of "1-10-12". The page lacked any signatures of the hospital's staff agreeing to the arrangement. Staff member #A2 confirmed there was no way to determine whether or not the hospital agreed to this arrangement or any way to know how much of the medication was on hand at the hospital. He/she also confirmed an emergency situation could occur at both facilities at the same time.</p>			

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S1166	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on document review and staff interview, the facility failed to assure preventive maintenance was conducted on the Front Loading Washer/Dryer and the lead aprons used for the C-arm.</p> <p>Findings included:</p> <p>1. At 1:45 PM on 9/5/2012, staff member #2 was asked to provide documentation the front loading washer and the dryer had periodic maintenance inspections. Staff</p>	S1166	<p>A Policy for the Inspection and Upkeep for the Front Load Washer/ Dryer will be written by the Safety Committee. It will be presented to the Governing Board for approval at the quarterly meeting. The Quality Assurance and Improvement Committee will develop a Quality Assurance form to track this. The Director of Nursing will maintain this annually and report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to the Governing Board at quarterly meetings</p>	10/22/2012			

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	<p>member #2 indicated the front-loading washer and dryer has never had a preventive maintenance inspection. The washer and dryer has been in the facility for about 8 years.</p> <p>2. The Kenmore Elite Front-loading Automatic Washer operator's manual specifies periodical inspections of the washer should be done on the inlet hoses for bulges, kinks, cuts, wear and/or leaks. The exterior and the interior of the washer needs to be cleaned with a damped wash cloth. The door seal needs to be cleaned with a damp cloth and check if there are any foreign objects wedged in the door seal. All the dispenser drawers need to be removed and be cleaned with a damp cloth. Every 5 years, the inlet hoses need to be replaced.</p> <p>3. At 10:45 AM on 9/6/2012, staff member #2 was asked to provide Occupational Radiation Exposure Reports for 2011 and 2012. The</p>			

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	<p>reports identified the badges being inspected for radiation exposure; however, the leaded vests were not on the reports.</p> <p>4. At 10:50 AM on 9/6/2012, staff member #2 indicated he/she did not realize the lead vests can go bad and they need also to be inspected. The staff member indicated Photon Measurement Plus who conducts annual preventive maintenance on the facility's C-arm explained to the staff member the lead vests have to be inspected routinely for radiation exposure. The staff member confirmed the lead vests have never been inspected for radiation exposure.</p>				

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S1174	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(A)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being 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:</p> <p>(A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice.</p> <p>Based on policy review, employee file review, document review, and interview, the infection control committee failed to ensure environmental services were provided to ensure the safety and well-being of the patients treated in the facility.</p> <p>Findings included:</p> <p>1. The facility policy "Housekeeping</p>	S1174	The Safety Committee and the Infection Control Committee will write a policy on in house housekeeping policy. This will be placed in the Policy and Procedure Book and be presented to the Governing Board for approval at the quarterly meeting. All staff that clean the facility will attend an inservice on properway to clean each area. This will be documented and placed in each of their employee	10/22/2012			

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	<p>Methods", last reviewed 10/19/11, indicated, "A professional janitorial service experienced in cleaning surgical suites will clean the surgical center."</p> <p>2. The facility policy "Housekeeping Cleaning Schedule", last reviewed 10/19/11, indicated, "The following duties for janitorial service are to be performed on surgery days unless otherwise noted. All cleaning will be done with a disinfectant. ...Schedule Nightly ...C. Surgery Area and Sub sterile 1. Empty trash and replace liners. 2. Clean and polish sinks. Mop floor."</p> <p>3. Review of the employee files for staff members #A2, A9, A10, A12, A13, A14, and A15 lacked any documentation of infection control or environmental cleaning training.</p> <p>4. At 11:00 AM on 09/06/12, a single page document, titled "Housekeeping Instructions", was provided by staff member #A2. The form indicated, "All personnel must use universal precautions when cleaning the facility. All bathrooms must be cleaned daily. Sinks wiped down with disinfectant wipe. Commodes cleaned with cleanser. Floors swept and mopped. Mirrors cleaned. All floors must be swept daily. All floors must be mopped daily, using a disinfectant</p>		<p>files. The Quality Assurance and Improvement Committee will develop a Quality Assurance form to track this. The Director of Nursing will maintain this on an annual basis. The Director of Nursing will report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to Governing Board at quarterly meetings.</p>				

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	<p>solution. 1 squirt Vesephene in 1 All counters should be wiped with a disinfectant wipe daily. Cavi wipe Trash removed daily. Windows cleaned weekly with Windex. Refrigerators cleaned out weekly, all foods must be checked for dates and remove expired or any that have been in there for 1 week." The page include a hand written date of "1-12-12" and was signed by staff members #A9, A12, an office staff member, and an illegible signature.</p> <p>5. At 11:00 AM on 09/06/12, staff member #A2 indicated the facility has not had a janitorial service for "quite a while" and the facility staff cleans the center. He/she indicated staff member #A12 was primarily responsible for the operating rooms, but no documentation of any specific cleaning instructions or procedures could be provided. He/she acknowledged the discrepancies between the policies and what was actually occurring and confirmed the lack of specific, detailed cleaning instructions and infection control training for staff to ensure a safe, sanitary environment was maintained.</p>						

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S1180	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on documentation review and staff interview, the facility failed to ensure there was a Safety Management Program that defined the safety committee which included the chief executive officer.</p> <p>Findings included:</p> <p>1. On 9/5/2012, the Administrative Policy and Procedure manual, last reviewed 10/19/2011, was reviewed and the Safety Management Plan could not be identified. However, the facility was having quarterly safety committee meetings in 2011. In 2012, the Safety Committee only met on 2/21/2012. All the Safety</p>	S1180	<p>The General Staff will appoint a Safety Committee. The Safety Committee will have the CEO included on this committee. The Safety Committee will develop a policy along the guide lines of Indiana State Licensure rules. This policy will be placed in the Policy and Procedure Book and presented to the Governing Board for approval at quarterly meeting. The Quality Assurance and Improvement Committee will include this Quality Assurance with the one that tracks the Policies been approved by the Governing Board. The Director of Nursing will report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to Governing Board at quarterly meeting.</p>	10/15/2012	

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	<p>Committee Meeting minutes that were reviewed revealed the Chief Executive Officer did not attend any of the meetings. The meetings consisted of the Director of Nursing, LPN, and CST.</p> <p>2. At 3:10 PM on 9/5/2012, staff member #2 confirmed the facility actually does not have a Safety Management Plan as defined in the Indiana State licensure rules. The staff member indicated the facility does not have in writing who was to be on the Safety Committee; however, the facility conducts them quarterly. The staff member confirmed the facility did not have a safety committee meeting for the second quarter of 2012. The staff member indicated the CEO has attended the meetings but was not regular attendee of the Safety Committee. The staff member indicated the committee meetings are very informal. The meetings could be discussed while cleaning a room or over a cup of coffee and staff member #2 would write the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<input checked="" type="checkbox"/> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001114	<input checked="" type="checkbox"/> (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	<input checked="" type="checkbox"/> (X3) DATE SURVEY COMPLETED  09/06/2012
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	minutes of the informal meeting.			

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S1182	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based on documentation review and staff interview, the facility failed to ensure there was a Safety Management Program that evaluated and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Findings included:</p> <p>1. On 9/5/2012, the Administrative Policy and Procedure manual, last reviewed 10/19/2011, was reviewed and the Safety Management Plan could not be identified. However, the facility was having quarterly safety committee meetings in 2011. In 2012, the Safety Committee only met on 2/21/2012. The minutes did</p>	S1182	<p>The Safety Committee will develop a check list for the CEO and the Director of Nursing to use to check for hazards in the facility this will be done on a weekly basis. The CEO and Director of Nursing if any hazard is found they will report to the Safety Committee and a plan of correction will be made and implemented. The Quality Assurance and Improvement Committee will develop a Quality Assurance form to track this. The Director of Nursing will maintain this on a monthly basis and report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to Governing Board at quarterly meetings.</p>	10/22/2012	

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	<p>not have a format or documentation provided to the meeting to make sound judgements on safety of the facility. The 2/21/12 safety committee meeting minutes discussed a fire drill that was held on 2/13/12. The committee also discussed the generator is running routinely each week and JC ran their preventive maintenance. The committee had no documentation of safety rounds or any other documentation to evaluate in the meeting. The four meetings held in 2011 discussed the same items that the 2/13/12 meeting discussed.</p> <p>2. At 3:10 PM on 9/5/2012, staff member #2 confirmed the facility actually does not have a Safety Management Plan as defined in the Indiana State licensure rules. The staff member indicated the facility does not have in writing who was to be on the Safety Committee; however, the facility conducts them quarterly. The staff member indicated safety rounds are conducted but are not written</p>						

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	down. The staff member confirmed the safety committee discusses the same items in each meeting. The staff member confirmed the safety committee does not do a good job in evaluating hazards in the facility.			

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S1184	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 2.5-7(c)(3)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(3) The safety program includes, but is not limited to, the following:</p> <p>(A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety.</p> <p>Based on documentation review and staff interview, the facility failed to ensure there was a Safety Management Program that evaluated and collect information about patient safety, health care worker safety and public and visitor safety.</p> <p>Findings included:</p> <p>1. On 9/5/2012, the Administrative Policy and Procedure manual, last reviewed 10/19/2011, was reviewed and the Safety Management Plan could not be identified. However, the facility was having quarterly safety committee meetings in 2011. In</p>	S1184	The Safety Committee will revise its format for meetings to include findings of safety rounds of the facility that were made by the CEO and the Director of Nursing. This will be include Patient Safety, Health Care worker safety, and Public and Visitor Safety. The Quality Assurance and Improvement Committee will develop a form to track this. The Director of Nursing will maintain this on a monthly basis and report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to the Governing Board at quarterly meeting.	10/22/2012	

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	<p>2012, the Safety Committee only met on 2/21/2012. The minutes lacked a format or documentation provided to the meeting to make sound judgements on safety of the facility. The 2/21/12 safety committee meeting minutes discussed a fire drill that was held on 2/13/12. The committee also discussed the generator is running routinely each week and JC ran their preventive maintenance. The committee had no documentation of safety rounds or any other documentation to evaluate in the meeting. The four meetings held in 2011 discussed the same items that the 2/13/12 meeting discussed.</p> <p>2. At 3:10 PM on 9/5/2012, staff member #2 confirmed the facility actually does not have a Safety Management Plan as defined in the Indiana State licensure rules. The staff member indicated the facility does not have in writing who was to be on the Safety Committee; however, the facility conducts them quarterly. The staff member</p>				

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	indicated safety rounds are conducted but are not written down. The staff member confirmed the safety committee discusses the same items in each meeting. The staff member confirmed the safety committee does not do a good job in evaluating safety concerns that could affect the patients, visitors, and staff.			

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S1198	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on documentation review, and staff interview, the facility failed to ensure the facility's Emergency and Disaster Plan coordinated with appropriate community, state, and federal agencies.</p> <p>Findings included:</p> <p>1. South Central Surgery Center Disaster Plan policy, last approved October 19th 2011, was reviewed. The entire Disaster Plan states, "In case of a disaster in the community or surrounding counties such as; airplane crash, flooding, tornado, Flu Pandemic, South Surgery Center will care for over flow of non-critical patients. We will</p>	S1198	<p>The Director of Nursing has been attending Disaster Preparedness classes the last one September 20, 2012 at Lighthouse Plainfield IN. the Director of Nursing also participates in District 5 meetings and has an 800mgHz radio and participates in monthly radio checks. The Director of Nursing is working with other Committee members on developing a policy for Disaster Preparedness. This Policy will be presented to the Governing Board for approval and placed in the Policy and Procedure Book. The staff will participate in Disaster Preparedness drills annually. The Quality Assurance and Improvement Committee will develop a Quality Assurance form to track this. The Director of Nursing will maintain this annually and report findings to the Quality Assurance and Improvement Committee. The Quality Assurance and Improvement Committee will report findings to the Governing Board.</p>	10/24/2012
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	<p>require to receive some needed medications from the hospital. We will supply IV fluids and IV supplies, oxygen, bandages and wound care any minor surgeries. As of this time this is the plan Johnson County emergency preparedness and disaster planning commission has for us."</p> <p>2. At 2:45 PM on 9/5/2012, staff member #2 indicated he/she has been working with his/her district on trying to write an effective Emergency Disaster Plan. The staff member indicated the county does not want to work with the surgery center. The staff member confirmed the Emergency Disaster Plan the surgery center was not effective and does not coordinate with appropriate community, state, and federal agencies.</p>				

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S1210	<p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1)</p> <p>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:</p> <p>(1) Radiology services must be supervised by a radiologist or radiation oncologist.</p> <p>Based on documentation review and staff interview, the facility failed to ensure that the facility's radiology services are supervised or monitored by a radiologist or radiation oncologist.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>South Central Surgery Center Radiology Equipment policy, last reviewed October 19th 2011, indicates a radiologist will read information he/she receives from the surgery center.</li> <li>The 2012 Quarterly QA Report for Radiology Service listed under the criteria column, Radiologists</li> </ol>	S1210	The Medical Director is working with the CEO of Johnson Memorial Hospital to contract a radiologist for the surgery center. The Quality Assurance and Improvement Committee will add this to the Quality Assurance to track contracts. The Director of Nursing will maintain this on an annual basis and report findings to the Quality Assurance and Improvement Committee. The Quality and Assurance Committee will report findings to the Governing Board at quarterly meeting.	10/19/2012	

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	<p>oversees image reports.</p> <p>3. At 11:00 AM on 9/6/2012, staff member #2 indicated the facility has a small C-arm (image intensifier) to take pictures of small areas like feet, hands, etc. The large C-arm does not work anymore, so the facility discontinued that service. The staff member indicated the facility used to have a radiologist that would review their policies and procedures; however, the facility does not have a radiologist anymore to consult with.</p>				