

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/08/2014
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NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 003633</p> <p>Survey Date: 05/07-08/14</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 05/15/14</p>	S000000		
S000104	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(a)(2)</p> <p>The governing body shall do the following:</p> <p>(2) Adopt bylaws and function accordingly.</p> <p>Based on documentation review,</p>	S000104	1 The Governing Board will meet in the month of April,	05/30/2014

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

TITLE

(X6) DATE

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

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S000116	<p>the Governing Board failed to conduct quarterly Governing Board meetings as defined in the Governing Board Bylaws.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Sullivan Surgicenter Operating Agreement (last approved 2/1/2013) stated, "The Governing Board shall meet quarterly." 2. The Sullivan Surgicenter Governing Board held only one meeting in 2013, on July 15. 3. At 2:00 PM on 5/7/2014, staff member #6 confirmed the Governing Board conducts only one meeting per year which was in conflict with the Governing Board Bylaws. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(2)(A-D)</p>		<p>July, October and January as stated in the Operating Agreement Bylaws. 2 Hold quarterly meetings as required by bylaws a calendar will be kept as a reminder system. with dates marked when meetings are to be held. 3. Dr. C. Lim 4. 5/30/14</p>				

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	<p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</p> <p>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on documentation review and staff interview, the Governing Board failed to ensure the CRNA requested privileges were approved.</p> <p>Findings included:</p> <p>1. Sullivan Surgery Center policy, Governing body: Powers and Duties (last reviewed 2/7/13) indicated the governing body was responsible to ensure all physicians and allied health worker's requested privileges are reviewed</p>	S000116	<p>1 Requested privileges will be approved by the Governing Board on new CRNA's, physicians, and anesthesiologists prior to performing any patient care 2 CRNA privileges will be signed and dated by Chief of Surgery. A check list will be implemented to ensure privileges has been approved. 3 Dr. C. Lim 4 5/30/14</p>	05/30/2014	

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S000153	<p>and approved by the Governing Board.</p> <p>2. The CRNA credential files were reviewed. The CRNA's requested privileges were not signed or dated by either the Chief of Surgery or Board of Directors.</p> <p>3. At 2:45 PM on 5/7/14, staff member #1 indicated the surgery center performs a select few surgery cases where the CRNA needs to be present to assist the surgeon. The staff member confirmed the CRNA requested privileges were not signed and approved by the Governing Board.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies</p>						

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	<p>and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on policy and procedure review, employee file review, and interview, the facility failed to ensure the staff member responsible for maintenance, cleaning, and laundry (A4), received facility or job specific orientation.</p> <p>Findings included:</p> <p>1. The facility policy "Infection Control in Environmental Services", last reviewed 05/19/11, indicated, "2. Housekeeping will follow procedures in providing a clean environment to prevent infections in patient rooms, offices, corridors, auxiliary departments and other areas falling within their responsibility. ...Established written procedures shall be followed in special areas such as Surgery, Post Anesthesia Care Unit, etc., in a joint effort between the department head and housekeeping. ...1. Personnel: ...1.2 Orientation to the housekeeping department must include: 1.2.2 cleaning procedures and schedules ...1.1.11 Preparation of agents for sanitizing and/or disinfection. ...2. Housekeeping duties and procedures: 2.1 Regular inspection will be made by the</p>	S000153	<p>1 Job specific orientation will be performed on all new employees and existing employees will be oriented accordingly 2 There will be a job specific orientation document sheet that will be signed and dated by employee and supervisor This sheet will be kept in employee files 3 Dr C Lim 4 5/30/14</p>	05/30/2014
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S000166	<p>Environmental Chief/Housekeeping supervisor to ensure compliance of established procedures."</p> <p>2. The employee file for staff member A4 indicated job descriptions for Maintenance Technician, Sterile Supply Technician, and Housekeeping/Laundry, all signed by the employee and dated 03/08/10. The only orientation document in the file was a form "Evaluation of Orientation/Required In-Services" which was signed by the employee, but not dated, and rated inservices provided. The file lacked any job specific orientation, written cleaning procedures, or any inspections of the services performed by staff member A4.</p> <p>3. At 1:00 PM on 05/08/14, staff member A1 indicated staff member A4 routinely came into the facility on Saturdays and did the laundry and cleaned the facility. He/she confirmed the personnel file lacked documentation of training or orientation and he/she also indicated he/she did not come in to observe the services provided.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I)</p>			

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	<p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(l) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on documentation review and staff interview, the Governing Board failed to ensure 6 policies were reviewed and approved at least triennially.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Sullivan Surgery Center policy, Governing body: Powers and Duties (last reviewed 2/7/13) section 3.4.9 stated, "Requires all services to have policies and procedures that are updated as needed and reviewed at least triennially." After reviewing the surgery center's policies and procedures on 5/7/2014, there were at least 6 policies that were not reviewed within the previous three years: Life and Fire Safety - 11/5/08; Infection Control in 	S000166	<p>1 Policies will be reviewed triennially</p> <p>2 A review sheet will be kept in the front of each policy book and will be dated and initialed by the reviewer The Governing Board will review and update (if needed) all policies and procedures at the next meeting in July 2014</p> <p>3 Dr C Lim</p> <p>4 5/22/2014</p>	05/22/2014

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S000172	<p>Housekeeping/Linen - 2/15/11; Hazardous Materials Management - 2/15/11; Control of Weapons and Firearms on Surgicenter Property - 2/11/11; Events Reports - 2/15/11; and Reporting Adverse Medical Device Incidents - 2/15/11.</p> <p>3. At 3:10 PM on 5/7/2014, staff member #1 indicated he/she initials and dates each individual policy when they have been last reviewed. The staff member confirmed the 6 policies were not reviewed triennially as required.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate</p>			

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	<p>to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on review of product information, employee files review, policy review, and interview, the facility failed to ensure TB testing was performed per policy, manufacturer's recommendations and CDC guidelines for 5 of 6 staff member files reviewed (A1, A2, A3, A4, and A6).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Manufacturer's literature with Aplisol, the solution used for the TB testing, indicated the result of the test was to be read 48 to 72 hours after placement. 2. The employee files for staff members A1, A2, A3, and A6 indicated annual TB tests were placed on 03/04/14 and read on 03/06/14, but no times were documented for either the placement or the reading to ensure compliance with the 48 to 72 hour time frame. 3. The employee file for staff member A4 indicated a positive reaction to the TB test on 02/05/13 and also indicated he/she had a history of being a positive reactor. The file lacked documentation of an annual risk assessment in place of the annual TB test. 	S000172	<p>1 TB testing will include a time and date when performed and read</p> <p>In lieu of an annual tuberculin skin test, employee with a past positive TB test will have an annual risk assessment for the development of symptoms suggestive of tuberculosis</p> <p>2 Documentation will show time and date of TB testing and will be placed in employee file. If TB testing was not performed due to past positive, an annual risk assessment will be performed and will be filed in employee file</p> <p>3 Dr C Lim 4 5/22/14</p>	05/22/2014

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S000310	<p>4. The facility policy "Employee Health-TB Screening", last reviewed 02/15/11, indicated, "4. The results of the intradermal skin test will be read at forty-eight to seventy-two (48- 72) and recorded in milliliters of induration. Documentation must also include date and time given, date read and time, and by whom administered/read. ...10. Employees with a documented history of a positive tuberculin skin test, adequate treatment for the disease, or preventative therapy for infection, shall exempt them from further skin testing. 11. In lieu of a tuberculin skin test, these employees should have an annual risk assessment for the development of symptoms suggestive of tuberculosis."</p> <p>5. At 10:00 AM on 05/08/14, staff member A1 confirmed the personnel findings and indicated the tests should be timed for accurate interpretations.</p> <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>						

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	<p>(1) All services, including services furnished by a contractor. Based on document review and staff interview, the facility failed to ensure 3 services were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Sullivan Surgery Center Quality Assessment and Performance Improvement Plan (last reviewed 2/7/2013) indicated all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. Review of the facility's QA&I program indicated it did not include the services of: Laundry/Linen, Maintenance, and Radiology. At 2:20 PM on 5/7/2014, staff member #1 indicated the 3 hospital services identified through Quality 	S000310	<p>1 QA&I program will be corrected to ensure all required services are included. 2 Laundry and Linen, Maintenance and Radiology will be added to existing QA&I program A spreadsheet will implemented to ensure all QA's are being monitored and evaluated 3 Dr C Lim and M Bedwell 4 06/02/14</p>	06/01/2014

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S000320	<p>Review were not being monitored or evaluated as part of the hospital's comprehensive quality assessment and improvement (QA&I) program.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on documentation review and staff interview, the facility failed to evaluate the function of Response to Patient Emergencies.</p> <p>Findings included:</p>	S000320	<p>1 QA and Performance Improvement Plan will include Response to Patient Emergencies</p> <p>2 Response to Patient Emergencies will be monitored by adding it to QA & I spreadsheet</p> <p>3 Dr C Lim</p> <p>4 06/2/14</p>	06/02/2014

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	<p>1. Sullivan Surgery Center Quality Assessment and Performance Improvement Plan (last reviewed 2/7/2013) indicates all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. The Quality Assurance Committee shall coordinate all activities designed to promote and attain the objectives of the Quality Assurance Plan. The Quality Committee serves as the focal point for integration of the quality activities conducted in the Center. It shall receive sufficient information from all sectors related to patient care and its evaluation to permit intelligent deliberation and to achieve the objectives of the Quality Assurance Plan. The QAPI conducts studies to evaluate the appropriateness of Response to patient emergencies.</p> <p>2. The 4 Quality Assurance Committee meeting minutes in 2013 did not evidence Response to Patient Emergencies was</p>			

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S000328	<p>monitored and evaluated as part of the facility's QAPI program.</p> <p>3. At 2:20 PM on 5/7/2014, staff member #1 indicated the function of Response to Patient Emergencies was not identified through Quality Review or evaluated as part of the hospital's comprehensive quality assessment and improvement (QA&I) program.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on documentation review</p>	S000328	1 Effectiveness, continued follow up and impact on patient care will	06/02/2014			

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	<p>and staff interview, the facility failed to ensure seven (7) services were documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the 2013 quality assurance reports and committee minutes indicated seven services were not documented as to their effectiveness with continued follow-up: Bioengineering, Biohazardous Waste, Housekeeping, Laboratory, Nursing, Pharmacy, and Security. 2. At 2:20 PM on 5/7/2014, staff member #1 confirmed Bioengineering, Biohazardous Waste, Housekeeping, Laboratory, Nursing, Pharmacy, and Security were not documented as to their effectiveness with continued follow-up. 		<p>be added to QA Assessment on all contracted services 2 New spreadsheet will be implemented with the above information added 3 M Bedwell 4 6/02/14</p>		

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S000432	<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 observation, interview, and policy review, the infection control committee failed to ensure the facility staff and the housekeeping staff used the proper cleaning products according to manufacturer instructions and adequately cleaned all patient care areas.</p> <p>Findings included:</p> <p>1. During the tour of the pre/post area at 2:15 PM on 05/07/14, accompanied by staff member A1, the following observations were made:</p> <p>A. Pre-op room 208- dusty table and dirty toilet and sink in the patient bathroom.</p> <p>B. Pre/post room 212- dusty ledges and window sills, dirty sink in patient bathroom.</p>	S000432	<p>1 Manufacturer instructions will be followed and adequate cleaning will be performed on facility 2 There will be a housekeeping check list and areas will be signed off on to ensure that all areas are cleaned adequately We have ordered Clear Lemon disinfectant for mopping floors in the Operating Suites and patient treatment areas 3 Dr C Lim 4 6/02/14</p>	06/02/2014			

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	<p>2. At 2:20 PM on 05/07/14, staff member A1 indicated the nurse cleaned any patient equipment and the bed after the patient was discharged, but the rest of the room cleaning, including the bathroom, was the responsibility of the housekeeping staff member that only cleaned on Saturdays.</p> <p>3. During the tour of the surgical area at 3:20 PM on 05/07/14, accompanied by staff member A3, the shelves containing the wrapped sterile packs were observed with a heavy layer of dust.</p> <p>4. At 3:30 PM on 05/07/14, staff member A3 indicated he/she cleans the operative suites, but not the storage areas. He/she indicated he/she mixes 100 milliliters of CitriGuard II with each gallon of water to mop the floors in the surgical areas. The manufacturer's label on the CitriGuard indicated the product was ready-to-use and did not list any dilution instructions. Staff member A3 also indicated he/she mixed three pumps of Empower Cleaner to about 2000 milliliters of water to clean the instruments. The manufacturer's label on the Empower Cleaner indicated one ounce of solution should be mixed with each gallon of water to clean the instruments.</p>			

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	<p>5. During the tour of the third floor procedure room at 12:20 PM on 05/08/14, accompanied by staff members A1, A3, and A6, the ledges, windowsill, and backs of equipment were observed dirty and dusty, with dead insects on the windowsill.</p> <p>6. The facility policy "Infection Control in Surgery", last reviewed 02/07/13, indicated, "1.10 Cleaning Between Cases: ...1.10.3 Wet mop floors with disinfectant solution. ...1.12 Monthly Cleaning: 1.12.1 Shelves, cupboards, closets, ceilings, and light tracks shall be cleaned monthly by housekeeping."</p> <p>7. The facility policy "Infection Control in Environmental Services", last reviewed 05/19/11, indicated, "1. The Surgicenter environment shall be maintained in a clean and sanitary condition ...2. Housekeeping will follow procedures in providing a clean environment to prevent infections in patient rooms, offices, corridors, auxiliary departments and other areas falling within their responsibility. This shall be implemented through cleaning and disinfection. Established written procedures shall be followed in special areas such as Surgery, Post Anesthesia Care Unit, etc., in a joint effort between the department head and housekeeping.</p>			

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	<p>...1.2 Orientation to the housekeeping department must include: ...1.2.2 Cleaning procedures and schedules</p> <p>1.2.11 Preparation of agents for sanitizing and/or disinfection ...5.1 Hospital approved disinfectant shall be used as effective wiping and mopping agents against gram negative and gram positive organisms. ...5.5 Damp clean or wipe with a germicidal solution: 5.5.1 Chairs, tops of bedside cabinets, lamps, tops with over bed trays, exposed areas of patient's beds, electrical cords, kick plates, foot stools, window sills, low vents, and other low level ledges. ...5.8 Clean and sanitize patients' washrooms and bathrooms."</p> <p>8. The facility policy "Quality Assurance in Central Supply", last reviewed 05/19/11, indicated, "1. Housekeeping personnel will be assigned to central supply to assist in the regular and routine housekeeping duties. ...1.3 Monthly disinfection of all cabinets and storage shelves is performed and recorded."</p> <p>9. The facility policy "Infection Control in Central Supply", last reviewed 05/19/11, indicated, "2.3 Work areas and furnishing must be cleaned daily with a disinfectant at the end of work period. ...7.5 ...Sterile packs should be placed in dust free closed storage areas or dust</p>			

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S000526	<p>cover plastic bags."</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on policy review, employee file review, and interview, the facility failed to ensure 2 of 2 registered nurses (A1 and A5), who performed out-of-lab testing on patients of the center, had annual competency for the testing.</p> <p>Findings included:</p> <p>1. The facility policy "Competency Assessment Program in Nursing Service", last reviewed 02/07/13, indicated, "All members of the nursing staff will be competent to perform their job responsibilities. All completed employee competency documents are maintained in the individual employee file in Personnel. ...Competence is measured through licensure, annual performance evaluations using the competency-based job descriptions, and periodic clinical competency assessments of the nursing staff."</p>	S000526	<p>1 Competency test and check off has been implemented for blood sugar testing This will be an annual test for all nurses A new policy will be written on glucometer and blood sugar testing Policy will be completed by May 29, 2014</p> <p>2 The competency test documentation and check off will be kept in nurse file</p> <p>3 Dr C Lim</p> <p>4 5/13/14</p>	05/13/2014

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S000772	<p>2. The personnel file for RN (registered nurse) A1, hired 03/23/10, lacked any competency for patient blood sugar testing with the glucometer.</p> <p>3. The personnel file for RN A5, hired 03/23/10, lacked any competency for patient blood sugar testing with the glucometer.</p> <p>4. At 4:20 PM on 05/07/14, staff member A1 confirmed the facility did not conduct glucometer competency for the nurses who performed the testing on patients of the center.</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>						

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	<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 policy review, medical record review, and interview, the facility failed to ensure a history and physical was completed according to policy and on the chart for 5 of 30 medical records reviewed (N17, N19, N23, N26, and N28).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "History and Physical", last reviewed 05/19/11, indicated, "Every medical record shall contain a history and physical examination completed immediately upon admission to the Surgicenter. 1. A history and physical shall contain the following: ...1.6 Review of systems 1.7 Physical examination." The history and physical for patient N17, admitted 03/28/14, lacked a review of systems, including cardiac and 	S000772	<ol style="list-style-type: none"> History and Physical will be performed prior to surgery on all patients A nurse will double check to ensure H&P is performed before transferring patient to procedure room Dr. C. Lim & M. Bedwell 05/22/14 	05/22/2014			

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S001026	<p>respiratory functions.</p> <p>3. The history and physical for patient N19, admitted 12/26/13, lacked a review of systems, including cardiac and respiratory functions.</p> <p>4. The history and physical for patient N23, admitted 12/20/13, lacked a review of systems, including cardiac and respiratory functions.</p> <p>5. The history and physical for patient N26, admitted 01/03/14, lacked a review of systems, including cardiac and respiratory functions.</p> <p>6. The history and physical for patient N28, admitted 03/28/14, lacked a review of systems, including cardiac and respiratory functions.</p> <p>7. At 2:15 PM on 05/08/14, staff member A1 confirmed the medical record findings and confirmed the history and physicals were incomplete.</p> <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</p>						

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	<p>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, policy review, and interview, the facility failed to ensure all medications were secured and only accessible to authorized personnel.</p> <p>Findings included:</p> <p>1. During the tour of the third floor procedure room at 12:20 PM on 05/08/14, accompanied by staff members A1, A3, and A6, various medications, Lidocaine, Sodium Bicarbonate, and Marcaine, were observed unsecured in a cabinet in the room. The cabinet did not have any locking capabilities and the room was open and unattended upon entry.</p> <p>2. The facility policy "Drug Control System", last reviewed 05/19/11, indicated, "The Pharmacy Storage Room</p>	S001026	<p>1 Medication cabinet on 3rd floor procedure room.. lock will be placed on cabinet doors by maintenance by May 20, 2014 The key for this cabinet will be kept with the keys for pharmacy on the 2nd floor 2 It will be locked when not monitored by nurse or doctor 3 Dr C Lim and M Bedwell 4 5/20/14</p>	05/20/2014

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S001146	<p>will be maintained by the Administrator, Director of Nursing, or other RN appointed by the Administrator and/or the Director of Nursing. 1. The Pharmacy Storage Room is located in Room 219 on the 2nd floor. 2. Designated nurses will have a key to the Room and will be given the key at the beginning of the shift and will return the key at the end of the shift."</p> <p>3. At 12:30 PM on 05/08/14, staff members A1 and A6 acknowledged the procedure room and medications would be accessible to the maintenance and cleaning staff members and the facility policy did not address the medications stored in that room.</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</p>			

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	<p>employees. Based on observation, policy review, document review, and interview, the facility failed to maintain the hospital environment in a sanitary condition for one (1) instance: 3rd floor Medical Records Room and failed to ensure a safe environment for patients with regard to warmed fluids.</p> <p>Findings included:</p> <p>1. At 10:00 AM on 5/8/2014, the 3rd floor medical record's file room was inspected. The room was observed with two large windows and the inside window panes were observed with the wall plaster crumbling and deterioration on inside window panes. Heavy accumulation of plaster dust was observed on the inside window sills and the metal file storage racks within the room.2. During the tour of the facility at 2:15 PM on 05/07/14, accompanied by staff member A1, the Amsco Warmer was observed with one 1000 ml.</p>	S001146	<p>1 The Medical Records Room has had repairs completed and the shelves were cleaned. The warmer temperature is being monitored and all liquids have been removed A policy was written that blanket warmer temperature will not exceed 130 degrees Fahrenheit. 2 Spreadsheet will be used to monitor temperature of blanket warmer. The Medical Records Room will be checked for cleanliness weekly 3 Dr. C Lim 4 5/14/14</p>	05/14/2014	

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	<p>(milliliter) bag of Lactated Ringers intravenous solution, four 250 ml. containers of normal saline irrigation solution, containers of ultrasound gel, containers of Hibiclens solution, and blankets. The temperature of the warmer was unable to be determined because the control only indicated "low, medium, high".</p> <p>3. AORN (Association of periOperative Registered Nurses) recommendations indicated both fluid and blanket warmers should be monitored regularly with blanket cabinets not above 130 degrees F. and fluids warmed and stored according to manufacturer guidelines.</p> <p>4. At 10:30 AM on 05/08/14, staff member A1 confirmed the facility followed AORN recommendations, but did not have a policy regarding the warmers. He/she indicated they did not have the manufacturer directions regarding warming and storing the fluids.</p>			

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S001148	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(A)</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 plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals must be available, along with training or instruction, or both, of the appropriate center personnel, in the maintenance and operation of fixed and movable equipment.</p> <p>Based on documentation review and staff interview, the facility failed to ensure routine preventive maintenance was performed on the facility's washer and dryer.</p> <p>Findings included:</p> <p>1. Sullivan Surgery Center policy, Governing body: Powers and Duties (Last reviewed 2/7/13)</p>	S001148	<p>1 Maintenance dept will perform preventative maintenance on the washer and dryer according to manufacturer guidelines 2 An inspection log will be kept with the date, equipment and part inspected check washer hose, cords, and water lineshot water heater and tempdyer, check filter, electrical cords, and belt 3 Maintenance Dept Supervisor 4 5/30/14</p>	05/30/2014

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	<p>section 3.4.16 indicated the governing body was responsible to development, implement and monitor safety management program to include periodic equipment inspections.</p> <p>2. Automatic Washers user manufacturer instructions require preventive maintenance which includes: replace hoses annually; check the filter screens; etc.</p> <p>3. The surgery center has 2 washers and 2 dryers that launder the scrubs, linen, etc for the facility. Neither the washers nor the dryers are on a scheduled routine preventive maintenance program.</p> <p>4. At 11:15 AM on 5/8/2014, staff member #1 indicated the washer and dryers are used to launder scrubs, linen, etc. The washers and dryers have never had a preventive maintenance performed on them.</p>			

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S001182	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based on documentation review and staff interview, the facility failed to ensure there was an ongoing center-wide process to evaluate and collect information about hazards and safety practices.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of safety committee minutes and quality assurance committee minutes evidenced the facility does not have a mechanism to evaluate safety practices of the facility. At 2:30 PM on 5/8/2014, staff member #1 indicated the surgery center does not have any safety walk throughs which evaluate the 	S001182	<p>1 Implement system to evaluate safety practices of the facility and conduct a safety walk through 2 Safety Checklist will be implemented to ensure this is being performed will be performed days of operation. 3 Dr C Lim and Maintenance Dept 4 5/30/14</p>	05/30/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/08/2014
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882		
(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	
	ongoing safety practices of the facility.				