

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2014
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NAME OF PROVIDER OR SUPPLIER  AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 011735</p> <p>Survey Date: 4-28/30-14</p> <p>Surveyors: Trisha Goodwin, RN BSE Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: 05/14/14</p>	S000000	Reviewed	
S000010	<p>410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a)</p> <p>Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules.</p> <p>Based on document review and staff interview, the facility failed to comply with all applicable state laws for 4 (#N2, N5, N6 and N7) of 5 unlicensed staff</p>	S000010	S-0010 The first three business days of employment will consist of orientation. This includes all policy & procedures, regulation and rules. Employee will be expected to review materials; and	07/07/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S000058	<p>members providing direct patient care.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of IC 16-28-13-4, a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</li> <li>Unlicensed, direct patient care staff members #N2, N5, N6 and N7 personnel files lacked evidence of a state nurse aide registry report and a limited criminal history report.</li> <li>Staff member #A1 verified the above at 3:30 p.m. on 4/30/14.</li> </ol> <p>410 IAC 15-2.3-2 POSTING OF LICENSE 410 IAC 15-2.3-2 (b)</p> <p>(b) A copy must be conspicuously posted in an area open to patients and</p>		signature will be obtained. PP manual being updated. Limited criminal checks were done by an outside agency. In the future all limited criminal checks will be done through the Indiana State Police Limited Criminal History online at IN.gov. Practice Admin will be responsible				

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	<p>the public on the premises of each separate building of a multiple building system.</p> <p>Based on observation, the surgery center failed to conspicuously post a copy of their current Indiana State license in an area open to patients and the public in one instance.</p> <p>Findings:</p> <p>1. During tour of the facility on 4/30/14 at 10:00am CST in the presence of employee #A2, it was observed that the facility license was posted in a hall, behind a locked door, away from the public area and that the license expired 12/2012.</p>	S000058	S-0058 License will be posted when received. Practice Admin will confirm facility license is current and displayed to meet state regulations. Posted May 09,2014	05/09/2014	
S000106	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Review the bylaws at least triennially.</p> <p>Based on document review and interview, the surgery center failed to show evidence of adopting and reviewing</p>	S000106	S-0106 Practice Admin will clearly title GB bylaws. Practice Admin is compiling a new PP manual for easier access of GB. Follow up	07/14/2014	

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	<p>governing body bylaws triennially.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of governing board meeting minutes indicated no review or adoption of bylaws by the governing body between 2011 and present date 2014.</li> <li>2. Review of the facility administrative policy and procedure (P&amp;P) manual indicated no P&amp;P or other documents for governing board bylaws.</li> <li>3. In interview on 4/30/14 at 1:30pm CST, employee #A1 indicated: <ol style="list-style-type: none"> <li>a. The facility never had separate governing board and medical staff bylaws since the one physician is the owner, CEO, and medical director.</li> <li>b. #A1 further indicated that the facility medical staff bylaws also covered the governing board.</li> <li>c. #A1 indicated minutes titled Mandatory Monthly Meetings include all staff and are therefore considered to also be the medical staff meetings.</li> </ol> </li> <li>4. Review of documents titled Mandatory Monthly Meetings from date range 2011 to 2014 indicated no adoption of medical staff bylaws.</li> <li>5. Review of the P&amp;P titled</li> </ol>		<p>will be triennial. GB will adopt and review bylaws in meeting. Documentation will be recorded to reflect the GB actions. Review will be done on an annual basis. Separate Medical Staff &amp; GB Meetings will be conducted according to policy. Practice Admin will be responsible.</p>				

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S000110	<p>AMBULATORY SURGERY CENTER FOR PAIN RELIEF, I. ORGANIZATIONAL FUNCTIONS, 6. Medical Staff , B. Objectives/Bylaws, approved date 12-1-08, last reviewed by MS member date 12-01-09 indicated the bylaws originate with the Medical Staff (MS) and provide for the organization of the MS.</p> <p>6. In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the governing board failed to review quality activities for 8</p>	S000110	S-0110 The GB will review quality activites, 8 directly provided services and 10 contracted services quarterly, when	07/01/2014

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	<p>directly-provided services/activities and 10 contracted services in calendar year 2013.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of documents entitled Governing Board Meeting indicated two meetings were held in calendar year 2013. One dated as Jan. 2013 and one 3-13-2013.</li> <li>2. Review of governing board minutes for calendar year 2013 indicated there were no reports of quality activities reviewed by the governing board for the directly-provided services of laundry, nursing, radiology, discharge, infection control, medication errors, response to patient emergencies and reportable events.</li> <li>3. Review of the governing board minutes for calendar year 2013 indicated there were no reports of quality activities reviewed by the governing board for the contracted services of biomedical engineering, biohazardous waste, housekeeping, maintenance, medical records, pharmacy, radiology, security, patient transfer, infection control.</li> <li>4. In interview on 4/30/14 at 1:30pm CST, employee #A1 confirmed the above</li> </ol>		<p>applicable. All documentation is located in P.A. office. Practice Admin will be responsible.</p>	

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S000122	<p>and no further documentation was provided prior to exit.</p> <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 document review and interview, the facility governing body failed to ensure that the medical staff (MS) had approved bylaws and rules triennially.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the document titled STATEMENT OF APPROVAL, AMUBLATORY SURGERY CENTER FOR PAIN RELIEF, POLICY AND PROCEDURE MANUAL, SECTION I, ORGANIZATIONAL FUNTIONS, indicated the most recent review date by the medical</li> </ol>	S000122	S-0122 The Medical Director reviewed on 10/13/10, 10/2100, 07/03/12,08/26/13. Dates were shown directly below 12/01/09. Adoption was shown by this method. Minutes will reflect this in future. Mandatory Monthly Meeting will be held separately and recorded. Medical Staff bylaws will be reviewed and adopted in those meetings. Medical Director and Practice Admin responsible	06/18/2014

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	<p>staff (MS), indicated by the initials of the Medical Director (MD#1), to be 12-01-09.</p> <p>2. Review of documents titled MANDATORY MONTLY MEETING, date range 2011 to present 2014 indicated no MS review of MS bylaws.</p> <p>3. In interview on 4/28/14 at 12:00pm CST, employee #A1 indicated the documents titled Mandatory Monthly Meeting served as the administrator staff meetings and MS meetings. A copy of all meeting minutes for 2011 to present 2014 was requested.</p> <p>4. In interview on 4/30/14 at 1:30 CST, employee #A1 indicated the document from the administrative policy and procedure (P&amp;P) manual titled AMBULATORY SURGERY CENTER FOR PAIN RELIEF, I. ORGANIZATIONAL FUNCTIONS, 6. Medical Staff, B. Objectives/Bylaws to show MS adoption by signature/initials and date on the front page of the section.</p>			

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S000153	<p>5. In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was received prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review and staff interview, the facility failed to document evidence of facility and job specific orientation for 1 (staff member #N1) of 1 Registered Nurse employed.</p> <p>Findings include:</p> <p>1. Staff member #N1 (hired 5/13)</p>	S000153	S-0153 Orientation packet checklist will be complied. Employees will be checked off when objectives have been met. This will be completed within 3 business days of hire. Updated PP manual will show new employee criteria Practice Admin is responsible.	07/07/2014

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S000156	<p>personnel file lacked evidence of orientation to the facility and job specific duties.</p> <p>2. Staff member #A1 verified the above at 3:30 p.m. on 4/30/14.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to conduct annual performance evaluations for 4 (#N3, N4, N5 and N7) of 7 employees.</p> <p>Findings include;</p> <p>1. Facility policy titled "Education and Training A. General Policies" last</p>	S000156	S-0156 Annual Performance Evaluation were completed. Attachment included. Evaluations will be done each year in September. Evaluations will bescheduled the end of each August and calendared for each year thereafter as such. Practice Admin performs yearly evaluations	05/30/2014

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S000230	<p>reviewed/revised 8/26/13 states "6. Yearly evaluations will be done to determine that individuals who provide patient care services, are, and continue to be competent to do so."</p> <p>2. Review of staff members #N3, N4, N5 and N7 personnel files indicated that they provide patient care services and the last performance evaluation was conducted 12/11.</p> <p>3. Staff member #A1 verified the above at 3:30 p.m. on 4/30/14.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility. Based on document review and</p>	S000230	S-0230 Three physicians with no financial interest in the ASC are	06/02/2014

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S000310	<p>interview, the facility failed to provide for a periodic review of the center and its operation by a utilization review (UR) committee composed of three (3) or more duly licensed physicians having no financial interest (ownership) in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the document titled Utilization Board Members 2012, 2013, 2014 indicated four physicians, the practice administrator and an LPN as members. One of the four (1/4) physicians listed is the owner/CEO/Medical staff director (MD#1).</li> <li>2. Review of the UR board meeting dated October 29th, 2013 indicated MD#1 called the meeting to order and made motion to approve old business.</li> <li>3. Review of the document titled Utilization Board Agenda; dated April 8th, 2014 included MD#1 as a member on the list.</li> <li>3. In interview on 4-30-14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.4-2</p>		<p>on the board. Three physicians were listed in the meetings. The CEO/Medical staff director does attend. CEO/Medical Staff will no longer be listed as a active member. Practice Admin and LPN are present to assist physicians. Agendas are faxed to board respective offices, phone call is madeto Office Manager to confirm receiving and confirmation of the dateand time. If physician is unable to travel that day a phone conference is set upfor him. Practice Admin arranges meetings.</p>				

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	<p><b>QUALITY ASSESSMENT AND IMPROVEMENT</b> 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to ensure an ongoing quality assessment and performance improvement program (QAPI) for 8 of 9 directly provided services and 10 of 10 contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the facility's QAPI program, 2013 Mandatory Monthly Meeting minutes and 2013 QAPI notes indicated the QAPI program included monitors, but did not include measurable standards for the directly provided services of laundry, medical records, nursing, radiology, infection control, medication errors, response to patient emergencies, and reportable events.</li> <li>Review of the document titled AMBULATORY SURGERY</li> </ol>	S000310	S-0310 Measureable standards will be incorporated into our QAPI program. State guideline will be used for comparisons to set goals and standards. Initial meeting will began June 20. Practice Admin	08/04/2014

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	<p>CENTER FOR PAIN RELIEF, V.PERFORMANCE IMPROVEMENT, 2.Quality management and Improvement, F. The QMI Program indicated in section I. A, under the second #2 that; In order to accomplish the above monitoring and evaluation process involves...Using measurable indicators to systematically monitor those aspects of care in an ongoing way.</p> <p>3. Review of the facility's QAPI program, 2013 Mandatory Monthly Meeting minutes and 2013 QAPI notes indicated the QAPI program failed to evaluate by monitor or standard the contracted services of bio-medical engineering, biohazardous waste, housekeeping, maintenance, medical records, pharmacy, radiology, security, hospital transfer, and infection control</p> <p>4. In interview, on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p>			

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S000320	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the facility failed to include the functions of medication errors and response to patient emergencies in quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include the activities of medication errors and response to patient emergencies</p> <p>2. In interview, on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above. No further documentation was provided prior to exit</p>	S000320	S-0320 QAPI Monitors will include reports on medications and patient emergency to Governing Board quarter, if applicable. QAPI standards from ISDH will be utilized as point of reference. R.N. will mointor. R.N., Surgery Center Nurse is responsible	06/30/2014

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S000414	<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>Based on document review and interview, the facility failed to ensure the infection control committee met on a quarterly basis and failed to ensure membership included a representative from the medical staff.</p> <p>Findings include:</p> <p>1. Facility policy titled "Infection Control A. Principles" last</p>	S000414	A-0414 Infection Control Committee met on 3/11/13 and 8/26/13 with medical staff present. Medical Staff member name was omitted from typed record. Amendment to be made to minutes. Medial staff member will be present in future quarterly meetings. LPN, Infection Control Coordinator	06/30/2014

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S000428	<p>reviewed/revised 8/26/13 stated on page 158: "Infection control committee will meet quarterly....."</p> <p>2. Review of infection control documents for previous 12 months indicated the facility had one (1) infection control meeting which was held on 8/26/13.</p> <p>3. The infection control meeting held on 8/26/13 lacked membership that included a representative from the medical staff.</p> <p>4. Staff member #N4 verified in interview at 12:55 p.m. on 4/30/14 that there was only one (1) infection control meeting held and that it lacked a representative from the medical staff.</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, interview and</p>	S000428	S*0428 Sanitation. Surfaces are	06/03/2014

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	<p>document review , the facility failed to follow manufacturer instructions when disinfecting surfaces in 2 instances and failed to follow manufacturer instructions for cleaning the glucometer.</p> <p>Findings include;</p> <ol style="list-style-type: none"> <li>Staff member #P1 was observed cleaning the operating room after a procedure beginning at 11:30 a.m. on 4/29/14. He/she sprayed Cavicide on the surfaces, failed to cover all surfaces of the table and pillows, and wiped the solution off with a dry towel in less than 1 minute.</li> <li>Staff member #N2 was observed cleaning patient care equipment in the recovery room beginning at 11:50 a.m. on 4/29/14. He/she sprayed Cavicide on the surfaces and immediately wiped it off with a dry cloth.</li> <li>Staff member #N4 indicated in interview at 2:30 p.m. on 4/30/14 that the glucometer is cleaned between patients with soap and water.</li> <li>Label instructions for Cavicide states under "FOR USE AS A DISINFECTANT ON NON-INSTRUMENT SURFACES: Spray CaviCide directly onto precleaned</li> </ol>		<p>now cleaned with CaviWipes 1 minute, 1 step germicidal wipes., dry time 1 minute. Glucometer is cleaned per manufacturer instructions. Isopropyl alcohol is used on glucometer. Glucometer is cleaned between each patient Instructions placed on container of glucometer. LPN, Infection Control Coordinator responsible. R.N. instructed all staff June 3,2014 to follow manufactures instruction on all sanitation products. All staff gave verbal understanding of instructions.</p>	

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S000442	<p>surface, thoroughly wetting area to be disinfected. Allow surface to remain visibly wet for 3 minutes at room temperature.....for Tuberculocidal**activity and effectiveness against Staphylococcus aureus, Pseudomonas....."</p> <p>5. Manufacturer instructions for the glucometer indicated it should be cleaned with isopropyl alcohol.</p> <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 document review and staff interview, the facility failed to ensure staff members had a current PPD or</p>	S000442	S-0442 N5 did have a questionnaire. X-ray is obtained every 2 years for compliance. N7 TB Chart indicates employee had	05/05/2014

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S000494	<p>completed a TB risk questionnaire for 2 (#N5 and N7) of 7 staff members and failed to ensure documentation of disease history or immunization to Varicella for 2 (#N2 and N6) of 7 staff members and Hepatitis B for 2 (#N5 and N7) of 7 staff members.</p> <p>Findings include;</p> <ol style="list-style-type: none"> <li>1. Staff member #N5 personnel file indicated the last PPD and/or questionnaire was conducted 9/12.</li> <li>2. Staff member #N7 (hired 1/09) personnel file lacked evidence of a PPD or TB risk questionnaire.</li> <li>3. Staff members #N2 and N6 personnel files lacked evidence of disease history or immunization to Varicella.</li> <li>4. Staff members #N5 and N7 personnel files lacked evidence of immunization/immunity to Hepatitis B.</li> <li>5. Staff member #A1 verified the above at 3:30 p.m. on 4/30/14.</li> </ol> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(2)(i)(2)(B)</p>		<p>chicken pox N2 TB was given on 4/25/13 as documented. N7 Hep B was given and documented in chart in year 2000 N5 Hep B copy documented as given 08/09 N6 TB chart indicates employee had chicken pox. Observer unfamiliar with color coded charts. Medical records are separate from other employee information. Presented to surveyor and explanation was given. Employees health history are documented in an ongoing manner. Forms are kept on file in Practice Admin office. Attached. LPN, Infection Coordinator is responsible.</p>	

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	<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 document review, observation and interview, the facility failed to assure proper laundering of linens according to facility policy and procedure (P&amp;P).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of facility P&amp;P titled AMBULATORY SURGERY CENTER FOR PAIN RELIEF, III. HUMAN RESOURCES, 7. Ancillary Personnel, B. Laundry, indicated in section V. OSHA RECOMMENDATIONS, 5. Laundry facilities use water temperature of at least 160 degrees Fahrenheit and 50 to 150 ppm of chlorine bleach ...</li> <li>On 4/30/14 at 10:10am CST, during tour of the laundry area in the presence of employee #A2, a</li> </ol>	S000494	<p>S-0494 To comply with the CDC temperature, gauges will be placed on the hot water line for the washer to maintain 160 F. Heating element unit work will be contract to outside source. Installed by August 1,2014. PR/Practice Rep responsible Log to be made on washer temperature and detergent concentration per manufacturers instructions. Log to be monitored by staff and R.N. Initials and date will be entered into log per load. R.N., Surgery Center Nurse is responsible</p>	08/01/2014

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S000710	<p>standard front load washer and dryer without temperature gauges were noted.</p> <p>3. In interview on 4/30/14 at 10:10am CST, employee #A2 indicated the facility does not keep a log book of water temperatures or bleach concentration for laundering linens.</p> <p>4. On 4/30/14 at 10:15am CST, in the presence of employee #A2, the temperature gauge of the facility hot water heater was observed to be at 142 degrees Fahrenheit.</p> <p>5. In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible</p>			

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	<p>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> <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</p>			

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	<p>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 document review and interview, the medical staff failed to maintain documentation of surgery center privileges and a current health statment for 1 allied health staff member who performed anesthesia services.</p> <p>Findings:</p> <p>1. Review of 1 allied health staff credential files indicated no documentation of the ambulatory surgery center privileges and no current health statement for credentialed staff member AH#1.</p> <p>2. In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	S000710	<p>S-0710 Medical staff chart has numerical index for reference Medical staff chart was presented to surveyor that included; IN Controlled Substance Registration DEA registration Documentation of experience in practice of medicine. Documentation of specialty board certification as applicable Documentation of privileges to surgical procedures performed Category of medical staff appt and delineation of privileges approved. Signed statement to abide by rules Current health status established by fed and state requirement Other items specified by center and medical staff Practice Admin responsible.</p>	05/09/2014

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S000732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based on document review and interview, the medical staff failed to triennially review the medical staff rules or the medical staff bylaws.</p> <p>Findings:</p> <p>1. Review of facility documents indicated there was no medical staff review of medical staff rules within the last 3 years.</p> <p>2. Review of facility documents indicated there was no medical staff review of medical staff bylaws within the last 3 years</p> <p>2. In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	S000732	S-0732 Medical staff reviewed the bylaws in regards to dates below 10/13/10,10/2011,/07/03/12,0and 08/26/13. Adoption of bylaws will be documented in future Medical Staff meetings. Front of each page in our PP indicates it was reveived and dated appropriately. No minutes were recorded for these entries. Approval will be reveived and adopted by GB by end of July 2014. Triennially thereafter. Attachment Practice Admin is responsible	07/30/2014			
S000736	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL</p>						

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410	<p>IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based on document review and interview, the medical staff failed to have a medical staff (MS) meeting each quarter (4 meetings) in calendar year 2013.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the document entitled AMBULATORY SURGERY CENTER FOR PAIN RELIEF, I. ORGANIZATIONAL FUNCTIONS, 6. Medical Staff, F. Medical Staff Executive Committee indicated The Medical Staff Executive Committee consists of: 1. Medical Director of the Center 2. One Peer Review Physician 3. Nursing Administrator 4. Administrator</li> <li>2. Review of Mandatory Monthly Meeting minutes for 2013</li> </ol>	S000736	S-0736 ASC meetings will be conducted singularly. Physician, Nurse Admin, and Administrator will comprise the Medical Staff Executive Committee. This will be indicated in PP updated manual by Practice Admin Q734-majority of members on the active medical staff is one; therefore the majority can not apply. Future minutes and meetings will reflect the issues for center only and ASC staffing will be shown separately Medical Staff will be present at future meetings. Practice Admin will be responsible.	06/30/2014

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S000790	<p>indicated meetings were held on 3/11/13, 6/20/13, and 10/15/13. Only the 10/15/13 minutes indicated a MS (MD#1) member to have been present.</p> <p>3. In interview on 4/28/14 at 12:00pm CST, employee #A1 indicated the documents entitled Mandatory Monthly Meeting serve as the administrator staff meetings as well as MS meetings.</p> <p>4. In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was received prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)</p> <p>(c) The anesthesia services of the center must meet the needs of the patient, within the scope of the services offered, in accordance with acceptable standards of practice, and must be under the direction of a licensed physician with specialized training or experience in the administration of anesthetics. The anesthesia service is responsible for all anesthesia administered in the</p>			

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	<p>center as follows: Based on observation, document review and interview, the facility failed to ensure the anesthesia provider provided services as indicated on the anesthesia form completed for 1 patient observation and failed to provide evidence of anesthesia services being provided under the direction of any physician in 1 instance. Findings include:</p> <ol style="list-style-type: none"> <li>1. During observation of patient #30 beginning at 10:50 a.m. (upon arrival to facility) on 4/30/14, the following was observed: (A) The anesthesia provider (CRNA #1) did not provide an assessment to the patient or discuss the risk and options prior to the procedure as he/she indicated in the medical record.</li> <li>2. Review of the medical record for patient #30 indicated the following: (A) The anesthesia provider (CRNA #1) documented that he/she reassessed the patient immediately prior to the procedure and the heart and lungs were checked. (B) He/she also documented that the risk and options were discussed with the patient and accepted by the patient.</li> <li>3. Review of the credential file for 1 allied health staff member (AH#1) failed</li> </ol>	S000790	S-0790 Assessment was conducted prior to procedure, in procedure room. Lungs, heart were assessed by by CRNA and supervised by physician. During pre op phrase of evaluation the CRNA will discuss risk and options of anesthia. Followed by question and answer session to confirm understanding of instructions. Patient signautre is obtained for verification of notice. PP will be update to reflect the new policy concerning pre and post assessments Medical staff, Dr. Rupert.	06/30/2014	

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S000826	<p>to show documentation of a responsible physician.</p> <p>4. In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(E) Safety training required of personnel.</p> <p>Based on document review and interview, the facility failed to provide documentation of safety training in areas where anesthetics are used for 2 of 2 medical staff credential files.</p> <p>Findings:</p> <p>1. Review of medical staff credential files indicated file MD#1 and AH#1 did not contain any documentation of safety training in areas where anesthetics are used.</p> <p>2. In interview, on 4/30/14 at 3:45pm</p>	S000826	Documentation will be ongoing with safety training in areas of anesthetics. CDC guidelines will be used to create pamphlet for training and signature Training session to be set by July 30. LPN responsible.	07/30/2014

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S000900	<p>CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</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 observation, document review, and interview, the facility failed to ensure care was provided according to acceptable standards of practice for 1 patient observation.</p> <p>Findings include:</p> <p>1. During observation of patient #30 in the recovery room on 4/30/14, the following was observed: (A) Staff member #N1 (RN) placed an O2 sat monitor (which measures O2 sat as well as pulse rate) on the patient's finger at 11:46 a.m. and gave four (4) pulse rates and O2 sat levels a few seconds apart to staff member #N2 to</p>	S000900	S-0900Patient's experiencing restlessness are accommdated in the following manner.Staff will remove atached equipment to create a more relaxing environment, if applicable.Staff will position themselves to obtain the same level as the patient, for safety of patient.Staff will use therapeutic communication skills and touch to calm the patient.If patient remains uncooperative and/or patient's condition is not resolved the physician will be notified to assesst patients status. When patient is calm and cooperative, assessment will resume and discharge process will continue. Attachment for S-900 Completed by RN. PP updated manual will indicate measurment taken to be recorded	05/05/2014			



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S001000	<p>policy for 6 of 8 employees.</p> <p>Finding include;</p> <ol style="list-style-type: none"> <li>1. Facility document listing in-service education requirements page 244 last reviewed/revised 8/26/13 states: "2. All personnel shall be required to attend an annual update in-service which consists of the following: Body Mechanics, Infection Control, Exposure Control Plan, Fire/Safety/Emergency Preparedness and Electrical Safety."</li> <li>2. Staff members #N6 and N7 personnel files lacked evidence of an annual Infection Control in-service.</li> <li>3. Staff members #N3-N7 and P1 personnel files lacked evidence of an annual Fire/Safety/Emergency Preparedness and Electrical Safety inservice.</li> <li>4. Staff member #A1 verified the above at 3:30 p.m. on 4/30/14.</li> </ol> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6</p> <p>The center shall provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the</p>		<p>requirements 2014 list attached to show topics covered. Manual containing these were given to surveyors, not kept in chart due to bulk. N3-N7 and P1 attached. LPN, Surgery Center staff (Only one LPN in Center)</p>				

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	<p>direction of an individual designated responsible for pharmaceutical services. Pharmaceutical services must have the following: Based on observation, interview and document review, the facility failed to ensure acceptable standard of practice was followed related to intravenous (I.V.) flush solution throughout the facility and failed to remove outdated medications from the crash cart for 1 of 1 crash cart observed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During tour of the surgical area beginning at 11:00 a.m. on 4/29/14, &gt; 20 syringes containing a clear liquid with a tag stating "FLUSH 4/29" were observed. The syringes were in the I.V. start bins in the pre operative room, the operating room and the clean utility room.</li> <li>2. During observation in the operating room (OR) beginning at 11:30 a.m. on 4/29/14 and accompanied by staff member #N4, the following was observed: (B) Six (6) vials of Sodium Chloride with an expiration date of 5/1/13 were observed in the crash cart.</li> <li>3. Staff member #N1 (RN) indicated in interview at 12:30 p.m. on 4/29/14 that he/she draws up the flush solution from a</li> </ol>	S001000	<p>Sodium Chloride was removed and replaced in front of surveyor. Recorded into log book. Disposed of in red bag for pick up by our contracted biohazard company. Log is kept of medication review and disposal checks will be evaluated monthly. Flush Solution of Sodium Chloride have been replaced with individual vial per patient . Copy of CDC safety material for single vial will be used. RN, Surgery Center Nurse will be responsible</p>	05/20/2014

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S001010	<p>bag of Sodium Chloride.</p> <p>4. The facility infection control plan last reviewed/revised 8/26/13 states "Control of the spread of infections is accomplished by adherence to current CDC guidelines."</p> <p>5. CDC injection safety guidelines state "Do not use bags or bottles of intravenous solution as a common source of supply for more than one patient."</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p>			
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	<p>Based on document review, observation and interview, the facility failed to develop a policy for destruction of non expired medications and failed to destroy medications according to standard of practice in 2 instances.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of facility policies and upon request of facility staff, it was determined the facility had no policy for destruction of non expired medications.</li> <li>2. Review of facility contract with waste management company #1 indicated that pharmaceuticals are accepted for destruction.</li> <li>3. Isovue M, Lidocaine, and Sodium Chloride were listed on the facility drug formulary list.</li> <li>4. During observation in the operating room (OR) beginning at 11:30 a.m. on 4/29/14, the following was observed:               <ul style="list-style-type: none"> <li>(A) Staff member #N7 was observed discarding a vial of Isovue M300 and a vial of Lidocaine with remaining contents of the medications in the vials in the regular trash in the OR.</li> <li>(B) Six (6) vials of Sodium Chloride with an expiration date of 5/1/13 were observed in the crash cart. Staff member</li> </ul> </li> </ol>	S001010	S-1010 All medication will be discarded in the red sharps box for pick up by our contracted company. No medication will go into regular trash. Updated PP manual concerning expired/unused med will be completed by Practice Admin. Drug formulary to be updated per PP. LPN responsible under RN supervision.	06/30/2014

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S001100	<p>#N4 discarded the vials into the regular trash in the OR.</p> <p>5. Staff member #N4 indicated in interview beginning at 2:30 p.m. on 4/30/14 that medications are destroyed by the waste management company, however did not provide a policy indicating this. He/she indicated that the trash from the OR is taken out to the dumpster outside the facility for pick up and verified the medications should not be placed in the regular trash.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(a)(1)</p> <p>(a) The center shall be constructed, arranged, and maintained to ensure the safety of the patient and to provide facilities for services authorized under the center license as follows:</p> <p>(1) The plant operations and maintenance service, equipment maintenance, and environmental services must be as follows:</p> <p>(A) Staffed to meet the scope of the services provided.</p> <p>(B) Under the direction of a person</p>			

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S001152	<p>or persons qualified by education, training, or experience according to center policy, approved by the governing body.</p> <p>Based on document review and interview, the facility failed to provide evidence of the center maintenance services being under the direction of a qualified person(s).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of facility documents indicated no designated maintenance personnel, either direct or arranged, with education, training or experience.</li> <li>2. In interview on 4/30/14 at 1:30pm CST, employee #A1 indicated the Public Relations/Practice Representative to be in charge of maintenance and confirmed this person was not listed among the surgery center's employees.</li> <li>3. In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(B)</p>	S001100	<p>S-1100 PR/Practice Rep contacts our contracted Building Management company, Given and Spindler, Given and Spindler in turn contacts the proper companies for the specific problems. PR/Practice Rep will be designated on new form as surgery center's employee. PR/Practice Rep is responsible.</p> <p>All companies that maintain building and equipment are in our files, specific to the items maintained. Schedule of maintenance log will be maintained in one file. Equipment in ASC maintenance monitored by LPN, under direction of R.N. Contracts were presented to observers. LPN, Infection Control Coordinator responsible</p>	05/30/2014

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	<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>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plan and equipment by qualified personnel as follows:</p> <p>(B) All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the facility failed to provide documentation of scheduled maintenance of the heating/ventilation/air conditioning (HVAC) system for calendar year 2013.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of facility documents indicated no documentation of schedule or maintenance for the HVAC system in any instance.</li> <li>Documentation of the HVAC maintenance schedule and maintenance log was requested of employee #A1 on 4/28/14 at 10:10am CST, on 4/29/14 at</li> </ol>	S001152	Equipment maintenance files were provided that showed HVAC maintenance done annually Individual equipment chart is maintained. HVAC is maintained through Midwest Mechanical. Schedule of appropriate frequency will be recorder in schedule of services. PR/Practice Rep is responsible.	05/30/2014			

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S001170	<p>3:30 CST and on 4/30/14 at 1:30pm CST.</p> <p>3. In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to document defibrillator checks in accordance with the manufacturer's instructions for 1 of 1</p>	S001170	Log was set up on day of survey. Defibrillator check was conducted with surveyor present. Log will be kept monthly. No discharge is required of the AED, per instructions. LPN responsible	05/02/2014

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S001184	<p>defibrillator.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of defibrillator manufacturer's manual chapter 4 entitled Maintaining the Welch Allyn AED10 indicated (for infrequent use), the unit should follow the operator's checklist 4-8.</li> <li>2. Review of the facility defibrillator logs indicated the above-stated checks were not conducted.</li> <li>3. In interview on 4/29/14 at 1:45pm CST, employee #A2 confirmed the above checks were not being performed.</li> <li>4. In interview on 4/30/14 at 3:45pm CST, employee #A2 confirmed the above and no further documentation was provided prior to exit.</li> </ol> <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>		with RN supervision		

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S001188	<p>Based on document review and interview, the facility failed to include public and visitor safety in the safety program.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of facility policy and procedure (P&amp;P) entitled AMBULATORY SURGERY CENTER FOR PAIN RELIEF; I. ORANIZATION FUNCTIONS, 5. Administrative Policies, G. Visitor Injury/Mishap, failed to include process for public and visitor safety.</li> <li>In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires.</p>	S001184	S-1184Attached marked as S1184.Updated PP will show revised policy on safety Practice Admins responsible.Safety Maintenance is an ongoing processLPN responsbile under RN supervision.	06/30/2014			

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S001198	<p>(B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on document review and interview, the facility failed to follow the written fire control plan in accordance with policy and procedure (P&amp;P) in calendar year 2013.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Based on review of the document entitled AMBULATORY SURGERY CENTER FOR PAIN RELIEF, V. ENVIRONMENTAL SAFETY, 2. Fire Safety, A. Introduction, section VI. DUTIES AND TRAINING, C. Fire drills are performed at least one per shift per quarter with yearly updates.</li> <li>Review of facility fire drill documents indicated calendar year 2013 fire drills were held on 3/11/13 and 8/26/13.</li> <li>In interview on 4/30/14 at 3:45pm CST, employee #A2 confirmed the above and no further documentation was provided prior to exit.</li> </ol>	S001188	<p>See attached S1188 PP to be updated by Practice Admin. Fire drills performed quarterly with annual updates 3/11/13 Fire Alarm pulled. 5/14/13 Fire Alarm pulled 8/26/13 Fire Alarm pulled 10/15/13 Fire extinguisher training After each of the training sessions when fire alarm is pulled the following is taught. ASC and waiting area is assessed for patients. As ASC is assessed the door is closed behind that staff member. This designates that the area was checked and cleared. Schedule of all patients is taken outside to the designated meeting area, (the large sign in front of parking lot). Roll call is taken of patients and staff. Critique of drills conducted with questions from ASC staff. 10/15/13 Fire extinguisher was taught. Staff went to outside area to discharge. The difference between electrical extinguishers and material extinguishers were discussed. LPN responsible under direction of RN</p>	05/05/2014
S001198	410 IAC 15-2.5-7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/30/2014
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NAME OF PROVIDER OR SUPPLIER  AMBULATORY SURGERY CENTER FOR PAIN RELIEF LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 LYNCH RD STE 100 EVANSVILLE, IN 47711
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S001210	<p>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. Based on document review and interview, the facility failed to coordinate emergency disaster and preparedness with an appropriate governmental agency for year 2013.</p> <p>Findings:</p> <p>1. Review of facility documents indicated there was no documentation of coordination of emergency disaster and preparedness with an appropriate governmental agency in calendar year 2013.</p> <p>2. In interview, on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1)</p>	S001198	S-1198 Made valid effort to acquire from our local official over a 2 year span. No cooperation was given. Contacted new official, Clint Weaver on May 21, 2014. Mr. Weaver stated he would assist with our emergency disaster and procedure plans. Contact is being maintained and coordination in process. Practice Admin responsible.	08/25/2014

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	<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 document review and interview, the center failed to ensure supervision of radiology services by a radiologist or radiation oncologist.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of facility documents failed to include documentation of supervision for radiology services by a radiologist or radiology oncologist.</li> <li>In interview on 4/30/14 at 1:30pm CST, employee #A1 indicated the medical director (MD#1) to be the supervisor over radiology services.</li> <li>Review of the credential file for MD#1 indicated no radiologist or radiology oncologist license/certification.</li> <li>In interview on 4/30/14 at 3:45pm CST, employee #A1 confirmed the above and no further documentation was provided prior to exit.</li> </ol>	S001210	<p>S-1210 Arnold Sorensen, B.S. Medical Physicist Indiana Inspector No. 100 Mr. Sorensen inspects our center and fluoroscopic c-arm each year Mr. Sorensen has been our physicist since our opening. Attached are his surveys of October 2012 and October 2013 Also, contracted with St Marys Medical Center Radiology that provides a full range of services for center. Medical Director and Practice Admin</p>	05/26/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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