

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001109	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/15/2015
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY SURGERY CENTER HOWARD	STREET ADDRESS, CITY, STATE, ZIP CODE 3503 S REED RD KOKOMO, IN 46902
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Q 0000  Bldg. 00	This visit was for a recertification of an ambulatory surgery center.  Dates of survey: 7/13/2015 through 7/15/2015  Facility number: 002781  QA: cjl 08/05/15	Q 0000	Report will be presented to the Operations Committee on November 4th and then to the Board of Managers on November 6th for approval All policy and procedure changes, new forms detailed in this response, will go to the Operations Committee on November 4th and then to the Board of Managers on November 6th for approval All policy and procedure changes will be presented to the staff at the November 11th staff meeting following approval from the Board of Managers	
Q 0101  Bldg. 00	416.44(a)(1) PHYSICIAN ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on document review and staff interview, the facility failed to ensure the five operating rooms met the required temperatures as defined by the surgery center's policy and AORN (Association of periOperative Registered Nurses) standards.  Findings included:	O 0101	1. We have contracted with a Controls Company (OCS, 905 N. Capitol, Indpls, IN 46204) to Calibrate/repair our thermostats For the last two weeks are temperatures have been within range 60% of the time in 4 out of the 5 OR's, the fifth room we are not using until corrected This is up from only 24% of the time at the time of the survey. All rooms	09/30/2015

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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	<p>1. Community Surgery Center Howard Temperature and Humidity in the perioperative suite policy (last reviewed January 2015) indicated the operating room temperatures should be maintained between 68 and 73 degrees Fahrenheit. The policy indicated the surgery center follows AORN standards in perioperative settings.</p> <p>2. AORN supports the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines on temperature ranges for perioperative settings. The Operating Rooms temperature range should be between 68 F and 73 F.</p> <p>3. Community Surgery Center Howard has five operating rooms. The temperature/humidity log indicated, "If the readings are out of range, notify Clinical Director or Support Services Manager." The surgery center daily logs evidenced 76% of the recorded temperatures were less than 68 degrees Fahrenheit for the five operating rooms. The recorded documentation did not evidence corrective actions on the five operating rooms for not meeting the required temperature range of 68 to 73 degrees Fahrenheit.</p>		<p>are within 1-2 degrees of the 68 degree low temperature. OCS continues to adjust the units and will replace the thermostats if they cannot consistently be within the 68-73 degree range by September 30th 2 During staff meeting on 9/23/15, staff will review the findings of this survey and instructed to notify the Team Lead of their area and/or the Executive Director of any temperatures that are out of range, reviewed the Temperature log for the OR's and use thereof 3 Reviewed Temperature logs and the use thereof 4 Will monitor via the Temperature logs Clinical Director, Cindy Tudor will be responsible to monitor weekly and report any out of range temperatures to the Executive Director</p>	

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	<p>a. Operating room #1 since the initial recorded date of 6/18/2015; documentation evidenced 12 of 12 recorded temperatures were less than 68 degrees Fahrenheit. The average recorded temperature was 65 degrees Fahrenheit.</p> <p>b. Operating room #2 since the initial recorded date of 6/04/2015; documentation evidenced 13 of 13 recorded temperatures were less than 68 degrees Fahrenheit. The average recorded temperature was 65 degrees Fahrenheit.</p> <p>c. Operating room #3 since the initial recorded date of 3/09/2015; documentation evidenced 9 of 24 recorded temperatures were less than 68 degrees Fahrenheit.</p> <p>d. Operating room #4 since the initial recorded date of 3/26/2015; documentation evidenced 9 of 12 recorded temperatures were less than 68 degrees Fahrenheit. The average recorded temperature was 66 degrees Fahrenheit.</p> <p>e. Operating room #5 since the initial recorded date of 5/07/2015; documentation evidenced 13 of 13 recorded temperatures were less than 68</p>			

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Q 0105	<p>degrees Fahrenheit. The average recorded temperature was 64 degrees Fahrenheit.</p> <p>4. At 10:30 AM on 7/15/2015, staff member #1 (Director of Nursing) indicated the physicians know what the required range of the operating room temperatures should be; however, the physicians still elect to have the temperature below 68 degrees Fahrenheit. The physicians do not want to sweat and the cooler temperatures in the operating rooms are more comfortable for the patients then 73 degrees Fahrenheit.</p> <p>5. At 11:05 AM on 7/15/2015, staff member #2 (Executive Director) indicated he/she has not required maintenance to adjust the temperature in the operating rooms because the thermostat was operating correctly. The thermostat was adjusted below 68 degrees Fahrenheit per the staff that are using the room for their surgery procedures. Therefore, operating room staff would not report temperature issues.</p> <p>416.44(c) EMERGENCY EQUIPMENT</p>			

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Bldg. 00	<p>The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC' s operating room. The equipment must meet the following requirements:</p> <p>(1) Be immediately available for use during emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel.</p> <p>Based on document review and staff interview, the facility failed to ensure the 6-month preventive maintenance was performed on the LIFEPAK Defibrillator as required by the surgery center's policy or as recommended by the manufacturer's maintenance schedule.</p> <p>Findings included:</p> <p>1. Community Surgery Center Howard Safety and Maintenance policy (last reviewed January 2015) indicated defibrillators should have a 6-month preventive maintenance inspection and the operators are to follow the manufacturer's recommended preventive maintenance schedule.</p> <p>2. The surgery center's defibrillator Operating Instructions has daily, 6-months, and 12-months preventive maintenance schedules. The 6-months</p>	O 0105	<p>1. PM was completed on the Lifepak per manufacturers guidelines on 9/14/15 and the PM schedule changed to q6m with the next PM due March of 2016 2 Support Services Team lead was remediated on the importance of following the manufacturers recommended guidelines for PM on equipment, PM's for the Lifepak were changed to q6m 3 Initiated change in PM schedule from yearly to q6m 4 PM maintenance will be monitored by Pat Donoghue, Support Services TL</p>	09/14/2015

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Q 0162 Bldg. 00	<p>preventive maintenance schedule includes: standard paddles monitoring check; standard paddles defibrillation and synchronized cardioversion check on battery pack; therapy cable monitoring check; therapy paddles defibrillation and synchronized cardioversion check on battery pack; and therapy cable pacing check.</p> <p>3. The July Crash Cart Daily Assessment Log evidenced that daily inspections are conducted; however, the daily assessment log did not document that the 6-months manufacturer preventive maintenance checks were also scheduled.</p> <p>4. At 2:45 PM on 7/14/2015, staff member #2 (Executive Director) indicated the most recent preventive maintenance work order on the LIFEPAK 12 Defibrillator was 9/8/2014. The staff member confirmed the defibrillator's preventive maintenance schedule was every 12 months and the recommended 6-months preventive maintenance was not conducted either by the surgery center staff or the contracted clinical engineers.</p> <p>416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be</p>			

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	<p>accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ul style="list-style-type: none"> <li>(1) Patient identification.</li> <li>(2) Significant medical history and results of physical examination.</li> <li>(3) Pre-operative diagnostic studies (entered before surgery), if performed.</li> <li>(4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body.</li> <li>(5) Any allergies and abnormal drug reactions.</li> <li>(6) Entries related to anesthesia administration.</li> <li>(7) Documentation of properly executed informed patient consent.</li> <li>(8) Discharge diagnosis.</li> </ul> <p>Based on document review and interview, the facility failed to ensure the medical records were accurate, complete, and authenticated per facility policy for 12 of 30 patient records reviewed (#1, 7, 8, 9, 11, 14, 15, 17, 19, 26, 27, and 30).</p> <p>Findings included:</p> <p>1. The facility policy "Medical Records, Completion Of", last reviewed 10/14, indicated, "Per State, Federal, and other regulatory agencies, the [facility] must ensure accurate and timely completion of all medical records within thirty (30) days following surgery."</p>	O 0162	<p>1 On September 14, 2015 a letter (attached) was sent to all Medical Staff regarding the Medical Record deficiencies noted in this report</p> <p>2 All active Medical Staff were included in the mailing</p> <p>3 Letter was sent to all active Medical Staff, all findings were reviewed with the Medical Records clerk and with the Medical Records Auditor to monitor for incomplete records for chronic offenders</p> <p>4 Medical Records clerk will notify the Executive Director and the Medical Director of any deficiencies for one on one discussions with the provider</p>	09/14/2015

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	<p>2. The facility policy "Medical Record Chart Explanation and Maintenance Of", last reviewed 10/14, indicated, "D. Operative Note: 1. Operative notes are dictated or written in the medical record immediately after surgery and contain a description of the: "</p> <p>3. The facility policy "Authentication of Medical Record Entries", last reviewed 10/14, indicated, "1. All entries will be legible and will be properly signed and marked with a time and date where applicable. ... All entries will be authenticated. By authenticating entries, the author has testifies that he/she has reviewed the information and validates its accuracy. 9. Entries may be authenticated by: a. The full signature, including first initial, last name, and discipline designation or, b. Written initials if full signature appears on the same page. c. Date and time of entry must follow the author's identification."</p> <p>4. The facility policy "Medical Record, Required Elements Of", last reviewed 10/14, indicated, "5. Pre and Post Anesthesia Records, when applicable, are to be completed by the anesthesiologist. ... 9. Dictated Operative Record is to be completed by the physician immediately following the procedure."</p>			

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	<p>5. The facility policy "Anesthesia Record", last reviewed 10/14, indicated, "It is the policy of the [facility] that the anesthesia record is to be completed in its entirety in the below stated manner. ...2. On the pre-op visit, the pre-anesthesia evaluation record is completed, including ASA classification."</p> <p>6. The facility policy "Anesthesia Equipment Safety", last reviewed 10/14, indicated, "It is the policy of the [facility] to test the anesthesia equipment for accurate and functional use prior to the administration of anesthesia."</p> <p>7. Medical record #1 indicated a procedure was performed on 05/01/14 and the operative report was dictated on 05/02/14, but not authenticated by the physician until 07/01/14.</p> <p>8. Medical record #7 indicated a procedure was performed on 04/08/15 and the operative report was dictated on 04/08/15, but not authenticated by the physician until 06/10/15.</p> <p>9. Medical record #8 indicated a procedure was performed on 03/16/15, but the Pre-Anesthesia Evaluation Record lacked a time to ensure it was performed prior to surgery.</p>			

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	<p>10. Medical record #9 indicated a procedure was performed on 04/24/15, but the operative report was not dictated until 04/28/15, four days later.</p> <p>11. Medical record #11 indicated a procedure was performed on 04/06/15, but the Pre-Anesthesia Evaluation Record lacked a time to ensure it was performed prior to surgery.</p> <p>12. Medical record #14 indicated a procedure was performed on 03/06/15, but the physician Pre-Anesthesia Evaluation Record lacked a time in the space provided.</p> <p>13. Medical record #15 indicated a procedure was performed on 05/06/15 and the Pre-Anesthesia Evaluation Record lacked a number of the anesthesia machine checked prior to surgery in the space provided. The record also indicated the operative report was dictated on 05/06/15, transcribed on 05/07/15, and dated as authenticated by the physician on 05/06/15, a day before the report would have been available.</p> <p>14. Medical record #17 indicated a procedure was performed on 05/05/15 and the Pre-Anesthesia Evaluation Record lacked a number of the anesthesia machine checked prior to surgery in the</p>			

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	<p>space provided.</p> <p>15. Medical record #19 indicated a procedure was performed on 04/30/15 and the operative report was dictated on 04/30/15, transcribed on 05/03/15, but not dated or timed with the physician authentication.</p> <p>16. Medical record #26 indicated a procedure was performed on 05/06/15 and the Pre-Anesthesia Evaluation Record lacked a number of the anesthesia machine checked prior to surgery in the space provided.</p> <p>17. Medical record #27 indicated a procedure was performed on 04/02/15, but the operative report was not dictated until 04/06/15, four days later.</p> <p>18. Medical record #30 indicated a procedure was performed on 04/30/15 and the Pre-Anesthesia Evaluation Record lacked a number of the anesthesia machine checked prior to surgery in the space provided.</p> <p>19. At 12:40 PM on 07/15/15, staff member #2, the Executive Director, reviewed and confirmed the medical record findings.</p>			

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Q 0183  Bldg. 00	<p>416.48(a)(2) BLOOD AND BLOOD PRODUCTS Blood and blood products must be administered only by physicians or registered nurses Based on policy review, personnel file review, and interview, the facility failed to ensure 7 of 7 registered nurses (RNs) had documentation of competency in blood administration (N1- N7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Blood and Blood Products Administration/Transfusion Reaction", last reviewed 10/14, indicated, "Purpose: To establish protocols of administering blood and blood components safely and effectively. Scope: Registered Nurses. ... A. Blood transfusions will be administered upon written order from a physician."</li> <li>Review of the personnel/training records for registered nurses #N1- N7 lacked documentation of any training/competencies in blood administration.</li> <li>At 2:45 PM on 07/13/15, staff member #2, the Executive Director, indicated blood could be administered at the facility, but the patient was then always transferred to the hospital.</li> </ol>			O 0183	<p>1 All nursing personnel complete blood administration training by 8/28/15 via Net Learning 2 All staff that would participate in the blood administration were included in the training 3 Staff completed Net Learning on Blood Administration, the attached competencies on Blood Administration will be included with our yearly competencies in October, the Blood and blood products administration/transfusion reaction policy was changed to reflect such 4 Staff will be required to complete the Blood Administration competency appropriate for their licensure status, any staff not completing the competency will be reported to the Clinical Director and the Executive Director</p>		08/28/2015

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Q 0241 Bldg. 00	<p>4. At 12:45 PM on 07/15/15, staff member #2 indicated staff from the hospital's blood bank provided some blood administration training a couple of years ago, but he/she did not have any current training/competencies for the nurses.</p> <p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on document review and interview, the center failed to ensure environmental services were provided to ensure the safety and well-being of the patients treated in the facility.</p> <p>Findings included:</p> <p>1. The facility policy "Cleaning of the Operating Room: Daily, Between Patients, and Terminal", last reviewed 10/14, indicated, "The Operating Room staff will perform cleaning of each room everyday in order to create a safe and visibly clean environment for all patients and staff. Scope: Operating Room Staff and Environmental Services. ... 4. Visibly soiled floors should be cleaned after every use. This includes a 3-4 foot perimeter around the surgical field. The</p>	O 0241	<p>1 Cleaning buckets were marked for the appropriate amounts of water (3 gallons) Environmental Services cleaning specifications policy was reflected to such and staff was inserviced on the changes to the policy and the appropriate amounts of water to germicidal detergent to use 2 All staff to be included in the inservice at the September 23rd Staff meeting 3 Inservice to staff on 9/23/15, immediate change of practice with marking of the bucket and announcement to staff of the appropriate amounts of water to germicidal solution 4 Support services team lead is responsible for auditing the mixing of the mop water weekly and reporting to the Clinical Director of any deficiencies</p>	09/23/2015

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	<p>entire floor will be terminally cleaned at the end of the day."</p> <p>2. During the tour of the facility at 11:00 AM on 07/14/15, a mop bucket about half full of a clear solution was observed in the housekeeping closet. A container of Wexcide 128 with a pump dispenser was also observed in the closet. Manufacturer label directions indicated one ounce of the chemical was to be mixed with each gallon of water for proper disinfection.</p> <p>3. At 11:05 AM on 07/14/15, staff member #7, a surgical aide, indicated the mop bucket was mixed each morning, sometimes by surgical staff and sometimes by the housekeeper, to be used between surgical cases. He/she indicated he/she thought the pump dispensed one ounce of the chemical and he/she used 1/2 ounce of the Wexcide for about a half a bucket of water.</p> <p>4. At 11:15 AM on 07/14/15, staff member #8, the housekeeper, indicated he/she had measured the amount of chemical dispensed by the pump and it was one ounce. He/she indicated he/she used two pumps of Wexcide to about a half a bucket of water. He/she indicated the amount of water in the bucket could not be accurately determined, but he/she</p>			

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S 0000 Bldg. 00	<p>thought it was about 3.5 to 4 gallons of water.</p> <p>5. At 11:40 AM on 07/14/15, staff member #9, a surgical tech, indicated he/ahe also mixed up the mop water and used two pumps to about four gallons of water, but the water wasn't measured.</p>	S 0000	Report will be presented to the Operations Committee on November 4th and then to the Board of Managers on November 6th for approval All policy and procedure changes, new forms detailed in this response, will go to the Operations Committee on November 4th and then to the Board of Managers on November 6th for approval All policy and procedure changes will be presented to the staff at the November 11th staff meeting following approval from the Board of Managers	
S 0176 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002781</p> <p>Survey Date: 7/13/2015 through 7/15/2015</p> <p>QA: cjl 08/05/15</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p>			

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	<p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on policy review, personnel file review, and interview, the facility failed to ensure 7 of 7 registered nurses (RNs) had documentation of competency in blood administration (N1- N7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Blood and Blood Products Administration/Transfusion Reaction", last reviewed 10/14, indicated, "Purpose: To establish protocols of administering blood and blood components safely and effectively. Scope: Registered Nurses. ... A. Blood transfusions will be administered upon written order from a physician."</li> <li>Review of the personnel/training records for registered nurses #N1- N7 lacked documentation of any training/competencies in blood administration.</li> <li>At 2:45 PM on 07/13/15, staff member #2, the Executive Director, indicated blood could be administered at the facility, but the patient was then always transferred to the hospital.</li> </ol>	S 0176	<ol style="list-style-type: none"> <li>All nursing personnel complete blood administration training by 8/28/15 via Net Learning</li> <li>All staff that would participate in the blood administration were included in the training</li> <li>Staff completed Net Learning on Blood Administration, the attached competencies on Blood Administration will be included with our yearly competencies in October, the Blood and blood products administration/transfusion reaction policy was changed to reflect such</li> <li>Staff will be required to complete the Blood Administration competency appropriate for their licensure status, any staff not completing the competency will be reported to the Clinical Director and the Executive Director</li> </ol>	08/28/2015

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S 0432 Bldg. 00	<p>4. At 12:45 PM on 07/15/15, staff member #2 indicated staff from the hospital's blood bank provided some blood administration training a couple of years ago, but he/she did not have any current training/competencies for the nurses.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, observation, manufacturer's directions, and interview, the infection control committee failed to ensure environmental services were provided to ensure the safety and well-being of the patients treated in the facility.</p> <p>Findings included:</p> <p>1. The facility policy "Cleaning of the</p>	S 0432	<p>1 Cleaning buckets were marked for the appropriate amounts of water (3 gallons) Environmental Services cleaning specifications policy was reflected to such and staff was inserviced on the changes to the policy and the appropriate amounts of water to germicidal detergent to use 2 All staff to be included in the inservice at the September 23rd Staff meeting 3 Inservice to staff on 9/23/15, immediate change of practice with marking of the</p>	09/23/2015

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	<p>Operating Room: Daily, Between Patients, and Terminal", last reviewed 10/14, indicated, "The Operating Room staff will perform cleaning of each room everyday in order to create a safe and visibly clean environment for all patients and staff. Scope: Operating Room Staff and Environmental Services. ... 4. Visibly soiled floors should be cleaned after every use. This includes a 3-4 foot perimeter around the surgical field. The entire floor will be terminally cleaned at the end of the day."</p> <p>2. During the tour of the facility at 11:00 AM on 07/14/15, a mop bucket about half full of a clear solution was observed in the housekeeping closet. A container of Wexcide 128 with a pump dispenser was also observed in the closet. Manufacturer label directions indicated one ounce of the chemical was to be mixed with each gallon of water for proper disinfection.</p> <p>3. At 11:05 AM on 07/14/15, staff member #7, a surgical aide, indicated the mop bucket was mixed each morning, sometimes by surgical staff and sometimes by the housekeeper, to be used between surgical cases. He/she indicated he/she thought the pump dispensed one ounce of the chemical and he/she used 1/2 ounce of the Wexcide for about a half</p>		<p>bucket and announcement to staff of the appropriate amounts of water to germicidal solution 4 Support services team lead is responsible for auditing the mixing of the mop water weekly and reporting to the Clinical Director of any deficiencies</p>	

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S 0640 Bldg. 00	<p>a bucket of water.</p> <p>4. At 11:15 AM on 07/14/15, staff member #8, the housekeeper, indicated he/she had measured the amount of chemical dispensed by the pump and it was one ounce. He/she indicated he/she used two pumps of Wexcide to about a half a bucket of water. He/she indicated the amount of water in the bucket could not be accurately determined, but he/she thought it was about 3.5 to 4 gallons of water.</p> <p>5. At 11:40 AM on 07/14/15, staff member #9, a surgical tech, indicated he/ahe also mixed up the mop water and used two pumps to about four gallons of water, but the water wasn't measured.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on document review, medical record review, and interview, the facility failed to ensure the medical records were accurate, complete, and authenticated per facility policy for 12 of 30 patient records reviewed (#1, 7, 8, 9, 11, 14, 15, 17, 19,</p>	S 0640	1 On September 14, 2015 a letter (attached) was sent to all Medical Staff regarding the Medical Record deficiencies noted in this report 2 All active Medical Staff were included in the mailing 3 Letter was sent to all active Medical Staff, all findings	09/14/2015

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	<p>26, 27, and 30).</p> <p>Findings included:</p> <p>1. The facility policy "Medical Records, Completion Of", last reviewed 10/14, indicated, "Per State, Federal, and other regulatory agencies, the [facility] must ensure accurate and timely completion of all medical records within thirty (30) days following surgery."</p> <p>2. The facility policy "Medical Record Chart Explanation and Maintenance Of", last reviewed 10/14, indicated, "D. Operative Note: 1. Operative notes are dictated or written in the medical record immediately after surgery and contain a description of the: "</p> <p>3. The facility policy "Authentication of Medical Record Entries", last reviewed 10/14, indicated, "1. All entries will be legible and will be properly signed and marked with a time and date where applicable. ... All entries will be authenticated. By authenticating entries, the author has testifies that he/she has reviewed the information and validates its accuracy. 9. Entries may be authenticated by: a. The full signature, including first initial, last name, and discipline designation or, b. Written initials if full signature appears on the</p>		<p>were reviewed with the Medical Records clerk and with the Medical Records Auditor to monitor for incomplete records for chronic offenders 4 Medical Records clerk will notify the Executive Director and the Medical Director of any deficiencies for one on one discussions with the provider</p>	

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	<p>same page. c. Date and time of entry must follow the author's identification."</p> <p>4. The facility policy "Medical Record, Required Elements Of", last reviewed 10/14, indicated, "5. Pre and Post Anesthesia Records, when applicable, are to be completed by the anesthesiologist. ... 9. Dictated Operative Record is to be completed by the physician immediately following the procedure."</p> <p>5. The facility policy "Anesthesia Record", last reviewed 10/14, indicated, "It is the policy of the [facility] that the anesthesia record is to be completed in its entirety in the below stated manner. ...2. On the pre-op visit, the pre-anesthesia evaluation record is completed, including ASA classification."</p> <p>6. The facility policy "Anesthesia Equipment Safety", last reviewed 10/14, indicated, "It is the policy of the [facility] to test the anesthesia equipment for accurate and functional use prior to the administration of anesthesia."</p> <p>7. Medical record #1 indicated a procedure was performed on 05/01/14 and the operative report was dictated on 05/02/14, but not authenticated by the physician until 07/01/14.</p>			

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	<p>8. Medical record #7 indicated a procedure was performed on 04/08/15 and the operative report was dictated on 04/08/15, but not authenticated by the physician until 06/10/15.</p> <p>9. Medical record #8 indicated a procedure was performed on 03/16/15, but the Pre-Anesthesia Evaluation Record lacked a time to ensure it was performed prior to surgery.</p> <p>10. Medical record #9 indicated a procedure was performed on 04/24/15, but the operative report was not dictated until 04/28/15, four days later.</p> <p>11. Medical record #11 indicated a procedure was performed on 04/06/15, but the Pre-Anesthesia Evaluation Record lacked a time to ensure it was performed prior to surgery.</p> <p>12. Medical record #14 indicated a procedure was performed on 03/06/15, but the physician Pre-Anesthesia Evaluation Record lacked a time in the space provided.</p> <p>13. Medical record #15 indicated a procedure was performed on 05/06/15 and the Pre-Anesthesia Evaluation Record lacked a number of the anesthesia machine checked prior to surgery in the</p>			

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	<p>space provided. The record also indicated the operative report was dictated on 05/06/15, transcribed on 05/07/15, and dated as authenticated by the physician on 05/06/15, a day before the report would have been available.</p> <p>14. Medical record #17 indicated a procedure was performed on 05/05/15 and the Pre-Anesthesia Evaluation Record lacked a number of the anesthesia machine checked prior to surgery in the space provided.</p> <p>15. Medical record #19 indicated a procedure was performed on 04/30/15 and the operative report was dictated on 04/30/15, transcribed on 05/03/15, but not dated or timed with the physician authentication.</p> <p>16. Medical record #26 indicated a procedure was performed on 05/06/15 and the Pre-Anesthesia Evaluation Record lacked a number of the anesthesia machine checked prior to surgery in the space provided.</p> <p>17. Medical record #27 indicated a procedure was performed on 04/02/15, but the operative report was not dictated until 04/06/15, four days later.</p> <p>18. Medical record #30 indicated a</p>			

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S 1146 Bldg. 00	<p>procedure was performed on 04/30/15 and the Pre-Anesthesia Evaluation Record lacked a number of the anesthesia machine checked prior to surgery in the space provided.</p> <p>19. At 12:40 PM on 07/15/15, staff member #2, the Executive Director, reviewed and confirmed the medical record findings.</p> <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 document review and staff interview, the facility failed to ensure the five operating rooms met the required temperatures as defined by the surgery center's policy and AORN (Association of periOperative Registered Nurses) standards.</p> <p>Findings included:</p>	S 1146	<p>1. We have contracted with a Controls Company (OCS, 905 N. Capitol, Indpls, IN 46204) to Calibrate/repair our thermostats For the last two weeks are temperatures have been within range 60% of the time in 4 out of the 5 OR's, the fifth room we are not using until corrected This is up from only 24% of the time at the time of the survey. All rooms</p>	09/30/2015

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	<p>1. Community Surgery Center Howard Temperature and Humidity in the perioperative suite policy (last reviewed January 2015) indicated the operating room temperatures should be maintained between 68 and 73 degrees Fahrenheit. The policy indicated the surgery center follows AORN standards in perioperative settings.</p> <p>2. AORN supports the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines on temperature ranges for perioperative settings. The Operating Rooms temperature range should be between 68 F and 73 F.</p> <p>3. Community Surgery Center Howard has five operating rooms. The temperature/humidity log indicated, "If the readings are out of range, notify Clinical Director or Support Services Manager." The surgery center daily logs evidenced 76% of the recorded temperatures were less than 68 degrees Fahrenheit for the five operating rooms. The recorded documentation did not evidence corrective actions on the five operating rooms for not meeting the required temperature range of 68 to 73 degrees Fahrenheit.</p>		<p>are within 1-2 degrees of the 68 degree low temperature. OCS continues to adjust the units and will replace the thermostats if they cannot consistently be within the 68-73 degree range by September 30th 2 During staff meeting on 9/23/15, staff will review the findings of this survey and instructed to notify the Team Lead of their area and/or the Executive Director of any temperatures that are out of range, reviewed the Temperature log for the OR's and use thereof 3 Reviewed Temperature logs and the use thereof 4 Will monitor via the Temperature logs Clinical Director, Cindy Tudor will be responsible to monitor weekly and report any out of range temperatures to the Executive Director</p>	

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	<p>a. Operating room #1 since the initial recorded date of 6/18/2015; documentation evidenced 12 of 12 recorded temperatures were less than 68 degrees Fahrenheit. The average recorded temperature was 65 degrees Fahrenheit.</p> <p>b. Operating room #2 since the initial recorded date of 6/04/2015; documentation evidenced 13 of 13 recorded temperatures were less than 68 degrees Fahrenheit. The average recorded temperature was 65 degrees Fahrenheit.</p> <p>c. Operating room #3 since the initial recorded date of 3/09/2015; documentation evidenced 9 of 24 recorded temperatures were less than 68 degrees Fahrenheit.</p> <p>d. Operating room #4 since the initial recorded date of 3/26/2015; documentation evidenced 9 of 12 recorded temperatures were less than 68 degrees Fahrenheit. The average recorded temperature was 66 degrees Fahrenheit.</p> <p>e. Operating room #5 since the initial recorded date of 5/07/2015; documentation evidenced 13 of 13 recorded temperatures were less than 68</p>			

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	<p>degrees Fahrenheit. The average recorded temperature was 64 degrees Fahrenheit.</p> <p>4. At 10:30 AM on 7/15/2015, staff member #1 (Director of Nursing) indicated the physicians know what the required range of the operating room temperatures should be; however, the physicians still elect to have the temperature below 68 degrees Fahrenheit. The physicians do not want to sweat and the cooler temperatures in the operating rooms are more comfortable for the patients then 73 degrees Fahrenheit.</p> <p>5. At 11:05 AM on 7/15/2015, staff member #2 (Executive Director) indicated he/she has not required maintenance to adjust the temperature in the operating rooms because the thermostat was operating correctly. The thermostat was adjusted below 68 degrees Fahrenheit per the staff that are using the room for their surgery procedures. Therefore, operating room staff would not report temperature issues.</p>			

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S 1152 Bldg. 00	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(B)</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>(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 staff interview, the facility failed to ensure the 6-month preventive maintenance was performed on the LIFEPAK Defibrillator as required by the surgery center's policy or as recommended by the manufacturer's</p>	S 1152	<p>1. PM was completed on the Lifepak per manufacturers guidelines on 9/14/15 and the PM schedule changed to q6m with the next PM due March of 2016</p> <p>2 Support Services Team lead was remediated on the</p>	09/14/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001109		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/15/2015	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY SURGERY CENTER HOWARD				STREET ADDRESS, CITY, STATE, ZIP CODE 3503 S REED RD KOKOMO, IN 46902			
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	<p>maintenance schedule.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Community Surgery Center Howard Safety and Maintenance policy (last reviewed January 2015) indicated defibrillators should have a 6-month preventive maintenance inspection and the operators are to follow the manufacturer's recommended preventive maintenance schedule.</li> <li>2. The surgery center's defibrillator Operating Instructions has daily, 6-months, and 12-months preventive maintenance schedules. The 6-months preventive maintenance schedule includes: standard paddles monitoring check; standard paddles defibrillation and synchronized cardioversion check on battery pack; therapy cable monitoring check; therapy paddles defibrillation and synchronized cardioversion check on battery pack; and therapy cable pacing check.</li> <li>3. The July Crash Cart Daily Assessment Log evidenced that daily inspections are conducted; however, the daily assessment log did not document that the 6-months manufacturer preventive maintenance checks were also scheduled.</li> </ol>		<p>importance of following the manufacturers recommended guidelines for PM on equipment, PM's for the Lifepak were changed to q6m 3 Initiated change in PM schedule from yearly to q6m 4 PM maintenance will be monitored by Pat Donoghue, Support Services TL</p>				

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	4. At 2:45 PM on 7/14/2015, staff member #2 (Executive Director) indicated the most recent preventive maintenance work order on the LIFEPAK 12 Defibrillator was 9/8/2014. The staff member confirmed the defibrillator's preventive maintenance schedule was every 12 months and the recommended 6-months preventive maintenance was not conducted either by the surgery center staff or the contracted clinical engineers.				