

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2015
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NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403
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Q 0000 Bldg. 00	This visit was for a re-certification survey. Facility Number: 009971 Survey Date: 10/5/2015 to 10/7/2015 QA: JIC 10/21/15	Q 0000		
Q 0041 Bldg. 00	416.41(a) CONTRACT SERVICES When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner. Based on document review and interview, the Governing Board failed to ensure maintenance services furnished in the surgery center under contract was part of its comprehensive quality assessment and improvement (QA&I) program. Findings include: 1. Review of the Quality Improvement Program and quality review of contracted services indicated the contractor that was	O 0041	Q 0041 1. Progressive Construction and Development (PCD) contracted maintenance services will be evaluated quarterly by Quality Assurance Committee to ensure effectiveness of services provided. Findings of study will be presented at Professional Staff Meeting. 2. PCD will be monitored and evaluated by the QA committee on quarterly basis for contracted services provided. Findings documented and presented to members of	11/17/2015

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

TITLE

(X6) DATE

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

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Q 0043 Bldg. 00	<p>responsible for the general maintenance of the building was not monitored and evaluated to ensure the effectiveness of the service that the contracted company provided.</p> <p>2. In interview At 9:00 AM on 10/6/2015, staff member #1 (Administrator) confirmed above and no other documentation was provided by exit.</p> <p>416.41(c) DISASTER PREPAREDNESS PLAN (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with State and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan. Based on document review and interview, the Governing Board failed to ensure the surgery center had a disaster</p>	O 0043	<p>committee. Studies will be conducted each quarter of calendar year (February, May, August, and November). 3. Administrator and Quality Assurance nurse will be responsible for evaluation. 4. Quality Assurance review conducted on services provided for fourth quarter. Presented findings to committee 11/17/2015.</p> <p>Q 0043 1. Disaster Preparedness Plan for SurgiCare LLC is in development and will participate in annual disaster</p>	12/18/2015

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Q 0101 Bldg. 00	<p>preparedness plan and failed to conduct annual disaster drills in 1 instance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the disaster plan indicated that it was written by a hospital organization who was majority owners of the center. However, the hospital organization was no longer part owners of Surgicare LLC as of 2012. The center did not have evidence of a disaster preparedness plan for Surgicare LLC nor had no evidence of a disaster preparedness drill since February 2012. In interview at 1:15 PM on 10/7/2015, Staff member #1 (Administrator) indicated the center has not had any disaster drill since he/she was hired in January of 2013. The staff member confirmed the surgery center does not have written a disaster plan since the previous hospital organization left the organization. <p>416.44(a)(1) PHYSICAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner</p>		<p>drill with Monroe Hospital, Bloomington, IN. Date and time of scheduled disaster drill to be determined by Andrew Stancombe, Emergency Operations/Education Coordinator/Safety Officer of Monroe Hospital, Bloomington, IN. 2. Disaster drill/preparedness will be conducted for SurgiCare personnel at December staff meeting. Topics to be included severe weather, fire, biochemical release, bioterrorism, or other threats that require response from community agencies. 3. Administrator will be responsible for conduction of drills. 4. Disaster Preparedness Plan to be completed 12/18/2015. Drill to be conducted 12/8/2015.</p>		

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	<p>that protects the lives and assures the physical safety of all individuals in the area. Based on document review, observation, and interview, the hospital failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff were assured in one instances.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Surgicare Safety Management Plan (last approved 9/1/2015) indicated the surgery center shall follow OSHA, Federal, state, and local regulations related the surgery center. 2. Review of the Occupational Safety and Health Administration's (OSHA) Medical and First Aid Standard 29 Code of Federal Regulations (CFR) 1910.151(c) indicated where the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Eyewash stations and showers shall be activated weekly for a period long enough to verify operation and ensure that flushing fluid is available. 	O 0101	<p>Q 0101 1. Eyewash station located in the pre/post area and shower located in the male locker room will be activated weekly for a period of 60-90 seconds to verify operation. Weekly eyewash station log has been initiated and included in the preventative maintenance checklist. 2. Eyewash station and shower will be activated each Monday morning for 60-90 seconds to ensure proper operation is verified. Log will be maintained to document to verify operation. 3. Administrator will complete verification and documentation. 4. Initiation of testing and documentation done 11/9/2015.</p>	11/09/2015	

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Q 0104 Bldg. 00	<p>3. Review of August, September, and October 2015 monthly Preventive Maintenance Checklists indicated the Eyewash stations had not been inspected to verify operation for three months respectively.</p> <p>4. In interview at 2:55 PM on 10/7/2015, staff member #1 (Administrator) confirmed above and no other documentation was provided by exit.</p> <p>416.44(b) SAFETY FROM FIRE (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to</p>			

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	<p>http://www.archives.gov/federalregister/code_of_federal-regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.</p> <p>(2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.</p> <p>(3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.</p> <p>(4) An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006.</p> <p>(5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if:</p> <ul style="list-style-type: none"> (i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities; (ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; (iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and 			

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	<p>(iv) The dispensers are installed in accordance with the following provisions:</p> <p>(A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m);</p> <p>(B) The maximum individual dispenser fluid capacity shall be:</p> <p>(1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms</p> <p>(C) The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other;</p> <p>(D) Not more than an aggregate of 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet;</p> <p>(E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code;</p> <p>(F) The dispensers shall not be installed over or directly adjacent to an ignition source;</p> <p>(G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments; and</p> <p>(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.</p> <p>Based on document review and interview, the facility failed to conduct quarterly fire drills per Life Safety Code 2000.</p> <p>Findings include:</p>	O 0104	Q 0104 1. Fire Drill was conducted 11/2/2015. Sandra Luman RN activated fire alarm in OR corridor at 1:32 p.m. Central Security Communications and Tri-State Fire Protection notified by L. Corron prior to drill. 2. Fire drills will be conducted quarterly	11/02/2015

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Q 0122 Bldg. 00	<p>1. Review of the Surgicare Safety Management Plan (last approved 9/1/2015) indicated the surgery center shall follow OSHA, Federal, state, and local regulations related the surgery center.</p> <p>2. Life Safety Code 2000 edition indicated fire drills are conducted quarterly on each shift at irregular intervals to familiarize employees on all shifts with their responsibilities</p> <p>3. In interview at 12:40 PM on 10/5/2015, staff member #1 (Administrator) indicated that fire drills are conducted once a year; however, the facility does not have documentation of fire drills for 2014 and 2015.</p> <p>416.45(b) REAPPRAISALS Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. Based on document review and interview, the facility failed to ensure the medical staff conducted</p>	O 0122	<p>with all staff members participating. Drill will be evaluated and critiqued using "Fire Drill Evaluation Tool" and findings will be discussed at staff meeting. Mandatory fire control and evacuation procedures will be conducted annually by Scott Smith, Fire Prevention Safety Officer, Bloomington, IN. 3. Administrator and S. Luman will responsible for conduction of fire drills in November, February, May, and August of each calendar year. 4. Fire drill conducted 11/2/2015.</p> <p>Q 0122 1. Medical staff credentialed to provide services at facility will be subject to outcome-oriented performance</p>	12/18/2015

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Q 0123	<p>outcome-oriented performance evaluations of its member at least biennially for 5 physicians (staff members #11, 12, 13, 14, and 15) and 1 allied health practitioner (staff member #16).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Surgicare Professional Staff - Bylaws (last reviewed January 1015) indicated the appointment and reappointment process for clinical privileges shall be based on professional competence and clinical judgment in the treatment of patients. 2. Review of 5 physicians (staff members #11, 12, 13, 14, and 15) and 1 allied health practitioner (staff member #16) credential files did not have documentation of outcome-oriented performance evaluations conducted by the Medical Staff. 3. At 12:30 PM on 10/7/2015, staff member #1 (Administrator) confirmed the above and no other documentation was provided by exit. <p>416.45(c) OTHER PRACTITIONERS</p>		<p>evaluations conducted by members of the medical staff. Evaluations will be done biennially during re-credentialing of privileges. 2. Each credentialed medical staff member will have performance evaluation completed by members of the medical staff based on professional competence and critical judgment. 3. Administrator will monitor completion of each medical staff members' outcome-oriented performance evaluation. 4. Evaluations of competence and clinical judgment will be completed 12/18/2015 and placed in file.</p>		

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Bldg. 00	<p>If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities.</p> <p>Based on document review and interview, the facility failed to have policies and procedures that addressed the overseeing and evaluating clinical activities to practitioners other than physicians in 1 instance.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of facility policies and procedures indicated there were none that addressed the overseeing and evaluating clinical activities to practitioners other than physicians 2. In interview at 2:15 PM on 10/7/2015, staff member #1 (Administrator) confirmed above and no other documentation was provided by exit. 	O 0123	<p>Q 123 1. Policy and procedure will be written to address the overseeing and evaluating clinical activities provided by practitioners (physician assistants and nurse practitioners) credentialed to provide service sat facility. 2. Policy will be written and approved by Board of Managers. Will be reviewed annually for revisions. 3. Administrator will be responsible for development of policy and presentation to Board of Managers. 4. Policy to be completed and approved 12/8/2015.</p>	12/08/2015	
Q 0241 Bldg. 00	<p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to</p>				

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	<p>professionally acceptable standards of practice.</p> <p>Based on document review, interview and observation, the infection control committee failed to ensure environmental services were provided, by both facility staff and contracted staff, to guard against transmission of disease to everyone in the facility in 2 instances.</p> <p>Findings include:</p> <p>1. Review of the facility policy Housekeeping Services, last reviewed 09/01/15, indicated, II. Responsibility: A. The Administrator is responsible for monitoring contracted housekeeping services that are provided to assure accepted levels of cleanliness. ... IV. Procedure: ... C. The Administrator shall monitor contract services and initiate corrective action if proper standards are not maintained.</p> <p>2. Review of the Infection Control Meeting minutes from March 3, 2015 and July 7, 2015 indicated, #C1, supervisor of contracted cleaning company, will keep in contact to ensure cleaning staff remains in compliance of standards.</p> <p>3. During the tour of the surgical area at 10:30 AM on 10/06/15, accompanied by staff member #P1, the facility</p>	O 0241	<p>Q 0241 1-2 (1) Indiana ProClean has been contracted to provide environmental services to facility. Tour of facility will be conducted daily to ensure cleanliness. Tour of facility and monitoring for compliance of standards will be conducted quarterly without knowledge of arrival to cleaning staff. Infection Control Committee and Quality Assurance Committee will conduct ongoing studies to ensure environmental services are following standards. Findings will be presented at meetings. 2. Periodic unannounced inspections of cleaning services provided will be done on a quarterly basis during hours in which facility is closed and cleaning services is present. Immediate findings will be provided to B. J. Ross, manager of Indiana ProClean. Results of inspection will be documented and presented to Infection Control Meeting and Quality Assurance Committee. 3. Administrator will conduct unannounced inspection and report findings to appropriate committee. 4. Unannounced inspection will be initiated 11/27/2015. 3-4 (1) Manufacturer's label directions will be followed by staff members utilizing chemical/cleaning supplies during operational hours. 2. Directions according to manufacturer's recommendations</p>	11/27/2015

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Q 0242 Bldg. 00	<p>administrator, the housekeeping closet in the surgical hall was observed with Clean Lemon disinfectant as the only chemical/cleaning supply. Manufacturer's label directions indicated 4 ounces of chemical were to be mixed with each gallon of water and floors/surfaces were to remain wet for 10 minutes for adequate disinfection. No other chemicals/supplies, used for cleaning the surgical area, or measuring devices were observed in the closet.</p> <p>4. In interview at 10:30 AM on 10/06/15, staff member #P8, a nurse in the surgical area, indicated staff mixed the chemical with water in a bucket for mopping between cases. He/she indicated the chemical wasn't measured when it was mixed with the water, therefore the proper mixture could not be determined.</p> <p>416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.</p>		<p>for use of chemicals and MSDS fact sheets will be available for staff use, measuring devices will be provide for use if necessary. 3. Administrator will monitor staff for compliance of following manufacturer's recommendations for use. 4. Initiation of process 11/23/2015.</p>				

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	<p>Based on document review and interview, the employee health program failed to ensure all staff had documentation of immunization status and TB testing, according to facility policy, for 10 of 10 employee files reviewed (#P1- P10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy Infection Control for Employee Health, last reviewed 09/01/15, indicated, 2. Tuberculosis: ...b. PPD Testing: i. PPD testing is mandatory for all employees yearly. The policy did not address two-step TB testing upon hire or any other required immunizations. 2. The Centers for Disease Control and Prevention (CDC) Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings from December 30, 2005 recommended all Health Care Workers (HCW) have base-line screening for tuberculosis (TB) upon hire, using the two-step Tuberculin Skin Test (TST) or single Blood Assay for Mycobacterium Tuberculosis (BAMT). 3. The CDC Guidelines for Immunizations for Health Care Personnel, Morbidity and Mortality 	Q 0242	<p>Q 0242 1. (1-14) Infection Control policy will be modified to include PPD testing for all employees yearly and two-step TB skin testing will be implemented for new hires. Results will be placed in each nursing personnel file. 2. All nursing personnel will show immunity to Hepatitis B, Pertussis, Measles, Mumps, Rubella, and Varicella. If unable to provide adequate documentation, employees will have titers drawn and proceed accordingly after results are obtained. All personnel will be required to complete TB skin testing 11/30/2015. New hires will be required to complete two-step testing which will be done 2-6 weeks after initial test. Documentation will be placed in employee file. Infection Control Nurse will begin process to obtain verification of exemption status of facility due to low risk. 3. Administrator and Infection Control nurse will monitor each employee for completion of health vaccinations, titers, and documentation. 4. TB skin testing will be conducted 11/30/2015, files completed 12/18/2015.</p>	12/18/2015

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	<p>Weekly Report from November 25, 2011, indicated personnel should have immunity to Hepatitis B, Pertussis, Measles, Mumps, Rubella, and Varicella.</p> <p>4. Review of the personnel file for staff member #P1, the facility administrator (hired 11/08/12), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>5. Review of the personnel file for staff member #P2, the Infection Control Nurse (hired 01/15/13), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test. The file also lacked documentation of immunity to Varicella, Rubella, or Rubeola.</p> <p>6. Review of the personnel file for staff member #P3, a Certified Surgical Tech (CST) (hired 03/17/14), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>7. Review of the personnel file for staff member #P4, an Registered Nurse (RN) (hired 03/01/13), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>8. Review of the personnel file for staff member #P5, a Radiology Tech Hired</p>			

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	<p>(05/19/08), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>9. Review of the personnel file for staff member #P6, a new CST hired 09/10/15, indicated a TB test from another facility dated 02/10/15, which could be used as the first step, but no documentation of a second step performed by the facility. The file also lacked documentation of immunity to Varicella, Rubella, or Rubeola.</p> <p>10. Review of the personnel file for staff member #P7, an RN (hired 07/01/10), indicated a TB screening from 05/04/15, but no documentation of an actual TB skin test.</p> <p>11. Review of the personnel file for staff member #P8, an RN (hired 03/03/13), indicated a TB screening from 05/12/15, but no documentation of an actual TB skin test.</p> <p>12. Review of the personnel file for staff member #P9, an RN (hired 10/24/13), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>13. Review of the personnel file for staff member #P10, a CST (hired 02/26/13),</p>			

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S 0000 Bldg. 00	<p>indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test. The file also lacked documentation of immunity to Varicella.</p> <p>14. In interview at 2:00 PM on 10/06/15, staff member #P1, confirmed all of the above findings and no other documentation was provided by exit. He/she confirmed the facility followed CDC guidelines regarding TB testing and the immunizations required for health care workers.</p>	S 0000		
	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 009971</p> <p>Survey Date: 10/05/2015 to 10/7/2015</p> <p>QA: JIC 10-21-15</p>			

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S 0110 Bldg. 00	<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 document review and interview, the Governing Board failed to review quarterly Quality Assessment and Improvement (QA&I) activities for 1 of 4 consecutive quarters in year 2014/2015.</p> <p>Findings include:</p> <p>1. Review of the most recent Governing Board/Professional Staff minutes of 6/9/15, 12/10/14 and 8/29/14, indicated the governing Board did not review quarterly reports of management operations of the facility's QA&I program in the first quarter of calendar year 2015.</p> <p>2. In interview at 9:00 AM on 10/6/2015, staff member #1 (Administrator) confirmed all the above and no other documentation was provided prior to</p>	S 0110	<p>S 110 1. Professional Staff meeting was conducted 11/17/2015. In attendance S. Bower RN, S. Luman RN, Dr. B. Logue, Dr. L. Brown, Dr. D. Bonham, Dr. R. Hoyer, Dr. J. Beck and Dr. E. Smith. Review of QA studies of services provided by outside contracted services included Morgan Linen, IU Health BiomedServices, LabCorp, Vanguard Alarm Service, Central Security Communications, and Progressive Construction and Development. 2. Professional Staff meetings will be conducted quarterly; February, May, August, and November of each calendar year. 3. Administrator will responsible for scheduling, conducting, and presentation of meeting. 4. Professional Staff meeting held 11/17/2015.</p>	11/17/2015

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S 0182 Bldg. 00	<p>exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (O)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(O) Annual implementation of internal and external disaster preparedness plans with documentation of outcome. Based on document review and interview, the Governing Board failed to ensure the surgery center had a disaster preparedness plan and failed to conduct annual disaster drills in 1 instance.</p> <p>Findings include:</p> <p>1. Review of the disaster plan indicated that it was written by a hospital organization who was majority owners of the center. However, the hospital organization was no longer part owners of Surgicare LLC as of 2012. The center did not have evidence of a disaster preparedness plan for Surgicare LLC nor had no evidence of a disaster</p>	S 0182	<p>S 182 1. Disaster Preparedness Plan for SurgiCare LLC is in development and will participate in annual disaster drill with Monroe Hospital, Bloomington, IN. Date and time of scheduled disaster drill to be determined by Andrew Stancombe, EmergencyOperations/Education Coordinator/Safety Officer of Monroe Hospital, Bloomington, IN. 2. Disaster drill/preparedness will be conducted for SurgiCare personnel at December staff meeting. Topics to be included severeweather, fire, biochemical release, bioterrorism, or other threats that requireresponse from community agencies. 3. Administrator will be responsible for conduction ofdrills. 4. Disaster</p>	12/18/2015

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	<p>interview, the Governing Board failed to ensure maintenance services furnished in the surgery center under contract was part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the Quality Improvement Program and quality review of contracted services indicated the contractor that was responsible for the general maintenance of the building was not monitored and evaluated to ensure the effectiveness of the service that the contracted company provided. 2. In interview at 9:00 AM on 10/6/2015, staff member #1 (Administrator) confirmed the above and no other documentation was provided by exit. 		<p>Construction and Development (PCD) contracted maintenance services will be evaluated quarterly by Quality Assurance Committee to ensure effectiveness of services provided. Findings of study will be presented at Professional Staff Meeting. 2. PCD will be monitored and evaluated by the QA committee on quarterly basis for contracted services provided. Findings documented and presented to members of committee. Studies will be conducted each quarter of calendar year (February, May, August, and November). 3. Administrator and Quality Assurance nurse will beresponsible for evaluation. 4. Quality Assurance review conducted on services provided for fourth quarter. Presented findings to committee 11/17/2015.</p>	

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S 0230 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the facility failed to provide for a periodic review of the center and its operation by three or more licensed physicians having no financial interest in the facility (physicians #11 and #13).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the Surgicare Professional Staff - Bylaws section 11.5 Utilization Review Committee (last reviewed January 2015) indicated, membership includes three or more professionals from the community who may or may not be members of the Professional Staff, none of whom have any financial interest in the center. The Utilization Review Committee 	S 0230	<p>S 230 1. (1-4) Utilization Review Committee will be revised to include physicians who have no financial interest in the facility. Committee to be comprised of S. Bower RN, S. Luman RN, Dr. D. Bonham, Dr. L. Brown, and Dr.J. Fritsch. 2. Utilization Review Committee shall be comprised of physicians who do not hold financial interest in the operation of SurgiCareLLC. Review and meetings will be conducted quarterly commencing 12/2015. 3. Administrator will be responsible for ensuring physician members of committee hold no financial interest in facility. 4. Utilization Review Committee will meet 12/10/2015.</p>	12/10/2015

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S 0300 Bldg. 00	<p>Minutes were reviewed for: 6/16/2015, 2/18/2015 and 11/19/2014. Attendance at each of the three meetings included 2 of 3 physicians (staff member #11 and staff member #13).</p> <p>3. Review of the Surgicare Organizational Chart indicated physician staff members #11 and #13 were part owners of the surgery center, which made them have financial interest in the operation of the facility.</p> <p>4. In interview at 8:52 AM on 10/6/2015, staff member #1 (Administrator) confirmed above and no other documentation was provided by exit.</p> <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</p>			

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	<p>be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the facility failed to ensure the Quality Assurance Committee met quarterly as per the facility's Quality Improvement (QA&I) Program in 1 of 4 consecutive quarters in year 2014/2015.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the Surgicare Quality Assurance Program (last reviewed 9/1/2015) indicated the Quality Assurance Committee shall meet quarterly. 2. Review of the most recent Governing Board/Professional Staff minutes of 6/9/15, 12/10/14, and 8/29/14, indicated the governing Board did not review quarterly reports of management operations of the facility's QA&I program in the first quarter of calendar year 2015. 3. In interview at 9:00 AM on 10/6/2015, staff member #1 (Administrator) confirmed all the above and no other documentation was provided prior to exit. 	S 0300	<p>S 300 1. Quarterly Assurance Committee will meet quarterly to review management operations of facility. Professional Staff meeting will be conducted quarterly and findings of studies presented to committee members. 2. Quality Assurance Committee will meet in December 2015, followed quarterly in March, June, September, and December of the calendar year. Professional Staff meetings will be conducted quarterly in February, May, August, and November of the calendar year. 3. Administrator will be responsible for scheduling and conducting meetings. 4. Quality Assurance Committee meeting will be 12/10/2015.</p>	12/10/2015

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S 0414 Bldg. 00	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on document review and interview, the facility failed to ensure the infection control committee met for 1 of 3 consecutive quarters in 2015 and failed to include the appropriate membership at the meetings.</p> <p>Findings include:</p>	S 0414	S 414 1. Infection Control Committee meeting will be held each quarter, December, March, June, and September. Members of committee will include S. Bower RN, S. Luman RN, Dr. B. Logue, and D. Elkins PA-C. 2. Meetings will be conducted on quarterly basis with each member of committee in attendance. 3. Administrator and Infection	12/10/2015

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S 0442 Bldg. 00	<p>1. Review of the facility's Infection Control Meeting minutes, indicated the meeting held March 3, 2015 was the first quarter meeting and the meeting held July 7, 2015 was the third quarter meeting. The minutes lacked documentation of an actual meeting held in the second quarter of 2015. The attendance at each of the meetings lacked representation from the medical staff.</p> <p>2. In interview at 1:30 PM on 10/05/15, staff member #P2, the Infection Control Nurse, indicated he/she met with the physicians at least quarterly to ensure completion of their Infection Tracking Logs, but indicated he/she did not document these times as meetings.</p> <p>3. In interview at 2:00 PM on 10/05/15, staff member #P1, the administrator, confirmed all of the above for physician attendance and quarterly infection control meetings and no further documentation was provided by exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p>		Control nurse will be responsible for presentation of meetings and will ensure other members will be present. 4. Infection Control meeting will be conducted 12/10/2015.	

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	<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>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on document review and interview, the employee health program failed to ensure all staff had documentation of immunization status and TB testing, according to facility policy, for 10 of 10 employee files reviewed (#P1- P10).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the facility policy Infection Control for Employee Health, last reviewed 09/01/15, indicated, 2. Tuberculosis: ...b. PPD Testing: i. PPD testing is mandatory for all employees yearly. The policy did not address two-step TB testing upon hire or any other required immunizations. The Centers for Disease Control and Prevention (CDC) Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health 	S 0442	<p>S442 1. (1-14) Infection Control policy will be modified to include PPD testing for all employees yearly and two-step TB skin testing will be implemented for new hires. Results will be placed in each nursing personnel file. 2. All nursing personnel will show immunity to Hepatitis B, Pertussis, Measles, Mumps, Rubella, and Varicella. If unable to provide adequate documentation, employees will have titers drawn and proceed accordingly after results are obtained. All personnel will be required to complete TB skin testing 11/30/2015. New hires will be required to complete two-step testing which will be done 2-6 weeks after initial test. Documentation will be placed in employee file. Infection Control Nurse will begin process to obtain verification of exemption status of facility due to low risk. 3. Administrator and Infection Control nurse will monitor each employee for completion of health</p>	12/18/2015

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	<p>Care Settings from December 30, 2005 recommended all Health Care Workers (HCW) have base-line screening for tuberculosis (TB) upon hire, using the two-step Tuberculin Skin Test (TST) or single Blood Assay for Mycobacterium Tuberculosis (BAMT).</p> <p>3. The CDC Guidelines for Immunizations for Health Care Personnel, Morbidity and Mortality Weekly Report from November 25, 2011, indicated personnel should have immunity to Hepatitis B, Pertussis, Measles, Mumps, Rubella, and Varicella.</p> <p>4. Review of the personnel file for staff member #P1, the facility administrator (hired 11/08/12), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>5. Review of the personnel file for staff member #P2, the Infection Control Nurse (hired 01/15/13), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test. The file also lacked documentation of immunity to Varicella, Rubella, or Rubeola.</p> <p>6. Review of the personnel file for staff member #P3, a Certified Surgical Tech (CST) (hired 03/17/14), indicated a TB</p>		vaccinations, titers, and documentation. 4. TB skin testing will be conducted 11/30/2015, files completed 12/18/2015.	

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	<p>screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>7. Review of the personnel file for staff member #P4, an Registered Nurse (RN) (hired 03/01/13), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>8. Review of the personnel file for staff member #P5, a Radiology Tech Hired (05/19/08), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>9. Review of the personnel file for staff member #P6, a new CST hired 09/10/15, indicated a TB test from another facility dated 02/10/15, which could be used as the first step, but no documentation of a second step performed by the facility. The file also lacked documentation of immunity to Varicella, Rubella, or Rubeola.</p> <p>10. Review of the personnel file for staff member #P7, an RN (hired 07/01/10), indicated a TB screening from 05/04/15, but no documentation of an actual TB skin test.</p> <p>11. Review of the personnel file for staff member #P8, an RN (hired 03/03/13), indicated a TB screening from 05/12/15,</p>			

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S 0526 Bldg. 00	<p>but no documentation of an actual TB skin test.</p> <p>12. Review of the personnel file for staff member #P9, an RN (hired 10/24/13), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test.</p> <p>13. Review of the personnel file for staff member #P10, a CST (hired 02/26/13), indicated a TB screening from 04/13/15, but no documentation of an actual TB skin test. The file also lacked documentation of immunity to Varicella.</p> <p>14. In interview at 2:00 PM on 10/06/15, staff member #P1, confirmed all of the above findings and no other documentation was provided by exit. He/she confirmed the facility followed CDC guidelines regarding TB testing and the immunizations required for health care workers.</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h) (h) All nursing and other center personnel performing laboratory</p>				

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	<p>testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on employee file review and interview, the facility failed to ensure 6 of 6 Registered Nurses (RNs) (# P1, P2, P4, P7, P8, and P9), who performed out-of-lab testing on patients at the center, had documentation of annual competency for the testing.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the personnel files for RNs #P1, P2, P4, P7, P8, and P9, all who had worked at the facility for longer than a year, lacked documentation of competency for blood glucose and urine pregnancy testing. Cover sheets in the files indicated annual inservices were completed in April 2015 and the out-of-lab testing was listed as a topic to cover, but the files lacked any documentation of competency performed or written testing. 2. In interview at 8:30 AM on 10/07/15, staff member #P1, the facility administrator, confirmed he/she could not provide documentation of annual competency for the nurses who performed blood glucose and urine pregnancy testing on the patients at the center, and no other documentation was 	S 0526	<p>S 526 1. Inservices and competencies for nursing personnel for blood glucose testing and urine pregnancy testing will be completed at December staff meeting. 2. Competencies of blood glucose testing and urine pregnancy testing will be included in annual mandatory inservice held in April. New employees will be given inservice and competencies upon hire. Documentation will be place in each employee's file. 3. Administrator and Infection Control Nurse will be responsible. 4. Competencies for blood glucose testing and urine pregnancy will be completed by nursing personnel 12/8/2015.</p>	12/08/2015

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S 0624 Bldg. 00	<p>provided by exit.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(7)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(7) The center shall ensure the confidentiality of patient records. The center must develop, implement, and maintain the following:</p> <p>(A) A procedure for releasing information or copies of records only to authorized individuals, in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records. Based on document review and interview, the facility failed to ensure the surgery center had policies and procedures that addressed the confidentiality of patient records in 1 instance.</p> <p>Findings include:</p> <p>1. Review of facility Policies and Procedures indicated there was no</p>	S 0624	S 624 1. Policy and Procedure will be developed to ensure confidentiality of patient's records and to address unauthorized individuals ability to gain access to patient's records without consent from patient. Release of information consent will be revised to reflect policy to ensure confidentiality. 2. Confidentiality of patient records and unauthorized access will be maintained and monitored. 3. Administrator and business office personnel will be	12/01/2015

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S 0704 Bldg. 00	<p>documentation of a policy or procedure that addressed the confidentiality of patient records.</p> <p>2. In interview at 2:15 PM on 10/7/2015, staff member #1 (Administrator) confirmed the surgery center did not have a policy that addressed the confidentiality of patient records and no other documentation was provided by exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(1)</p> <p>The medical staff shall do the following:</p> <p>(1) Conduct outcome-oriented performance evaluations of its member at least biennially.</p> <p>Based on document review and interview, the facility failed to ensure the medical staff conducted outcome-oriented performance evaluations of its member at least biennially for 5 physicians (staff members #11, 12, 13, 14, and 15) and 1 allied health practitioner (staff member #16).</p>	S 0704	<p>responsible for maintaining confidentiality. 4. Policy to be revised and implemented 12/1/2015.</p> <p>S 704 1. Medical staff credentialed to provide services at facility will be subject to outcome-oriented performance evaluations conducted by members of the medical staff. Evaluations will be done biennially during re-credentialing of privileges. 2. Each credentialed medical staff member will have performance evaluation</p>	12/18/2015

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S 0736 Bldg. 00	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Surgicare Professional Staff - Bylaws (last reviewed January 1015) indicated the appointment and reappointment process for clinical privileges shall be based on professional competence and clinical judgment in the treatment of patients. 2. Review of 5 physicians (staff members #11, 12, 13, 14, and 15) and 1 allied health practitioner (staff member #16) credential files did not have documentation of outcome-oriented performance evaluations conducted by the Medical Staff. 3. At 12:30 PM on 10/7/2015, staff member #1 (Administrator) confirmed the above and no other documentation was provided by exit. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p>		completed by members of the medical staff based on professional competence and critical judgment. 3. Administrator will monitor completion of each medical staff members' outcome-oriented performance evaluation. 4. Evaluations of competence and clinical judgment will be completed 12/18/2015 and placed in file.		

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	<p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based on document review and interview, the facility failed to ensure the Professional Staff meetings were quarterly as defined by the Professional Staff Bylaws in 1 instance.</p> <p>Findings include:</p> <p>1. Review of Surgicare Professional Staff Bylaws section 12.2A (last reviewed January 2015) indicated the Professional Staff meetings shall be held at least quarterly.</p> <p>2. Review of the Professional Staff meeting minutes indicated there were no minutes for the first quarter of 2015.</p> <p>3. In interview at 8:30 AM on 10/6/2015, staff member #1 (Administrator) confirmed above and no other documentation was provided by exit.</p>	S 0736	<p>S 736 1. Professional Staff meeting conducted 11/17/2015 attended by S. Bower RN, S. Luman RN, Dr. B. Logue, Dr. L. Brown, Dr. D. Bonham, Dr. R.Hoyer, Dr. J. Beck, and Dr. E. Smith. 2. Professional Staff meeting will be scheduled and conducted each quarter; February, May, August, and November. Meetings of previous meeting will be read and approved prior to new business. 3. Administrator will be responsible for scheduling the quarterly meetings to ensure attendance by participating members. 4. Professional Staff meeting conducted 11/17/2015.</p>	11/17/2015

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S 1146 Bldg. 00	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation, and interview, the hospital failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff were assured in one instances.</p> <p>Findings include:</p> <p>1. Review of Surgicare Safety Management Plan (last approved 9/1/2015) indicated the surgery center shall follow OSHA, Federal, state, and</p>	S 1146	<p>S 1146 1. Eyewash station located in the pre/post area and shower located in the male locker room will be activated weekly for a period of 60-90 seconds to verify operation. Weekly eyewash station log has been initiated and included in the preventative maintenance checklist. 2. Eyewash station and shower will be activated each Monday morning for 60-90 seconds to ensure proper operation is verified. Log will be maintained to document to verify operation. 3. Administrator will complete verification and documentation. 4.</p>	11/09/2015

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	<p>local regulations related the surgery center.</p> <p>2. Review of the Occupational Safety and Health Administration's (OSHA) Medical and First Aid Standard 29 Code of Federal Regulations (CFR) 1910.151(c) indicated where the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Eyewash stations and showers shall be activated weekly for a period long enough to verify operation and ensure that flushing fluid is available.</p> <p>3. Review of August, September, and October 2015 monthly Preventive Maintenance Checklists indicated the Eyewash stations had not been inspected to verify operation for three months respectively.</p> <p>4. In interview at 2:55 PM on 10/7/2015, staff member #1 (Administrator) confirmed above and no other documentation was provided by exit.</p>		Initiation of testing and documentation done 11/9/2015.	

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S 1174 Bldg. 00	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following:</p> <p>(A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice.</p> <p>Based on document review, interview and observation, the infection control committee failed to ensure environmental services were provided, by both facility staff and contracted staff, to guard against transmission of disease to everyone in the</p>	S 1174	S 1174 1-2 (1) Indiana ProClean has been contracted to provide environmental services to facility. Tour of facility will be conducted daily to ensure cleanliness. Tour of facility and monitoring for compliance of standards will be conducted quarterly without	11/27/2015

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	<p>facility in 2 instances.</p> <p>Findings include:</p> <p>1. Review of the facility policy Housekeeping Services, last reviewed 09/01/15, indicated, II. Responsibility: A. The Administrator is responsible for monitoring contracted housekeeping services that are provided to assure accepted levels of cleanliness. ... IV. Procedure: ... C. The Administrator shall monitor contract services and initiate corrective action if proper standards are not maintained.</p> <p>2. Review of the Infection Control Meeting minutes from March 3, 2015 and July 7, 2015 indicated, #C1, supervisor of contracted cleaning company, will keep in contact to ensure cleaning staff remains in compliance of standards.</p> <p>3. During the tour of the surgical area at 10:30 AM on 10/06/15, accompanied by staff member #P1, the facility administrator, the housekeeping closet in the surgical hall was observed with Clean Lemon disinfectant as the only chemical/cleaning supply. Manufacturer's label directions indicated 4 ounces of chemical were to be mixed with each gallon of water and floors/surfaces were to remain wet for 10</p>		<p>knowledge of arrival to cleaning staff. Infection Control Committee and Quality Assurance Committee will conduct ongoing studies to ensure environmental services are following standards. Findings will be presented at meetings. 2. Periodic unannounced inspections of cleaning services provided will be done on a quarterly basis during hours in which facility is closed and cleaning services is present. Immediate findings will be provided to B. J. Ross, manager of Indiana ProClean. Results of inspection will be documented and presented to Infection Control Meeting and Quality Assurance Committee. 3. Administrator will conduct unannounced inspection and report findings to appropriate committee. 4. Unannounced inspection will be initiated 11/27/2015. 3-4 (1) Manufacturer's label directions will be followed by staff members utilizing chemical/cleaning supplies during operational hours. 2. Directions according to manufacturer's recommendations for use of chemicals and MSDS fact sheets will be available for staff use, measuring devices will be provide for use if necessary. 3. Administrator will monitor staff for compliance offollowing manufacturer's recommendations for use. 4. Initiation of process 11/23/2015.</p>	

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S 1188 Bldg. 00	<p>minutes for adequate disinfection. No other chemicals/supplies, used for cleaning the surgical area, or measuring devices were observed in the closet.</p> <p>4. In interview at 10:30 AM on 10/06/15, staff member #P8, a nurse in the surgical area, indicated staff mixed the chemical with water in a bucket for mopping between cases. He/she indicated the chemical wasn't measured when it was mixed with the water, therefore the proper mixture could not be determined.</p> <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 document review and</p>	S 1188	S 1188 1. Fire Drill was conducted 11/2/2015. Sandra	11/02/2015

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S 1198	<p>interview, the facility failed to conduct quarterly fire drills per Life Safety Code 2000.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the Surgicare Safety Management Plan (last approved 9/1/2015) indicated the surgery center shall follow OSHA, Federal, state, and local regulations related the surgery center. 2. Life Safety Code 2000 edition indicated fire drills are conducted quarterly on each shift at irregular intervals to familiarize employees on all shifts with their responsibilities 3. In interview at 12:40 PM on 10/5/2015, staff member #1 (Administrator) indicated that fire drills are conducted once a year; however, the facility does not have documentation of fire drills for 2014 and 2015. <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT</p>		<p>Luman RN activated fire alarm in OR corridor at 1:32 p.m. Central Security Communications and Tri-State Fire Protection notified by L. Corron prior to drill. 2. Fire drills will be conducted quarterly with all staff members participating. Drill will be evaluated and critiqued using "Fire Drill Evaluation Tool" and findings will be discussed at staff meeting. Mandatory fire control and evacuation procedures will be conducted annually by Scott Smith, Fire Prevention Safety Officer, Bloomington, IN. 3. Administrator and S. Luman will responsible for conduction of fire drills in November, February, May, and August of each calendar year. 4. Fire drill conducted 11/2/2015.</p>		

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(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
Bldg. 00	<p>MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the Governing Board failed to ensure the surgery center had a disaster preparedness plan and failed to conduct annual disaster drills in 1 instance.</p> <p>Findings include:</p> <p>1. Review of the disaster plan indicated that it was written by a hospital organization who was majority owners of the center. However, the hospital organization was no longer part owners of Surgicare LLC as of 2012. The center did not have evidence of a disaster preparedness plan for Surgicare LLC nor had no evidence of a disaster preparedness drill since February 2012.</p> <p>2. In interview at 1:15 PM on 10/7/2015, Staff member #1 (Administrator) indicated the center has not had any disaster drill since he/she was hired in January of 2013. The staff member confirmed the surgery center does not</p>	S 1198	<p>S 1198 1. Disaster Preparedness Plan for SurgiCare LLC is in development and will in annual disaster drill with Monroe Hospital, Bloomington, IN. Date and time of scheduled "disaster drill to be determined by Andrew Stancombe, Emergency Operations/Education Coordinator/Safety Officer of Monroe Hospital, Bloomington, IN.</p> <p>2. Disaster drill/preparedness will be conducted for SurgiCare personnel at December staff meeting. Topics to be included severe weather, fire, biochemical release, bioterrorism, or other threats that require response from community agencies. 3. Administrator will be responsible for conduction of drills. 4. Disaster Preparedness Plan to be completed 12/18/2015. Drill to be conducted 12/8/2015.</p>	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2015
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
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	have written a disaster plan since the previous hospital organization left the organization.				