

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001037	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/14/2012
NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 REX GROSSMAN BLVD BLOOMINGTON, IN 47403		
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S0000	<p>The visit was for a State licensure survey.</p> <p>Facility #: 006102</p> <p>Date: 2-13/14-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/22/12</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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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 document review and staff interview, the facility failed to ensure staff members received a post offer physical or health examination according to policy for 2 of 6 nursing staff members.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Facility policy titled "HEALTH EXAMINATION" last reviewed/revised 12/7/10 states under purpose "To determine that the employee is physically and mentally qualified to perform duties of the position for which they were hired." and under policy: "Each employee will have a health examination or history upon employment." Staff member #N2 was hired in November 2011. His/her personnel file lacked evidence of a post offer physical or health examination. 	S0164	<p>410IAC 15-2.4-1(c)(5)(H) S 0164 All employee health records have been reviewed for compliance with post offer physical and/or health examination documentation. All employee files are current, updated and now complete for 2012. Tetanus/DT shots offered to all employees. Records to be monitored per Administrator. Attachment WW, XX. (Nurse #2 was terminated on 02/28/2012.)</p> <p>03/10/12</p>	03/10/2012			

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	<p>3. Staff member #N4 was hired in November 2011. His/her personnel file lacked evidence of a post offer physical or health examination.</p> <p>4. Staff member #1 verified the above at 2:15 p.m. on 2/14/12.</p>			

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S0230	<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.</p> <p>Based on document review and interview, the governing body failed to ensure periodic reviews of the center and its operations were conducted by a Utilization Review Committee composed of 3 or more licensed physicians having no financial interest in the facility.</p> <p>Findings included:</p> <p>1.) Review of the listing of medical staff committees for 2010, provided by B#1 on 2-14-12 at 1330 hours indicated MD's # 16, 17 and 18 (no financial interest in the facility) composing the Utilization Review Committee for 2010; a listing for 2011 and a current listing for 2012 medical staff committee members was requested but not provided during the visit.</p>	S0230	<p>410 IAC15-2.4(e)(5) S 0230 Utilization/ Review of Peers will be outsourced and therefore the Committee will have no financial interest in Southern Indiana Surgery Center. The committee staff members are Dr. Lenz, Dr. Hoff and Dr. Ludlow. This committee will be doing the quarterly Utilization/ peer reviews for Southern Indiana Surgery Center. Quarterly Reviews will be monitored per the Administrator. Attachment VV. Center.</p> <p>410IAC 15-2.4-1(c)(5)(H) Q0164 All employee health records reviewed for compliance with post offer physical and/or health examination. All employee files updated and completed for 2012. Tetanus/DT shots offered to all employees. Records to be monitored per Administrator.</p>	03/10/2012	

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	<p>2.) Review of Utilization Review Committee activities/reviews for 2011 were reviewed on 2-14-12; the periodic reviews of the center and its operations by the Utilization Review Committee were conducted by 6 physicians, MD#6 and MD's#11 - 15, all of whom are owners in the ASC.</p> <p>3.) Interview with B#1 on 2-14-12 at 1350 hours confirmed the activities of the Utilization Review Committee in 2011 were conducted by MD#6 and MD's #11-15, all of whom are owners in the ASC; B#1 confirmed there was no listing of the 2011 or 2012 physician committee assignments.</p>		<p>Attachment WW, XX. (Nurse #2 was terminated on 02/28/2012.)</p> <p>03/10/12</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 interview, the facility failed to include all services, including those services provided by contract, in the facility's Quality Assessment and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <p>1.) Review of facility documents on 2-13-12 and 2-14-12 lacked evidence that the direct services of laboratory and radiology and the contracted services of radiology and transcription were included in the facility's QAPI program.</p> <p>2.) Review of facility documents on 2-13-12 and 2-14-12 lacked evidence that the data collected related to the direct lab services and tissue transplant were reported to the QAPI committee.</p> <p>2.) Interview with B#1 on 2-14-12 at 1300 hours confirmed the direct services of laboratory and radiology and the contracted services of radiology and</p>	S0310	410 IAC 15-2.4(a)(1) S 0310 All contracted and direct services (for example laboratory, radiology, tissue transplant and transcription) will be immediately added to the facility's quarterly QAPI program. A quarterly report will be given to the QAPI committee. The Administrator in turn will take this report to each Board meeting quarterly. The Administrator has a calendar for monthly and quarterly administrative meetings and an agenda minutes format so that all assessed information can be added without the possibility of deletion. The first Board meeting of 2012 is 04/09. Each contracted and direct service is evaluated yearly per the Administrator utilizing a contract tool. The evaluation tool addressed the performance of the contractor in regards to responsiveness to need, meeting of obligation, performance expectation and compliance with regulation. Each and all contracted and direct services is	02/27/2012			

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	transcription are not included in the facility's QAPI program; B#1 confirmed the data collected related to the direct lab services and tissue transplant were not reported to the QAPI committee.		taken to the Board of Director's yearly for approval each December. Attachment C, UU.		

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S0332	<p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the center: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained.</p>			

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	<p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to</p>			

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	<p>the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is</p>			

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	<p>progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or (BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the center.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p>			

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	<p>Based on document review and interview, the facility Quality Assessment and Performance Improvement (QAPI) committee failed to develop a comprehensive listing of serious adverse events to be monitored by the QAPI committee and a process for determining serious occurrences reportable to the Indiana State Department of Health (ISDH).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of facility policy titled DISCLOSURE OF UNANTICIPATED EVENTS on 2-14-12 lacked evidence that the facility had a process to identify reportable events, those reportable to the ISDH, in the facility policy. 2. Interview with B#1 on 2-14-12 at 1300 hours confirmed the facility policy related to serious adverse events titled DISCLOSED OF UNANTICIPATED EVENTS lacked evidence that reportable events required by the ISDH were included in the policy/procedure and the policy/procedure lacked a process to identify, investigate, and report serious adverse events by the QAPI committee to the ISDH. 	S0332	<p>410 iac 15-2.4.2 (a)(1) S 0332 The Reportable Events Rule Section 410 IAC 15-2.4-2.2 TAG Q0332 Section 2.2 of the Indiana State Department of Health will be added as an addendum to Southern Indiana Surgery Center's policy & procedure for Reportable Events after approval from the SISC Board of Directors. A Reportable Event/serious adverse effect will be identified by the facility's Risk Manager (ex. transfer of a patient to the hospital). The medical chart/records will be reviewed in order to investigate the occurrence per the Risk Manager and the Administrator. A QAPI report will be made and taken to the committee. A report will be made to the State Board of Health department in writing (a letter) within 15 working days and will provide information about the event and any action taken. A root cause analysis form will be completed with each event. The Board of Directors will be notified of any event that need to be reviewed and analyzed. Completed per Administrator. Attachment YY, ZZ, QQ.</p>	03/10/2012			

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S0334	<p>410 IAC 15-2.4-2.2(a)(2) QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) center employee involved; or any other information.</p> <p>(2) A potential reportable event may be identified by a center that:</p>			

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	<p>(A) receives a patient as a transfer; or</p> <p>(b) admits a patient subsequent to discharge; from another health care facility subject to a reportable event requirement. In the event that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually.</p> <p>(e) Any serious reportable listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the center between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)</p> <p>Based on document review and interview,</p>	S0334	410 iac 15-2.4-2.2(A)(2) S 0334	02/27/2012

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NAME OF PROVIDER OR SUPPLIER SOUTHERN INDIANA SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 REX GROSSMAN BLVD BLOOMINGTON, IN 47403		
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	<p>the facility failed to develop a process for reporting to the Indiana State Department of Health (ISDH) each serious adverse event determined by the facility's Quality Assurance and Performance Improvement (QAPI) committee.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled DISCLOSURE OF UNANTICIPATED EVENTS on 2-14-12 lacked evidence that the facility's QAPI committee had developed a process to report serious adverse events to the ISDH, submitted not later than 15 working days after the serious adverse event is determined to have occurred. 2. Interview with B#1 on 2-14-12 at 1300 hours confirmed the facility's QAPI committee had not developed a process to report serious adverse events to the ISDH, submitted not later than 15 working days after the serious adverse event is determined to have occurred. 		<p>Each Reportable Event follows a process for reporting. First, it will be determined if an event of a reportable nature has occurred. The event will be identified, initiated and documented by the Risk Manager Officer then submitted to the Administrator for review and a QAPI report. For instance, with a patient transfer from SISC to the hospital the need is determined, the Anesthesiologist/Surgeon is notified, the receiving facility is notified, a report is given to the receiving hospital/ Physican, 911 is called for transportation, all records go with patient for continuity of care and an adverse event report is made. The event must be submitted in writing (letter) within 15 working days to the State department of Health. Utilizing the QAPI report the event will be reported to the SISC Board of Director's at the quarterly meeting per the Administrator. Attachment UU, ZZ, QQ.</p>		

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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 document review and staff interview, the facility failed to ensure the communicable disease history was complete for 3 of 3 nursing personnel.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Staff member #N1 personnel file lacked documentation of communicable disease history to Rubella and Rubeola. 2. Staff member #N2 personnel file lacked documentation of communicable disease history to Rubella, Rubeola, Varicella, and Hepatitis B. 3. Staff member #N4 personnel file lacked documentation of communicable 	S0442	<p>410 iac 15-2.5-1 (f)(2)(E)(viii) S 0442 All employee health documentation has been reviewed for completeness in regards to Rubella, Rubeola and Chicken Pox vaccinations/titers as required by state and federal agencies. Any employee who is deficient in documentation will have titers done. This documentation will be monotored per the Administrator and kept in each employees health records. Attachment RR, XX.</p>	03/10/2012			

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	disease history to Rubella, Rubeola, Varicella, and Hepatitis B. 4. Staff member #1 verified the above at 2:15 p.m. on 2/14/12.			

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S0630	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on document review and staff interview, the facility failed to ensure the discharge summary was accurate for 2 of 4 patients transferred. (patients N1 and N2)</p> <p>Findings include:</p> <p>1. Patient #N1 was transferred to an acute care hospital on 4/18/11 due to complications. The discharge summary dictated on the day of surgery stated "....The patient was discharged in good condition from the recovery room to go home in the care of family....."</p> <p>2. Patient #N2 was transferred to an acute care hospital on 10/21/11. The discharge summary dictated on 10/25/11 stated "She was discharged home in the care of her family when the discharge criteria had been met....."</p>	S0630	4410 iac 15-2.5-3(d) S 0630 Each Physician will be notified via memo that discharge summaries need to be complete, accurate and initiated at the time of discharge in accordance with the SISC policy. An audit or review of medical records resulting in a QAPI report will be done to determine completeness and accuracy of entries. If a patient requires transferring to the hospital then the Surgeon will be contacted and updated for the continuity of patient care. A SISC physician must refer the patient to the hospital and the transfer agreement goes into effect. The Risk Management Officer will initiate the QAPI report and then submit the report to the Administrator. The QAPI report will then be submitted at the Board of Directors meeting per the Administrator. Attachment TT.	02/28/2012			

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	3. Staff member #2 verified the above documentation at 1:45 p.m. on 2/14/12.			

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S0664	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(9)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(9) A written or dictated report describing techniques, findings, and tissue removed or altered.</p> <p>Based on document review and staff interview, the facility failed to ensure M.D. #1 dictated the operative report after the procedure and not before the procedure for 2 of 2 patients.</p> <p>Findings include:</p> <p>1. Review of patient #N8 medical record indicated the following: (A) He/she had surgery performed by M.D. #1 on 8/30/11. (B) Document titled "Operative Record" indicated the patient was in the operating room at 8:16 with surgery beginning at 8:25 a.m. and ending at 8:55 a.m. (C) The operative report describing technique, findings, and estimated blood loss was dictated prior to the procedure at 7:16 a.m. (dictation is Texas time which would be 8:16 a.m. Indiana time)</p> <p>2. Review of patient #N9 medical record indicated the following:</p>	S0664	<p>410 IAC 15-2.5-3(f)(9) S 0664 Each Physician will be notified via a memo that operative reports are to be dictated after the surgical procedure is completed. Dictation phones will be checked by the Safety Officer for time correctness weekly and added to the SISC safety report. A QAPI report will be utilized to evaluate the outsourced dictation (Surgical Notes) in an effort to pinpoint any future issues. A letter from Surgical Notes will be kept on file stating the dictation time is on Central Time not Eastern Time. Completed per the Administrator and Safety Officer. Attachment TT, SS.</p>	02/28/2012	

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	<p>(A) He/she had surgery performed by M.D. #1 on 8/30/11.</p> <p>(B) Document titled "Operative Record" indicated the patient was in the operating room at 9:31 a.m. with surgery beginning at 9:55 a.m. and ending at 10:58 a.m.</p> <p>(C) The operative report describing technique, findings, and estimated blood loss was dictated prior to the surgery at 8:17 a.m. (dictation is Texas time which would be 9:16 a.m. Indiana time)</p> <p>3. Staff member #2 verified the above information at 1:45 p.m. on 2/14/12. Additionally, he/she verified that the time on the dictation phones is correct and indicated that the dictation is completed in Texas and the dictation time would be their time and not Indiana time.</p>				

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S1026	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)(i)</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>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(i) Drug cabinets must be accessible only to authorized personnel.</p> <p>Based on observation, the facility failed to ensure drug cabinets were accessible only to authorized personnel for one (1) anesthesia block cart observed.</p> <p>Findings include:</p> <p>1. During tour of the pre-operative area beginning at 12:10 p.m. on 2/13/12 an unlocked, unmonitored drug cart was observed against the wall across from patient bays. The cart was accessible to family members/visitors of the patients. The cart contents included, but was not limited to, Dexamethasone, Naropin, and Lidocaine.</p>	S1026	410 iac 15-2.5-6(E)(i) S 1026 Anesthesia Block Cart moved to specially designated monitored area at the Nurse's Station in the Pre Op area per the Administrator and kept locked at all times.	02/27/2012			

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	2. Staff member #N7 indicated that the cart is kept unlocked for easy access for anesthesia providers.			

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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 and interview, the facility created a condition that could result in a hazard to patients, public, and employees.</p> <p>Findings included:</p> <p>1.) While touring the facility on 2-14-12 at 0920 hours with B#1, it was observed that one oxygen tank was unsecured in the oxygen tank storage room, creating a condition that could result in a hazard to patients, public, and employees.</p> <p>2.) Interview with B#1 on 2-14-12 at 0920 hours confirmed the oxygen tank was unsecured and could result in a hazard to patients, public, and employees.</p>	S1146	<p>410 IAC 15-2.5-7(b)(2) S 1146 Medical Gas Room tanks are checked on a daily basis for containment and security per the Administrator and the Safety Officer. This information is charted on a daily safety checklist as evidenced in Attachment PP. Each gas tank is individually secured with a wall chain in order to maintain the safety and well-being of patients, the public and staff. Indiana Oxygen (the company that delivers gases to SISC) was notified that it is unacceptable and could result in a hazard to all to unchain and move the gas tanks in order to achieve more accessibility during delivery.</p>	02/27/2012			

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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 document review and interview, the facility notified the county emergency management, the local health department, and IU Health Bloomington Hospital that the facility will not participate in the event of a disaster.</p> <p>Findings include:</p> <p>1.) Review of facility documents on 2-13-12 and 2-14-12 indicated the facility contacted the Monroe County Emergency Management, the local health department, and IU Health Bloomington Hospital to establish their role in a disaster situation. The document indicates the surgery center will not have coordination with community health clinics; patients will not be transferred or received from community health clinics or health care facilities.</p> <p>2.) Review of the Executive Summary indicates:</p>	S1198	<p>410 IAC 15-2.5-7(c)(6)S 1198The facility has notified the County emergency management office, Bloomington health department and Bloomington hospital that the facility does coordinate care. The facility will ask the agencies for critiques of its drills for evacuation and fire safety and will discuss with the hospital the system for transferring of patients should any transfers be needed in the event of a disaster. The Center will not place a burden on the community health facilities by trying to remain open during a disaster. The facility will release its patients if any are present or not open if disaster occurs when no surgeries or recovery is underway. This will enable physicians to assume their role at hospital triage stations and in the hospital operating rooms. The facility is not equipped with extended emergency power, is not equipped for long term recovery and is not equipped for all types of surgeries. The</p>	03/10/2012	

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	<p>Coordination with local and state jurisdictions: The surgery center will not participate in community wide disasters since the Center is not equipped or staffed to provide emergency patient care.</p> <p>Coordination with local and state emergency management jurisdictions: The surgery center will not participate in disasters that are community wide.</p> <p>Coordination with community health clinics: The surgery center will not have coordination with community health clinics.</p> <p>Coordination with federal health facilities: The surgery center will not have coordination with federal health facilities. Patients will not be transferred to or received from federal health facilities.</p> <p>Coordination with local, county, and state law enforcement agencies: The surgery center will not accept patients from other health care facilities or provide care for the general public.</p> <p>3.) Interview with B#1 on 2-14-12 at 1315 hours indicated the surgery center will not participate in a disaster situation because it is a surgery center; confirmed center wrote a letter to Monroe County Emergency Management due to AAAHC visit outlining in the policy that the ASC will not participate in the event of a disaster.</p>		<p>coordinating efforts enable nursing staff and physicians to be available for triage and surgery in an appropriate setting. If the disaster should occur at the facility when it is open jthe emergency management office and hospital will be aware of the maximum number of patients that could be in surgery or in recovery that may need transfer to a higher level of care. Methods of communication and transfer of patients will be communicated and coordinated per the Administrator, County emergency management office, Bloomington health department and Bloomington hospital notified of SISC's coordination during a disaster per the Administrator. Attachment OO.</p>		