

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001060	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/01/2015
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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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S 0000 Bldg. 00	This visit was for a State licensure survey. Facility number: 009234 Dates: 6/30/15 to 7/1/15 QA: cjl 07/17/15	S 0000		
S 0400 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on policy review, observation and interview, the facility failed to provide a safe and healthful environment which minimizes infection exposure and risk in regard to surgical attire. Findings: 1. Facility policy Surgical Dress Code, #3245, reviewed 04/2015, indicated head and facial hair will be covered in the OR corridors and suites. 2. On 07/01/2015 at 0930 hours while	S 0400	S 400 Physicians were notified of need to wear hair covering in the OR that covers all hair in Medical Staff meeting on August 3, 2015. Rounding in the OR for compliance with the dress code will determine need for further action. Director of Operations and OR Charge Nurses will be responsible for enforcing. Problems with provider compliance will be addressed by Medical Executive Committee.	08/03/2015

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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S 0616 Bldg. 00	<p>observing a surgery, it was noted that the physician #1's hair wasn't covered. Approximately one and one-half inches of hair was visible below the surgical cap, risking contamination of surgical sites.</p> <p>3. Staff member #A5, director of operations, concurred with this finding.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on document review, the facility failed to maintain medical records which positively identified who made changed entries, or when the changes were made for 3 of 11 medical records reviewed.</p> <p>Findings:</p>	S 0616	<p>S 616 Staff Inservice was provided on August 3 regarding proper correction of the medical record. Physicians were notified in Medical Staff meeting on August 3, 2015. Routine chart auditing performed quarterly will monitor compliance</p>	08/03/2015

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	<p>1. Facility Policy 6008, Maintenance of Medical Records, last reviewed 7/2013, indicated if the correction is timely or otherwise authorized, it shall be made by drawing a single line neatly through the error, leaving the incorrect information, and should be signed (if a Patient) or initialed (if Surgery Center personnel or Medical Staff) and dated with the word "error" written above the line so that it is obvious that the entry has been corrected.</p> <p>1. Medical record (MR) #1, an operative note written by physician #2, contained five instances of having words and phrases crossed out with no evidence as to who did it or the date when the changes were made.</p> <p>2. MR #4, a preoperative nursing note, written by nursing staff #A9 and an illegible staff name, contained two instances of words marked out with no identifier or date of changes.</p> <p>3. MR #8, a preoperative nursing note, written by staff member #A9 and an illegible staff name, had one instance of a phrase being marked out without evidence of who did it or the date of the changes.</p>		with proper maintenance of the medical record. Outliers found on chart audits will result in individual counseling. Medical Record Coordinator will be responsible for auditing process.	

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S 0736 Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 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 (MS) failed to meet quarterly within the past 4 quarters (2/2104 to 6/2015).</p> <p>Findings:</p> <p>1. Review of MS Bylaws indicated, in section 11.1.1 titled Regular Meetings: The MS shall hold at least one meeting per Medical Staff Year. The Bylaws were last reviewed 9/24/14.</p> <p>2. Review the past 4 quarters of MS meeting minutes indicated the MS held meetings on the following dates: 2/9/15, 7/7/14, & 2/10/14.</p> <p>3. On 7/1/15 at 10:10am, A3,</p>	S 0736	<p>S 736 Medical Staff meetings will be held quarterly beginning with scheduled August 3, 2015 meeting. Meetings will occur on 1st Monday of the month in February, May, August, and November. Facility Administrator is responsible for seeing that meeting is scheduled, Medical Staff President or designated appointee will conduct meeting. Medical Staff Bylaws will be amended to reflect compliance with 410 IAC 15-2.5-4 for quarterly meetings. Amendment to bylaws to be presented for approval on August 3, 2015 with subsequent approval by Managing Board on August 26, 2015 at regularly scheduled meeting.</p>	08/03/2015

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S 1166 Bldg. 00	<p>Administrator, indicated in 2014 the MS changed their meeting requirements to annually and had not met quarterly in 2014.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(ii) There must be evidence of preventive maintenance on all patient care equipment. Based on document review and interview, the center failed to provide evidence of preventive maintenance (PM) on 2 types of patient care equipment (wheelchairs & patient beds).</p> <p>Findings:</p> <p>1. Review of the policy & procedure</p>	S 1166	S 1166 Preventive maintenance will be conducted on wheelchairs and non-electric patient beds by Plant Operation Coordinator yearly beginning July 27, 2015. Contact to equipment manufacturer stated that annual checks are recommended. Plant Operation Coordinator will document PM using form. (See Ex.	07/27/2015

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	<p>(P&P) titled Equipment Management Plan indicated the following: Biomedical Services have implemented a preventive maintenance program...to provide preventive maintenance work routines (these routines...comply with manufacturer's recommendations). Clinical and physical risk is assessed and minimized through inspection, testing and maintenance of equipment. The P&P was last approved 2/25/15.</p> <p>2. Review of preventive maintenance documentation for 2014 to 6/2015 lacked documentation of PM for any wheelchair and/or non-electric patient bed.</p> <p>5. On 7/1/15 at 11:15am, A6 indicated the center does utilize non-electric wheelchairs and patient beds, but does not perform regular PM on these pieces of equipment.</p>		S1166) Performance Improvement Coordinator will verify that PM are performed yearly.	