

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001060	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2013
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NAME OF PROVIDER OR SUPPLIER EVANSVILLE SURGERY CENTER ASSOCIATES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 520 MARY ST STE 130 EVANSVILLE, IN 47710
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 009234</p> <p>Survey Date: 10/9/2013 through 10/10/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/22/13 QA:</p>	S000000		

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

TITLE

(X6) DATE

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

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S000400	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review, observation, and staff interview, the facility failed to provide an environment that minimized risk to patients for 1 surgical area observed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "ENVIRONMENTAL SERVICE PLAN" last reviewed/revised 10/2011 states on page 2: "a. Operating Rooms and high-touch surfaces in patient care areas are to be cleaned and disinfected with an EPA registered disinfectant.....c. All furniture, beds, carts, and flat surfaces will be cleaned between patient use. 2. Label instructions for Cavicide disinfectant indicate the surface must remain wet for a period of three (3) minutes for the product to be effective. 3. During observation of instrument cleaning beginning at 9:30 a.m. on 10/10/13 and accompanied by staff 	S000400	<p>S400- Staff education In-services involving cleaning the operating room between cases, correct usage of Cavicide disinfectant to include required set time for product to be effective, and policy changes will be conducted by the Education Coordinator beginning 10/28/2013 and be completed by 12/31/2013. Follow up infection control observations will be conducted on a monthly basis beginning 11/1/2013 using the Infection Control Practices Audit tool by the Infection Control Officer or their designee. Any observed deficiencies will be addressed and corrected on the spot. Results of audits will be reported to the QAPI Committee quarterly, and reviewed by the Medical Executive Committee. On 10/14/2013 Plant Operations Manager removed all silk tape from arm boards in the operating rooms and applied a permanent Velcro type adhesive patch to hold the padding to the arm board. Arm boards will be cleaned prior to use. During the week of 10/14-18/2013 Performance Improvement Coordinator spoke with the</p>	12/31/2013			

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	<p>member #1, the following was observed:</p> <p>(A) Medical assistant #1 was observed cleaning a case cart after a procedure. He/she sprayed the surface of the cart with Cavicide and immediately wiped the surface off with a dry towel.</p> <p>4. During observation in the surgical area beginning at 10:00 on 10/10/13, the following was observed:</p> <p>(A) Operating room #2 had an armboard resting on the floor against the wall. The arm board had numerous pieces of cloth tape on it as well as black electrical type tape. Staff members picked up the armboard and attached it to the OR table for the next procedure. The armboard was not sanitized and could not be sanitized due to the cloth tape wrapped around it.</p> <p>(B) Staff members also utilized an armboard in OR #6. The armboard had numerous pieces of cloth tape on it. The tape was stained with a yellow solution. The armboard could not be sanitized due to the cloth tape.</p> <p>(C) OR #6 was observed being cleaned and set up for the next procedure. The anesthesia cart had medications, syringes, and an LMA ready for a case. The anesthesia cart flat surfaces was not cleaned nor could be cleaned due to the supplies and medications stored on top</p>		<p>anesthesia provider regarding inability for staff to effectively clean the OR between cases if items are stored on flat surfaces (anesthesia cart) that are his/her responsibility. Items not being used during the actual case are not to be stored or left unattended by the anesthesia provider. Compliance will be verified using the monthly Infection Control Audit. Results of audits will be shared with QAPI Committee, Chief of Anesthesia, Medical Executive Committee and Medical Director.</p>				

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S000414	<p>of it.</p> <p>5. RN #1 indicated the following in interview at the time of the above observation (4.C.):</p> <p>(A) The items on the anesthesia cart were ready for the next case.</p> <p>(B) The anesthesia work surface is cleaned "1-2 times a day".</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible 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 staff</p>	S000414	S414- The 3rd quarter QAPI meeting was held on 10/21/2013.	10/21/2013			

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S000444	<p>interview, the facility failed to conduct quarterly infection control meetings for 1 set of infection control meeting minutes reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of infection control meeting minutes for November 2012 to present indicated the facility did not hold an infection control meeting in the 3rd quarter of 2013. The last meeting held was on 6/17/13. 2. Staff member #2 verified in interview at 11:55 a.m. on 10/9/13 that the facility did not hold a 3rd quarter infection control meeting. <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p>		<p>QAPI meeting dates and reminders have been assigned for the next calendar year. The Performance Improvement Coordinator will be responsible for ensuring meetings are held quarterly and reported to the Medical Executive Committee.</p>	

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	<p>Based on document review, observation, and staff interview, the facility failed to ensure the anesthesia provider adhered to facility policy related to dress code for 1 anesthesia provider observed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "SURGICAL DRESS CODE" last reviewed/revised 2/20/13 states "All personnel must wear masks when entering a room with open sterile items and/or during any sterile procedure." 2. Facility policy titled "EMPLOYEE ATTIRE AND APPEARANCE" last reviewed/revised 7/13 states "8.....T-shirts worn under scrub tops in the Operating Room must be entirely covered by scrub tops or jacket....." 3. During observation in the surgical area beginning at 10:00 a.m. on 10/10/13 and accompanied by staff member #1, the following was observed: (A) Anesthesia provider #1 was observed entering and administering anesthesia to a patient without a mask on. He/she had the surgical mask hanging around his/her neck. The room was set up with open sterile instruments. (B) Anesthesia provider #1 had a red t-shirt visible under his/her navy scrub 	S000444	S 444- The policy titled "Employee Attire and Appearance" (Pol. 4022) has been revised making it "permissible for the neck line of the t-shirt to be visible" while wearing "surgical scrubs." During the week of 10/14-18/2013 the Performance Improvement Coordinator spoke with the anesthesia provider regarding ESC Pol. 3245 (Surgical Dress Code) and entering a room with open sterile items as well as not having his/her mask on appropriately. This issue was also brought to the attention of the Medical Director by the Facility Administrator 10/30/2013. This incident will also be discussed at the Medical Staff meeting on 11/4/2013 and the Medical Executive Committee on 11/11/2013 for further consideration and recommendation.	11/11/2013			

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S000646	<p>attire.</p> <p>4. Staff member #1 indicated after the observation that the red t-shirt was not part of scrub attire that would be laundered with the facility scrubs.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(3)</p> <p>All entries in the medical record must be as follows:</p> <p>(3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule.</p> <p>Based on medical record review, policy and procedure review, and interview, the facility failed to ensure the operative notes were authenticated according to policy for 9 of 23 patients having procedures at the center (#P4, P13, P14, P16, P20, P21, P22, P24, and P25).</p> <p>Findings included:</p> <p>1. Medical record #P4 indicated an operative note dictated 07/01/13, the day of the procedure, but not authenticated by the physician until 08/06/13, greater than 30 days later.</p> <p>2. Medical record #P13 indicated an operative note dictated 06/27/13, the day</p>	S000646	S646- The Evansville Surgery Center Medical Records Coordinator sends reminder notices to physicians whose medical records remain incomplete more than 14 days after the date of surgery. Notifications are sent via fax, telephone, mail, e-mail or postings within the center. Some records are electronically tagged for physician signature. Continuing education is provided to those physicians unfamiliar with the electronic signing of the medical record. Suspension of privileges occurs via letter from the Medical Director. Delinquent physicians may not schedule surgeries until all medical records have been completed. The Medical Records Coordinator will	03/01/2014			

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	<p>of the procedure, but not authenticated by the physician until 08/06/13, greater than 30 days later.</p> <p>3. Medical record #P14 indicated an operative note dictated 06/27/13, the day of the procedure, but not authenticated by the physician until 08/02/13, greater than 30 days later.</p> <p>4. Medical record #P16 indicated an operative note dictated 05/16/13, the day of the procedure, but without a date for the physician's authentication to determine if it was signed within 30 days.</p> <p>5. Medical record #P20 indicated an operative note dictated 06/06/13, the day of the procedure, but without a date for the physician's authentication to determine if it was signed within 30 days.</p> <p>6. Medical record #P21 indicated an operative note dictated 08/23/13, the day of the procedure, but without a date for the physician's authentication to determine if it was signed within 30 days.</p> <p>7. Medical record #P22 indicated an operative note dictated 04/13/13, the day of the procedure, but without a date for</p>		<p>be responsible for continual internal auditing for completeness of the medical record. In order to increase accuracy and completeness of the entire medical record, a monthly audit of one day's charts to number at least 30 will be completed by the Medical Records Coordinator or their designee. The start date for the auditing will be 11/1/2013. The Performance Improvement Coordinator will be responsible for communication to the Facility Administrator and subsequently to the Medical Executive Committee on the progress of medical record completion. Ultimately, the Facility Administrator and the Medical Director will be responsible for addressing physician compliance with the medical record. Progress toward the completion of the medical record will be reported to the Medical Executive Committee (MEC) beginning 11/11/2013. Incremental improvement is expected until compliance rate of 95% is achieved. Target date of completion is 3/1/2014.</p>		

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	<p>the physician's authentication to determine if it was signed within 30 days.</p> <p>8. Medical record #P24 indicated an operative note dictated 05/16/13, the day of the procedure, but without a date for the physician's authentication to determine if it was signed within 30 days.</p> <p>9. Medical record #P25 indicated an operative note dictated 08/15/13, the day of the procedure, but not authenticated by the physician until 09/30/13, greater than 30 days later.</p> <p>10. The facility policy "Maintenance of Medical Records", last revised 07/2013, indicated, "3. All entries in any Record shall: ...C. Be authenticated (full name and professional status) by the person making the entry. ...E. State the current date and time of the entry, and if different, the date and time of the event that is the subject of the entry. ...10. ...Medical records should be completed and signed by the providers within thirty (30) days of the procedure."</p> <p>11. At 11:00 AM on 10/10/13, staff member confirmed the medical record findings and acknowledged the operative reports were not authenticated</p>				

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S000772	<p>according to policy.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on medical record review, policy and procedure review, and interview, the facility failed to ensure the pre-operative assessment was completed according to policy for 6 of 23 patients having</p>	S000772	S772- In order to increase accuracy and completeness of the entire medical record, a monthly audit of one day's charts to number at least 30 will be completed by the Medical Records Coordinator or their	03/01/2014			

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	<p>procedures at the center (#P14, P16, P18, P19, P21, and P24).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Medical record #P14 indicated a "Physician Progress Notes" form with the " Pre-surgical assessment performed" box checked and a physician signature and date of 06/27/13, the day of the procedure, but without a time to ensure the assessment was done prior to surgery. 2. Medical record #P16 indicated a "Physician Progress Notes" form with the " Pre-surgical assessment performed" box checked and a physician signature and date of 05/16/13, the day of the procedure, but without a time to ensure the assessment was done prior to surgery. 3. Medical record #P18 indicated a "Physician Progress Notes" form with the " Pre-surgical assessment performed" box checked and a physician signature and date of 04/11, the day of the procedure, but without a time to ensure the assessment was done prior to surgery. 4. Medical record #P19 indicated a "Physician Progress Notes" form with 		<p>designee. The start date for the auditing will be 11/1/2013. The plan for the audits and the gathered data will be presented to the Medical Executive Committee (MEC) beginning 11/11/2013. The Performance Improvement Coordinator and the Facility Administrator will be responsible for communication with the governing body. Ultimately, the Facility Administrator and Medical Director will be responsible for addressing physician compliance with completion of the medical record. Incremental improvement is expected until a compliance rate of 95% is achieved. Target date of completion is 3/1/2013.</p>				

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	<p>the" Pre-surgical assessment performed" box not checked and without any other documentation other than a physician signature and date of 6/6/13, the day of the procedure.</p> <p>5. Medical record #P21 indicated a "Physician Progress Notes" form with the" Pre-surgical assessment performed" box checked and a physician signature and date of 08/23/13, the day of the procedure, but without a time to ensure the assessment was done prior to surgery.</p> <p>6. Medical record #P24 indicated a "Physician Progress Notes" form with the" Pre-surgical assessment performed" box checked and a physician signature and date of 05/16, the day of the procedure, but without a time to ensure the assessment was done prior to surgery.</p> <p>7. The facility policy "History and Physical", last reviewed February 20, 2013, indicated, "A pre-surgical assessment will be performed on each patient by the surgeon or operating practitioner. This assessment will be performed immediately before surgery, and will include, at a minimum, an examination for any changes in the patient's condition since the completion</p>						

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S001010	<p>of the most recently documented history and physical assessment, including any allergies to drugs and biological."</p> <p>8. At 11:00 AM on 10/10/13, staff member confirmed the medical record findings and acknowledged the "Physician Progress Notes" form was not completed accurately.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on document review and observation, the facility failed to ensure anesthesia providers stored and administered medications appropriately for 1 anesthesia provider observed.</p> <p>Findings include:</p> <p>1. Facility policy titled "MEDICATION MANAGEMENT" last reviewed/revised 7/12 states on page 5 under preparation:</p>	S001010	S1010- During the week of 10/14-18/2013 the Performance Improvement Coordinator discussed ISDH observations during survey on 10/10/2013 with anesthesia provider regarding medication labeling, workspace clutter, medication preparation and administration per facility Pol. 3010. Compliance will be verified using the monthly Infection Control Audit beginning 11/1/2013. Results of audits will be shared with QAPI Committee,	11/11/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001060		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/10/2013	
NAME OF PROVIDER OR SUPPLIER EVANSVILLE SURGERY CENTER ASSOCIATES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 520 MARY ST STE 130 EVANSVILLE, IN 47710			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>"b. When preparing medication staff will: i. Use clean or sterile techniques ii. Maintain clean, uncluttered and functionally separate area to minimize possibility of contamination....." and page 7 states "c. All multidose vials will have date accessed marked on vial....."</p> <p>2. During observation in the surgical area beginning at 10:00 a.m. on 10/10/13 and accompanied by staff member #1, the following was observed:</p> <p>(A) A multidose vial of Lidocaine was observed in the anesthesia cart in operating room (OR) #6. The vial had been used and was not dated as to when it was accessed.</p> <p>(B) The anesthesia cart was extremely cluttered with syringes, vials of medications, and equipment in OR #6.</p> <p>(C) Anesthesia provider #1 was observed drawing up/preparing medications for administration in the cluttered area in OR #6. He/she was observed drawing up and administering medications > 5 times. He/she did not use an alcohol swab to the vials of medication prior to drawing up the medication nor did he/she use an alcohol swab to the port of the patients I.V. prior to administering the medications.</p>		Chief of Anesthesia, Medical Executive Committee and Medical Director. Findings were discussed by the Facility Administrator with the Medical Director on 10/30/2013 and reported during the Medical Staff meeting on 11/4/2013, and will be presented to the Medical Executive Committee on 11/11/2013.				