

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/08/2013
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NAME OF PROVIDER OR SUPPLIER ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 012278</p> <p>Survey Date: 8/6/2013 through 8/7/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 08/21/13</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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S000110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on documentation review and staff interview, the Governing Board failed to meet quarterly as per Governing Board Bylaws for the 1st and 2nd quarter of 2013.</p> <p>Findings included:</p> <p>1. The Governing Board Bylaws (last recorded approval of the bylaws were July 1, 2011) Article I states, "Meetings of the Governing Board shall be held as often as required but no less frequently than once per calendar quarter. All actions of the Governing Board shall be recorded and maintained in minutes of the meeting."</p>	S000110	<p>Deficiency will be corrected by scheduling dates for the Governing Board quarterly meetings annually and notify the members of the scheduled meeting at the beginning of each calendar year, with reminders announced at each meeting for the next meeting Minutes of all actions will be taken and recorded at each quarterly meeting and will be presented to the Governing Board at the following quarterly meeting for approval and/or corrections to the minutes. Copies of the minutes will be maintained. Deficiency will be prevented in the future by ensuring that meetings are held on a consistent meeting date of the last Wednesday of the third month of each quarter (i.e. March, June, September, December) and time (5:30pm) will be discussed and approved by the Governing Board at the next quarterly meeting. The approved</p>	09/06/2013	

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	<p>2. The facility only provided the following Governing Board Meeting minutes for the previous 2 years: 3/29/12, 7/30/12, 9/30/12, and 12/30/12. The facility did not provided any meetings for 2013.</p> <p>3. At 1:15 PM on 8/6/2013, staff member #3 indicated the Governing Board met informal in 2013, but never recorded the actions of the informal meetings. One of the actions was to re-approved the Governing Board Bylaws and it was done on 5/21/2013. However, the minutes of the meeting were never recorded. The staff member confirmed the facility does not have any minutes or notes of the meetings that were held for the first 2 quarters of 2013.</p>		<p>schedule will be implemented for calendar year 2014. Centers Practice Administrator Mitch Couvillion, Board Member and Center employee is assigned the responsibility of recording and maintaining meeting minutes. Mitch Couvillion is responsible for correcting deficiency and ensuring that deficiency does not reoccur. The Governing Board will meet September 6, 2013 at 5:30 pm. At this meeting, the Center's ISDH survey of 8/8/2013 will be reviewed and the Center's plan of correction will be reviewed. In addition, regular Center business will be reviewed and Board Members will approve the date for the last quarterly meeting to be held in December, 2013 and meeting dates/times for mandatory board meeting to be held in 2014 will be established.</p>		

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S000153	<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 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 personnel file review, and interview, the facility failed to ensure 3 of 4 staff members hired in February 2013, (#N4, N5, and N6), and 1 of 1 contracted cleaning staff member (#N10), received facility or job specific orientation.</p> <p>Findings included:</p> <p>1. The personnel file for staff member #N4 indicated an Orientation Record from 02/05/13 that was incomplete and not signed by a preceptor or other facility staff member. The file lacked documentation of specific center orientation.</p> <p>2. The personnel file for staff member #N5 indicated an Orientation Record from 02/05/13 that was incomplete and not signed by a preceptor or other facility staff member. The file lacked</p>	S000153	<p>Nursing Administrator Heather Cox, RN will ensure that deficiency is corrected by 9/9/2013. Ms. Cox has reviewed all Center personnel files and has identified those gaps in training that must be corrected. A Center-wide orientation meeting occurred 9/04/2013 with 6 staff members in attendance. Two employees that were unable to attend the 9/4/2013 meeting will meet with Ms. Cox on Monday, 9/09/2013. Center employees are participating in these orientation meetings regardless of whether or not Center has a complete orientation already in their personnel file. Ms. Cox met with a representative of the contracted cleaning service on 8/19/2013 to conduct orientation training. This will ensure that the employees listed in survey such as N4, N5, A12, A1and contracted cleaning staff will have the necessary orientation and this orientation will be documented accordingly. To prevent a repeat</p>	09/09/2013			

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	<p>documentation of specific center orientation.</p> <p>3. The personnel file for staff member #N6 indicated an Orientation Record from 02/19/13 that was incomplete and not signed by a preceptor or other facility staff member. The file lacked documentation of specific center orientation.</p> <p>4. At 1:45 PM on 08/07/13, staff member #A12 confirmed the personnel file findings and indicated he/she did not have any file or training documentation for the contracted cleaning staff member #N10.</p> <p>5. At 4:00 PM on 08/07/13, staff member #A1 indicated he/she was not aware of any orientation or training of the cleaning staff unless it was done by the previous nurse administrator and did not have any documentation of this.</p>		<p>of this deficiency, all required employee educational events including job orientation, job performance appraisals, life safety training and staff meetings will be placed on a master training and meeting calendar and this calendar will be posted and emailed to each staff member. In addition, Center's new-hire checklist has been reviewed and updated. This checklist mandates that job orientations are complete and documented the first day of employment for new staff members. Because the Governing Board is ultimately responsible for ensuring that all employees are properly trained and orientation is documented, Ms. Cox will include a brief summary of the status of all Center staff regarding job orientation and staff education.</p>		

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S000162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on policy review, personnel file review, and interview, the facility failed to ensure all nurses had current BCLS (Basic Cardiac Life Support) and ACLS (Advanced Cardiac Life Support) as required for 1 of 3 RNs (Registered Nurses) (#N7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Departmental Organization- Staffing Guidelines and Acuity Measurement", approved July 1, 2011, indicated, "All Center personnel will be certified in Basic Cardiac Life Support. All nursing personnel are required to be ACLS certified." The personnel file for PACU (Post Anesthesia Care Unit) RN, staff member #N7, hired 02/21/13, indicated his/her 	S000162	Center's President and Medical Director, Mahendra Sanapati, MD, Nursing Administrator Heather Cox, RN, and Center's Administrator, Mitch Couvillion, MHA reviewed the circumstances of the Center's deficiency regarding current BCLS and ACLS certification requirements for RNs. The RN in question, referred in survey report as RN, staff member #N7 was terminated by Center effective 8/13/2013. A replacement RN, Jessica Meadors has accepted an employment offer by Center. Her effective start date is September, 9, 2013 and Center has verified her current status regarding BCLS and ACLS. Center will contract with Medical Staffing Solutions of Evansville to provide RN coverage for Center if additional RN staffing is needed.. Medical Staffing Solutions will provide Indiana	09/06/2013			

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	<p>BCLS expired 03/13 and his/her ACLS expired 02/11.</p> <p>3. At 11:00 AM on 08/06/13, staff member #A3 indicated all nurses at the facility were ACLS certified.</p> <p>4. At 1:45 PM on 08/07/13, staff member #A12 confirmed the personnel file findings.</p> <p>5. At 3:15 PM on 08/07/13, staff member #N7 indicated he/she was trying to get a class scheduled. Both staff members #A1 and A3 indicated they were not aware of the expired certifications.</p>		<p>licensed and currently certified BCLS and ACLS RN contract personnel as required by Center. Nursing Administrator Heather Cox will review personnel files to ensure that all Center personnel have the current licensing required to comply with Center and State of Indiana licensure requirements. The Center's previous Nursing Administrator had been designated as the Center employee responsible for ensuring that all Center personnel had met the Center and State of Indiana's licensure requirements. Ms. Cox assumed the Nursing Administrator's role shortly before the survey was conducted. Ms. Cox has assumed the responsibility for correcting this deficiency and as Center's Nursing Administrator, she will be responsible for preventing this deficiency from re-occurring.</p>		

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S000172	<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 to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on documentation review and staff interview, the facility failed to ensure Radiation Exposure Review Records are placed in 3 of 3 Radiology Technicians Employee Health Files as per policy (#4, 6 and 13).</p> <p>Findings included:</p> <p>1. Radiographic Dosimeter Badges policy (Last approved July 1, 2011) states, "A Radiation Exposure Review Record will be completed and placed in the Employee Health file."</p>	S000172	<p>Deficiency will be addressed by Center's Administrator and Radiation Safety Officer Mitch Couvillion and Nursing Administrator and Health Nurse, Heather Cox, RN. While radiation exposure reports have been documented and stored in Center's Radiation Safety Binder, those individual Radiation Exposure Review Records were not forwarded to Ms. Cox. Ms. Cox maintains Employee Health Personnel Files for each employee. These files contain all relevant employee health information for each staff member such as the employee's TB testing records. Because Center has only used one contracted vendor (Landauer, Inc.), all employees exposed to</p>	09/06/2013			

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	<p>2. Surgery Center's Employee health files were reviewed for three Radiology Technicians: #4, 6 and 13. The three employee health files did not evidence Radiation Exposure Review Records.</p> <p>3. At 2:30 PM on 8/7/2013, staff member #6 confirmed the Radiation Exposure Review Records were not part of the Radiology Technicians' health files.</p>		<p>radiation through Center's Radiation Program have radiation exposure tracked through Center's Radiation Exposure Monitoring Plan and documented through Landauer's Radiation Dosimetry Reports. These reports include the current period tracked (monthly) and also include "Quarter to Date", "Year to Date" and "Lifetime to Date" totals for each employee. The Landauer Radiation Dosimetry Reports will be evaluated and Center has an internal tracking form titled "Advanced Ambulatory Surgery Center Employee Radiation Exposure Review" to be completed by Center's Radiation Safety Officer. This report takes the Launauer reports and provides an individualized tracking form for each staff member. Mr. Couvillion and Ms. Cox will ensure that deficiency will not be repeated by completing individual Employee Radiation Exposure Review reports for each employee and placing these reports in each employee's Employee Health File on a Quarterly basis. The Landauer reports will continue to be maintained in Center's Radiation Safety Binder.</p>		

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S000300	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>Based on documentation review and staff interview, the facility failed to ensure the Continuous Quality Improvement Committee (CQI) met quarterly as defined in the Continuous Quality Improvement Program for the years 2012 and 2013.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Continuous Quality Improvement Program (Last approved July 1, 2011) stated, "CQI meetings will be held quarterly and documentation will be maintained." 2. The CQI committee minutes 	S000300	<p>Deficiency will be corrected by scheduling Continuous Quality Improvement Committee (CQI) meeting to mirror the Governing Board quarterly meetings. CQI meetings will be announced annually and the members of the CQI committee will be notified at the beginning of each calendar year, with reminders announced at each meeting for the next meeting. Minutes of all actions of the CQI committee will be recorded and will be presented to the Governing Board before the Governing Board meets. Copies of the minutes will be maintained. Deficiency will be prevented in the future by ensuring that like Governing Board meetings, CQI meetings are held on a consistent meeting date of the last Wednesday of the third month of each quarter (i.e. March, June, September, December) and time (5:00 pm). The approved CQI schedule will be implemented for calendar year</p>	10/18/2013			

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S000310	<p>were provided by staff member #3. The minutes revealed 6 meetings for 2011; however, the facility did not provide documentation that meetings were held for the 4 quarters of 2012 and the first 2 quarters of 2013.</p> <p>3. At 1:00 PM on 8/6/2013, staff member confirmed the facility does not have CQI meeting minutes for 2012 and 2013.</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> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and staff interview, the facility failed to ensure 8 services provided by the contractors and 3 internal services were part of its comprehensive quality assessment and improvement (QA&I)</p>	S000310	<p>2014. Center's Practice Administrator Mitch Couvillion, Board Member and CQI member is assigned the responsibility of recording and maintaining meeting minutes. Mr. Couvillion is responsible for correcting deficiency and ensuring that deficiency does not reoccur. The CQI committee will meet September 20, 2013 at 5:00 pm. At this meeting, the Center's ISDH survey of 9/20/2013 will be reviewed and CQI members will review all relevant CQI reports for FY 2013 and will approve the date for the last quarterly meeting to be held in December, 2013.</p> <p>Center will review, document, and report the results of all services with direct or indirect patient care as part of Center's Continuous Quality Improvement (CQI) program. Eight external and three internal services identified by ISDH surveyors that have direct or indirect impact on patient care quality will be assessed for</p>	10/16/2013			

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	<p>program: Biohazard Waste, Biomedical, Housekeeping, Laboratory, Maintenance, Medical Records, Nursing, Pharmacy, Radiology, Security, and Transcription.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Continuous Quality Improvement (CQI) Program (Last approved July 1, 2011) indicates all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. 2. Contract Service Agreement policy (Last approved 7/1/2011) notes that the facility will monitor all contracted ancillary services for quality of services in relations to the terms of the contract and patient outcomes. Documentation will be maintained regarding the monitoring. A Contractor/Vendor Evaluation form must be completed and provided to the Governing Board the evaluation 		<p>suitability, credibility and accreditation will be reviewed. These are the services identified by ISDH surveyors that were not assessed and monitored properly leading to Center's survey deficiency under ID Prefix Tag: S 310. Ancillary contracted services will be monitored in relation to the terms of the contract/service agreement between Center and service provider in relation to the terms of the contract/service agreement and patient outcomes. Documentation of how the services is meeting the requirements and the quality of services will be assessed at least annually. Deficiency reoccurrence will be prevented in the future by establishing a binder of all contracts and agreements, including attachments such as required insurance coverage by service provider and documentation by Center to ensure that service providers have been cleared by OIG Sanction database and EPLS database. As new services and/or service contractors are proposed, references from previous clients will be required and verified as deemed necessary. All existing contracts will be reviewed at least annually to verify current licensures, certifications and accreditations. Center will determine which licensures, certifications and accreditations of service providers are due for renewal before the next</p>		

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	<p>of the service that was provided.</p> <p>3. After the review of the Contractor/Vendor Evaluation forms and the CQI committee minutes for 2012 and 2013, there were 8 services provided by the contractors and 3 internal services that were not being monitored by the CQI committee. The 11 services were: Biohazard Waste, Biomedical, Housekeeping, Laboratory, Maintenance, Medical Records, Nursing, Pharmacy, Radiology, Security, and Transcription.</p> <p>4. At 2:30 PM on 8/6/2013, staff member #3 confirmed the 8 contracted services and the 3 internal services identified were not monitored and evaluated by the CQI committee. The staff member indicated the Governing Board selects the Quality Improvement Projects each year and the facility only monitors and evaluates the selected projects. The Governing Board selected 2</p>		<p>scheduled contract review period and will take steps to ensure that licensures, certifications and accreditations are not expired while service provider is providing services to Center. Business Associate Agreements and/or confidentiality agreements will be required and executed with all vendors and renewed yearly. Administrator will submit evaluations and seek input from key Center employees such as Center's Nursing Administrator before completing evaluations and submitting recommendations to Center's Governing Board. Center Administrator will be responsible for correcting and preventing the cited deficiency and will report the results of CQI monitoring of contracted services to the CQI Committee and these reports will then be forwarded to the Governing Board. Mr. Couvillion will have the reports ready for the scheduled 9/20/2013 CQI meeting.</p>				

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	<p>1. The CQI committee minutes were provided by staff member #3. The minutes revealed 6 meetings for 2011; however, the facility did not provided documentation that meetings were held for the 4 quarters of 2012 and the first 2 quarters of 2013. The data staff member #3 provided did not identify Discharge and Transfer functions were being evaluated.</p> <p>2. At 1:00 PM on 8/6/2013, staff member #3 confirmed Discharge and Transfer functions were not being evaluated by the CQI committee.</p>		<p>by a Deann L. Schoenfield, contracted RHIA. Ms. Schoenfield conducts quarterly audits of Center medical records.*Peer Chart Review - Anesthesia audits conducted by Center's peer review committee (Yusef Rashada, MD)The findings of these reviews are to be forwarded to Center's CQI committee on a quarterly basis. Ms. Cox and Mr. Couvillion have reviewed Center's CQI program and found that these audits were not complete for 2013. In addition, the monthly internal chart audits for Q1, 2013 did not find the deficiencies in Center's Discharge and Transfer patient care functions and were not properly forwarded to Center's CQI committee. The internal chart audits were not maintained with Center's CQI reports and therefore were not presented to ISDH surveyors during the survey. Center has found that staff conducting the internal chart audits were not properly trained by Center's previous Nursing Administrator and that Center failed to forward chart audit findings to Center's CQI committee in a timely manner.Center Administrator, Mr. Couvillion, will be responsible for ensuring that Discharge and Transfer patient care functions are being reviewed and these findings will be forwarded to Center's CQI committee. The results of these findings will be</p>		

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			included in Center's CQI meeting minutes with the completed chart review worksheets. Center Administrator Mitch Couvillion did find the complete set of 2012 CQI meeting minutes with the correct and appropriate CQI reports such as "Retrospective Medical Review" checklists and the Center's completed CQI monthly summaries. The 2012 CQI book was not labeled properly and therefore was not produced for the ISDH surveyors at the time of the survey. Therefore, Center is not disputing cited deficiency regarding 2012 documentation but Center Administrator Mitch Couvillion felt an explanation was necessary. Deficiency will be prevented from recurrence by an ongoing review and update of Center's entire CQI program. Chart audits are underway for 2013 including another review of Q1 charts, additional staff training and Center's contracted RHIA, Ms. Schoenfield and Yusef Rashada are scheduled to be complete Q1 and Q2, 2013 by 10/16/2013.	

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S000414	<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 facility document review and interview, the facility failed to ensure the infection control committee met quarterly to ensure all aspects of the Infection Control Program were reviewed.</p> <p>Findings included:</p> <p>1. Review of the Infection Control Meeting minutes with the infection</p>	S000414	Deficiency will be corrected by scheduling Infection Control meetings the same day that Governing Board, Medical Executive, CQI, Safety and other committee meetings take place. Infection control committee members will include Nursing Administrator Heather Cox, RN as committee chairman, and Center Administrator Mitch Couvillion and President and Medical Director Mahendra Sanapati, MD as fellow	09/06/2013

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	<p>control nurse, staff member #A1, failed to indicated any meeting minutes after 12/28/12.</p> <p>2. At 2:15 PM on 08/06/13, staff member #A1 indicated there had not been any official meetings in 2013 and indicated the prior nursing administrator made changes and handled infection control issues without his/her knowledge or committee agreement.</p>		<p>committee members. Ms. Cox is responsible for the overall direction and implementation of Center's Infection Control Plan. This includes documentation and reporting of Infection Control plan activities and preparation of Infection Control committee meeting minutes. After a review of this deficiency, it was determined that Center's previous Nursing Administrator had made changes to Center's Infection Control program without notifying Ms. Cox, Center's Infection Preventionist. Center's previous Nursing Administrator is no longer employed by Center and Ms. Cox is now the Center's Nursing Administrator. Ms. Cox is currently reviewing Center's Infection Control plan and identifying and correcting any deficiencies. No changes to Center's Infection Control plan will be allowed without Ms. Cox's input. Center staff will be educated about Infection Control plan during staff meetings scheduled 9/4/2013 and 9/9/2013. Education will include a review of this deficiency and the process to which changes to Center's Infection Control plan are implemented. This will prevent a reoccurrence of changes to Center's Infection Control Plan being made without Ms. Cox or other Infection Control Committee Members being notified. Ms. Cox will lead an Infection Control Meeting on</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, policy review, facility document review, and interview, the infection control committee failed to ensure the facility was cleaned according to policy and the contracted housekeeping staff used the proper cleaning products according to manufacturer instructions.</p> <p>Findings included:</p> <p>1. During the tour of the surgical area at 1:00 PM on 08/06/13, accompanied by staff member #A1, a container of Cavicide ready-to-use disinfectant, with an open date of 10/12/11, was observed in the housekeeping closet. A sign on the door indicated, "Dilute 5 oz. of</p>	S000432	<p>9/20/2013 and will report on the correction of this deficiency and other matters relating to Infection Control.</p> <p>Deficiency was reviewed by Nursing Administrator Heather Cox, RN. Ms. Cox is responsible for correcting deficiencies cited in Tag S 432. Ms. Cox is Center's Nursing Administrator and Center's Infection Control Preventionist.1 and 2. Cavicide cited in deficiency was removed from Center and replaced with new container of Cavicide. This Cavicide is within its expiration date as per Center policy.3. and 4. Only Cavicide is being used in restricted area. Center has approved the contracted cleaning service, Hasgoe, for use in unrestricted areas. Center's policy that states "Terminal end of day cleaning will be performed by the (facility) staff" has been amended to read that Hasgoe is</p>	08/29/2013			

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	<p>Cavicide with 5 liters of water for floor cleaning in between cases and at the end of the day."</p> <p>2. At 1:00 PM on 08/06/13, staff member #A1 indicated he/she was not aware of what the housekeeping staff used to clean or why the container was still there after 2 years. He/she indicated the contracted cleaning service mopped the floors when they performed the terminal cleaning. He/she also indicated Cavicide was the approved chemical for use in the facility.</p> <p>3. The facility policy "Environmental Controls, Cleaning Operating Room", approved July 1, 2011, indicated, "4. AASC approved solutions are: i. Dispatch ...ii. Cavicide ...6. Terminal end of day cleaning will be performed by the [facility] staff."</p> <p>4. Review of the Infection Control Meeting Minutes from 01/15/12, indicated, "Effective January 30, 2012, the ASC personnel will be responsible for all housekeeping duties. ...We will be using the Cavicide throughout the facility on the floors and walls, Dispatch on all equipment and surfaces." The meeting minutes from 02/15/12, 03/14/12, 04/14/12, 05/11/12, 06/29/12, 09/28/12, and 12/28/12 all had the entry</p>		<p>responsible for Terminal cleaning at end of day and Center staff is responsible for cleaning patient care items between patients. 5. As mentioned in items 1 and 2, contracted cleaning service chemicals HDQ C2 and DMQ have been approved for use by Center. Contracted cleaning service is following manufacturer's directions in regards to use of DMQ bottle. Ms. Cox has provided training to contracted cleaning service to ensure that manufacturer's directions are being adhered to. All changes to Center's Infection Control program and the response to this particular deficiency have been documented by Ms. Cox and documentation will be reviewed by the Infection Control Committee and forwarded to Center's Governing Board on 9/6/2013. Deficiency will be prevented by coordinating Infection Control committee meetings with Center's CQI, Safety Committee and Governing Board to ensure that timely reports and the resulting meeting minutes are reviewed and are available for review. Ms. Cox will have another Infection Control meeting on 9/20/2013 which will be a comprehensive review of the entire Infection Control program.</p>				

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	<p>"Cleaning guidelines were covered again with staff and questions answered." There were no other meeting minutes to indicate a contracted cleaning service would be performing the terminal cleaning or that any other chemicals would be used.</p> <p>5. Tour and interview with the contracted cleaning service staff member #A10 at 4:15 PM on 08/06/13, indicated other chemicals, HDQ C2 was used on surfaces and DMQ was used on floors. Staff member #A10 indicated 4 squirts from the DMQ bottle was mixed with a bucket 1/2 to 3/4 full of water to mop the floors. He/she indicated the water was not measured in the bucket. The manufacturer's directions on the DMQ bottle were to mix 2 ounces of chemical with each gallon of water. He/she indicated the cleaning company provided the chemicals and he/she received training from the company, but not from the facility. He/she indicated the facility staff did not observe while he/she was cleaning.</p> <p>6. At 9:00 AM on 08/07/13, staff member #A3 indicated the contracted cleaning service started at the beginning of 2013, but was handled by the previous nurse administrator.</p>			

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S000526	<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 files review, and interview, the facility failed to ensure 3 of 3 nurses (# N1, N7, and N9), who performed out-of-lab testing on patients of the center, had initial and annual competency for the testing.</p> <p>Findings included:</p> <p>1. The facility policy "CLIA Waived Testing", approved July 1, 2011, indicated, "1. The following CLIA waived tests are performed within the surgery center: a. Blood Glucose (Capillary Blood Glucose) b. Urine Pregnancy Tests. ...3. All staff performing CLIA waived testing will receive initial and follow up competency education regarding equipment, specific types of products utilized and procedures."</p> <p>2. The employee files for staff members #N1, hire date 07/14/11 and N9, hire date 04/07/11, lacked documentation of annual blood glucose and urine</p>	S000526	<p>Heather Cox, RN, the Center's Nursing Administrator, has reviewed all Center personnel files and has scheduled a Center - wide reorientation meeting for all Center employees. The items listed in deficiency tag S 526 will be addressed in this in-service. On September 6, 2013, all RN's responsible for receive annual blood glucose and urine pregnancy competency testing.</p>	09/06/2013			

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S000668	<p>pregnancy competency for 2012 or 2013.</p> <p>3. The employee file for staff member #N7, hire date 02/21/13, lacked documentation of any competency for blood glucose or urine pregnancy testing.</p> <p>4. At 1:45 PM on 08/07/13, staff member #A12 confirmed the personnel file findings. Staff member #A1 also confirmed the lack of annual training for the nurses performing the testing.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(11)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(11) Condition on discharge, disposition of the patient, and time of dismissal.</p> <p>Based on policy review, medical staff rules and regulations review, medical record review, and interview, the facility failed to ensure patients were discharged according to policy for 21 of 25 charts reviewed (#P1, P3- 8, P10- 13, P15- 20, and P22- 25).</p> <p>Findings included:</p>	S000668	Deficiency will be addressed by Nursing Administrator Heather Cox, RN with all staff members responsible for direct patient care during Center's re-orientation staff meeting scheduled Sept 9, 2013. The specific deficiency listed as #0668 will be addressed and Center's policy on documenting patient's condition on discharge, disposition of the patient and time of	09/09/2013

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	<p>1. The facility policy "Discharge, Patient Criteria Guidelines", approved July 1, 2011, indicated, "10. All patients shall be accompanied by a responsible adult at the time of discharge and advised to be at home to care for them for twenty- four hours following surgery unless individually preapproved by the physician who is responsible for the patient's care in the Center. The physician may exempt patients who have straight local anesthesia. ...11. Patient is discharged in a wheelchair to car or transportation home in care of a responsible adult, or may ambulate to transportation escorted by the Center's clinical staff member according to the Center's policies and when appropriately assessed by discharging RN."</p> <p>2. The medical staff rules and regulations, approved July 1, 2011, indicated, "Section E- Discharge: ...3. Discharge from the Center is based upon the patient's ability to leave the Center safely when accompanied by a responsible adult."</p> <p>3. Twenty-five medical records for patients who received pain procedures at the facility between 03/13 through 06/13 were reviewed. Ten patients (#P3, P4, P6, P10, P12, P13, P16, P18, P22, and</p>		dismissal. After a thorough review of this deficiency, Center Administrator Mitch Couvillion, Nursing Administrator Heather Cox, RN and Center President and Medical Director Mahendra Sanapati, MD terminated the employment of the Center's PACU RN that was directly responsible for ensuring the proper documentation of Center patients upon discharge from Center. In addition, it was determined that the previous Center RN Administrator had failed to properly oversee Center's PACU documentation. A replacement RN, Jessica Meadors has been hired by Center and will serve as Center's PACU nurse. Ms. Meadors will be required to review PACU documentation to ensure that patient's condition on discharge and disposition of the patient and time of dismissal have been properly addressed. Ms. Cox will conduct chart reviews as part of Center's CQI program to ensure that Center's discharge and transfer functions including documentation are being evaluated.				

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	<p>P25) received intravenous sedation for their procedures. The PACU (Post Anesthesia Care Unit) records for those patients lacked documentation of discharge with a responsible person. Eleven patients (#P1, P5, P7, P8, P11, P15, P17, P19, P20, P23, and P24) received local anesthesia for their procedures. The records for those patients lacked documentation of discharge with a responsible person, any notation of an exemption by the physician, or the space "N/A" on the form beside the responsible driver marked.</p> <p>4. At 3:30 PM on 08/07/13, staff member #A1 confirmed the medical record findings and indicated there should be documentation of discharge with a responsible person or N/A if it was not necessary due to the local anesthesia.</p>			

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S000736	<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 documentation review and staff interview, the Medical Executive Committee failed to meet quarterly in 2013.</p> <p>Findings included:</p> <p>1. Medical Staff Bylaws (Last approved August 2, 2011) Article IX Section 1 states, "The Medical Executive Committee will meet at least quarterly."</p> <p>2. The Medical Executive Committee meeting minutes revealed there were 4 quarterly meetings in 2012 and there was no evidence of any committee</p>	S000736	<p>Deficiency will be corrected in a manner identical to item S110. Medical Executive meetings will occur the same da as the dates identified for Governing Board quarterly meetings. Like the Governing Board quarterly meetings, Medical Executive meetings will be scheduled at quarterly intervals and members of Medical Executive Board will receive reminders of upcoming meetings. Minutes of all Medical Executive meetings will be documented and presented to Governing Board on a quarterly basis. Copies of the minutes will be maintained. Deficiency will be prevented from reoccurrence by ensuring that like Governing Board meetings, Medical Executive meetings will be held on a consistent meeting date determined to be the last Wednesday of the third month of each quarter (i.e. March, June,</p>	09/06/2013			

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S000780	<p>meeting minutes for the first and second quarter of 2013.</p> <p>3. At 2:42 PM on 8/6/2013, staff member #3 confirmed the facility does not have any documentation that the Medical Executive Committee met in 2013.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure all physician written/standing orders were authenticated according to</p>	S000780	<p>September, December) and time (4:30pm). The approved schedule will be implemented for the remainder of calendar year 2013 and for calendar year 2014. Center's Practice Administrator Mitch Couvillion is assigned the responsibility of recording and maintaining meeting minutes. The Medical Executive Committee will meet September 6 at 4:30 pm. Future meetings will mirror Governing Board meeting dates. The ISDH survey will be reviewed.</p> <p>A review of the deficiency by Nursing Administrator Heather Cox, RN and President and Medical Director Mahendra Sanapati, MD has led to the</p>	09/20/2013			

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	<p>policy and standard of practice for 22 of 25 patients whose records were reviewed (#P1, P3- 13, P15- 20, and P22- 25).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The facility policy "Clinical Record Entries", approved July 1, 2011, indicated, "d. All entries must be signed with the first initial, last name and title of the individual completing the entry." 2. Twenty-five medical records for patients who received pain procedures at the facility between 03/13 through 06/13 were reviewed. The post-op orders for all of the patients were pre-printed with specific doses of medication written in and signed, dated, and timed by the physician. The pre-printed orders contained discharge orders and orders to discontinue the IV (intravenous). The records for 22 of the patients, #P1, P3- 13, P15- 20, and P22- 25, lacked any notation by a nurse to indicated the orders had been implemented or carried out. 3. At 9:45 AM on 08/07/13, the nurse in charge of the PACU (Post Anesthesia Care Unit), staff member #A8, indicated the post-op orders should be signed/noted by a nurse. 		<p>following findings and changes: The Center's PACU nurse has the responsibility for PACU operations to include noting in the patient charts that the physician orders have been implemented, signing post op orders and ensuring that Center's standard of practice must include signing/noting the implementation of all physician orders. The PACU nurse at the time of the survey has been released and her employment with Center has been terminated. A new PACU nurse, Jessica Meadors, RN has been hired by Center and will be responsible for ensuring that Center's standard of practice in PACU is adhered to. Ms. Cox is responsible for ensuring that Ms. Meadors will be trained and that Center's Medical Staff; Anesthesia and Surgical Bylaws and IAC 410 15-2.5-4(b)(3)(N) is complied with. A Center-wide re-orientation with clinical staff is scheduled for 9/4/2013 and 9/9/2013 and this deficiency will be reviewed and addressed. In addition, Ms. Cox has reviewed Center's chart review process and has determined that previous Nurse Administrator had failed to find the listed deficiency and that previous staff training had failed to ensure that Center's standards of practice would be adhered to. As part of upcoming staff orientation, Ms. Cox has completed revamped Center's education and staff training</p>		

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S001028	<p>4. At 3:30 PM on 08/07/13, staff member #A1 confirmed the medical record findings and indicated standard of practice was for all orders to be signed/noted by a nurse to acknowledge the implementation of those orders.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)(ii)</p> <p>Pharmaceutical service must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(E) Drugs must be accurately and clearly labeled and stored in specially-designed, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(ii) Drug cabinets for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse must be permanently affixed compartments that are separately locked.</p> <p>Based on policy review, facility document review, and interview, the facility failed to maintain the controlled</p>	S001028	<p>program. Additionally, a revamped chart review process will be implemented and charting deficiencies such as PACU documentation will be identified and corrective measures will be taken in a timely manner. Ms. Cox has targeted 9/20/2013 as the date when the chart review process will be implemented to prevent reoccurrence of deficiency.</p> <p>This deficiency and the Center's entire Pharmaceutical program was reviewed and an in-service was held with Center's consulting</p>	10/02/2013			

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	<p>inventory count for all controlled substances according to policy.</p> <p>Findings included:</p> <p>1. The facility policy "Controlled Substance Policy", approved July 1, 2011, indicated, "11. Daily Narcotic Documentation Procedure: A page is used to keep the continual inventory for the C II's and the C III-V's. A. First thing in AM, all controlled substances will be counted by two (2) Registered Nurses, to verify that amount in inventory is correct (chain of custody). The starting count (AM count) should be the amount carried over from the ending count (PM count) of the previous day. ...F. Last thing each day, two licensed persons of the nursing staff, will count narcotics attesting that the count is accurate in accordance with the controlled substance documentation sheets."</p> <p>2. During the tour of the surgical area at 12:50 PM on 08/06/13, accompanied by staff member #A1, the narcotic sign-out sheets were observed with only one signature for the AM and PM counts, (#A1). Review of logs for other days and months indicated a few days with 2 signatures, but also quite a few with only one signature.</p>		<p>pharmacist Jacob Mayer, Pharm-D, CGP on 8/26/2013. In attendance were Center's Administrator Mitch Couvillion, Nursing Administrator Heather Cox, RN and Center's Business Office Manager Carol Wilzbacher. As part of Mr. Mayer's review, he suggested that Center correct the ISDH cited deficiency by amending the Pharmacy Policy and Procedure Manual to allow a designated Center RN licensed by the State of Indiana to complete the Center's morning inventory count with another Center staff member. The second Center employee will be an RN licensed by the State of Indiana. If the second Center RN is not available, Center's Administrator will be the second staff member included in the count. If Center's Administrator is not available, Center's Business Office Manager will be the second staff member to participate in the count. These changes will ensure that Center will have two staff members complete the count. and will eliminate the risks involved in having only one employee complete the Daily Narcotic Documentation Procedure. Only Center RN's licensed by the State of Indiana will administer the medications. Heather Cox, RN and Center's Nursing Administrator, will be responsible for monitoring the daily count and ensuring that two</p>				

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S001146	<p>3. At 12:50 PM on 08/06/13, staff member #A1 indicated two nurses usually counted when the previous nurse manager was here, but also confirmed the count was not consistently done according to policy. He/she indicated he/she was the only one with a key to the narcotic cabinet.</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 documentation review and staff interview, the facility failed to monitor temperature and humidity for the two Operating Rooms (OR) for 2013 as per policy.</p> <p>Findings included:</p>	S001146	<p>Center employees participate and properly conduct the count when Center is open. Ms. Cox will also ensure that only Center RN's will administer the medications.</p> <p>Deficiency was reviewed by Center's President and Medical Director - Mahendra Sanapati, MD, Nursing Administrator - Heather Cox, RN and Administrator Mitch Couvillion, MHA. The Safety, Air Quality Control policy includes a daily temperature and humidity checklist that is part of the Center's Life Safety Manual. Daily checking of the Temperature and Humidity logs has been assigned to</p>	08/26/2013			

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	<p>1. Safety, Air Quality Control - Operating Rooms policy (Last approved July 1, 2011) states, "Air quality (temperature and humidity control) shall be monitored and documented on a daily basis and variations will be immediately reported to the Administrator or designee."</p> <p>2. The Temperature/Humidity Logs were reviewed for December 2012 through June 2013. The logs revealed that OR 1 and OR 2 were monitored daily in December 2012. However, the facility did not provide daily logs for January through May 2013. The June 2013 Daily Temperature/Humidity Logs for OR #1 and #2 revealed only June 18th, the temperature and humidity were recorded for OR 1.</p> <p>3. At 1:00 PM on 8/7/2013, staff member #8 indicated the ORs were having issues with the humidity control. In December, a humidifier was installed to</p>		<p>Administrator Mitch Couvillion. Mr. Couvillion is now responsible for all daily, weekly, quarterly and annual facility safety checks including Safety Air Quality controls. These daily duties had been assigned to Center's previous Nursing Administrator. That employee is no longer part of Center and these duties have been reassigned to Center's Administrator. In Mr. Couvillion's absence, Center's Nursing Administrator, Healthier Cox, RN will conduct daily Life Safety checks. In her absence, another Center employee will be designated to carry out these duties.</p>				

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S001180	<p>maintain the humidity in the rooms. However, the facility did not realize the daily logs were not maintained in 2013.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on documentation review and staff interview, the facility failed to conduct a fire drill for 1 of 4 previous quarters as defined by policies,</p> <p>Findings included:</p> <p>1. Emergency Action Plan - Fire policy (Last approved July 1, 2013) states, "Fire Drills including the transmission of a fire alarm signal and simulation of emergency fire conditions will be held quarterly for each working</p>	S001180	Center's disaster and fire drills conducted in FY 2012 were reviewed by Center Administrator Mitch Couvillion. While Center did conduct a disaster drill in Q4, 2012, no fire drill was conducted in Center. Mr. Couvillion instructed the vendor responsible for Center's fire safety program, Federal Fire and Security based in Owensboro, KY to conduct a fire drill 8/28/2013. Vendor was instructed to include the transmission of a fire alarm signal and simulation of emergency fire conditions for this and all future fire drills. Vendor has agreed to provide Quarterly training and Mr. Couvillion is designated as the Center employee responsible to ensure Center's compliance.	08/28/2013			

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	<p>shift and documentation including evaluation of the drill."</p> <p>2. Advanced Ambulatory Surgery Center, LLC Fire Evacuation Dill documentation evidenced fire drills were conducted: 3rd quarter of 2012; 1st quarter of 2013; and 2nd quarter of 2013. The facility did not evidenced a Fire Drill for the 4th quarter of 2012.</p> <p>3. At 10:00 AM on 8/2/2013, staff member #3 confirmed the facility did not conduct a fire drill for the 4th quarter of 2012.</p>		Center's fire and disaster drills are to be maintained in Center's Life Safety Policy and Procedure Binder as part of Center's Physical Plan, Equipment Maintenance program.	

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S001188	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on documentation review and staff interview, the facility failed to appoint a Safety Committee as defined by policy.</p> <p>Findings included:</p> <p>1. Advanced Ambulatory Surgery Center, LLC Principles policy (Last approved July 1, 2011) section 8 subsection D states, "Safety is the utmost priority of the Center. Safety management is achieved by appointing a safety committee to oversee the</p>	S001188	<p>Deficiency will be corrected by implementing a three person safety committee. Administrator Mitch Couvillion, Nursing Administrator Heather Cox, RN and Business Office Manager Carol Wilzbacher will comprise the committee and will oversee the Center's safety management program. Should any of these employees leave Center, they will be replaced by employees with similar Center titles and backgrounds. Deficiency will be prevented from reoccurring by regularly scheduled Quarterly meetings. The results of these meeting will be forwarded to the CQI committee and then reviewed by Governing Board. Heather Cox, RN will chair the committee. Daily, weekly, monthly</p>	09/20/2013	

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S001204	<p>development, implementation, and monitoring of safety issues."</p> <p>2. At 3:00 PM on 8/7/2013, staff member #3 indicated the Governing Board has not appointed a Safety Committee to oversee the safety of the surgery center.</p> <p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(a)</p> <p>(a) The center shall provide or make available diagnostic services and reports required in connection with any surgery to be performed, necessary to meet the needs of the patients, as determined by the medical staff.</p> <p>Based on documentation review and staff interview, the facility failed to ensure radiology quarterly reports were provided to the Continuous Quality Improvement Committee (CQI) and monthly visual checks of all lead aprons, gloves, and shields were documented in the radiology book as per policies.</p> <p>Findings included:</p>	S001204	<p>and quarterly safety reports, inspections, drills and other relevant safety such as Center's Facilities and Environment Policy and Procedure Manual will be reviewed by the Safety Committee.</p> <p>Center has begun the process of correction beginning with a completed review of Center's Radiation Safety Program. On 8/15/2013, an in-service was conducted by Center's consulting physicist (Arnold Sorenson, Medical Physicist Indiana Inspector No. 100) to review the Center's entire Radiation and Safety Policy and Procedure Manual. It was determined that the Center's annual contracted inspection by Mr. Sorenson would now be expanded to include both visual and radiographic testing of all lead aprons, gloves and shields. In addition, Mr.</p>	09/04/2013

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	<p>1. Radiation Safety Officer policy (Last approved July 1, 2011) stated, "The Radiation Safety Officer is Responsible for Preparing Quarterly Reports for the CQI Committee regarding radiation exposure."</p> <p>2. At 2:42 PM on 8/7/2013, staff member #6 indicated he/she was new to the position as the Radiation Safety Officer. The staff member indicated there were no Radiation Service quarterly reports provided to the CQI Committee. The staff member indicated the Radiation Safety Officer before him/her also never prepared reports for the CQI committee.</p> <p>3. The Radiation Safety Program (Last approved July 1, 2011) states, "A visual check for visible signs of cracking of all lead aprons, gloves, and shields will be performed monthly and documented in the radiology</p>		<p>Sorenson has agreed to provide training to a designated Center Radiologist Technician licensed by the State of Indiana to ensure that an additional inspection will be conducted in-house by this RT six months after Mr. Sorenson's annual inspection. The Policy and Procedure Manual was updated and reviewed by the Center's President, Medical Director, Nursing Administrator and Radiation Safety Officer. These inspection changes were then reviewed by Administrator Mitch Couvillion with ISDH Health Physicist 2 Lorna A. Wheet the same week via a telephone call to ensure that an annual lead inspection by Mr. Sorenson followed by a six month in-house inspection by an Indiana licensed RT would be sufficient to meet the Center's obligation to provide radiation protection for personnel exposed to the Center's fluoroscopy (radiation) equipment. Mr. Sorenson will complete this inspection and training by 9/4/2013. The Center's previous requirement to perform visual checks and radiographic imaging of protective leads has been changed from a monthly to a bi-annual basis. Quarterly dosimetry reports are received by Center by Center's contracted raditation detection company and these reports will be reviewed by Center's Radiation Safety Officer, Mitch Couvillion and a Center</p>		

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	<p>book."</p> <p>4. The Radiation Book was reviewed. The book identified reports on visual inspections of lead aprons and shields. The Advanced Ambulatory Surgery Center, LLC Lead-Apron and Other Shielding Testing and Evaluation logs were dated 9/2/2011, 2/8/2012, and 12/3/2012. Therefore, the Radiology book evidenced 10 monthly visual checks were missing from 2012 and 7 monthly visual checks were missing from 2013.</p> <p>5. At 2:45 PM on 6/7/2013, staff member #6 indicated visual checks on the lead aprons and other shielding items were done annually. The staff member indicated the prior staff trained him/her to conduct visual checks annually and not monthly as specified by the The Radiation Safety Program.</p>		<p>designated and Indiana Licensed Radiation Technologist to ensure that Center personnel exposed to radiation have not exceeded established radiation dosage levels. The Center's dosimetry reports will be forwarded to Center's CQI program on a Quarterly basis and these reports will be forwarded to Center's Health and Safety files established for Center personnel. Personnel responsible for correcting the noted deficiencies include Administrator and Radiation Safety Officer Mitch Couvillion and a designated Center Radiation Technologist licensed by the State of Indiana. As of 8/16/2013, this RT is Pamela Hart. Should Ms. Hart leave Center, another staff RT licensed by the State of Indiana will fulfill these duties. Center will ensure that the deficiency will not occur in the future by mandating Quarterly dosimetry readings and a review of these reports now be part of Center's CQI program which will be part of Governing Board's Quarterly agenda.</p>				