

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0000 Bldg. 00	The visit was for a licensure survey. Facility Number: 009555 Survey Date: 6-2/3-15 QA: cjl 06/22/15	S 0000		
S 0162 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G) Require that the chief executive officer develop and implement policies and programs for the following: (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. Based on document review and interview, the CEO (chief executive officer) failed to ensure that 1 of 3 pre/post RNs (registered nurses) were current for ACLS (advanced cardiac life support) certification, as required per the job description (Staff member N8). Findings:	S 0162	Staff member N8 was re-certified in ACLS on June 12 - 13, 2015. Staff member N8 was allowed to re-certify in ACLS with an expired provider card (April 2015) per the discretion of the American Heart ACLS instructor that taught the course. The ASC Director will be responsible for assuring adherence to the job description as well as the "BLS/ACLS/PALS	06/13/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>1. Review of the job description titled "Pre-Post RN" for the "Ambulatory Surgery Center", indicated in section "C. Educational Requirements": "...3. Certifications: BLS (basic life support) and ACLS."</p> <p>2. Review of the "American Heart Association" document titled "Program Administration Manual", "Guidelines for Program Administration and Training" with an effective date of February 1, 2013, indicated on page 50 under "Provider Update or Renewal Procedure": "The recommended update or renewal interval for all AHA (American Heart Association) courses is 2 years. Providers who intend to take an update course must show a valid provider card to enroll in an update or renewal course. At the discretion of the..., course director, or lead instructor, exceptions may be allowed... has the final authority and responsibility for allowing a student to take an update course if he or she does not have a current AHA Provider card...".</p> <p>3. Review of the policy "BLS/ACLS/PALS (pediatric advanced life support) Requirements", policy number ASC-AD-115, last reviewed/revised January 2009, indicated: a. Under "Guidelines", it reads: "A.</p>		Requirements Policy", ASC-AD-115, going forward. The Human Resources Director and the ASC Director will ensure compliance by monthly review of the ACLS, BLS, and PALS spread sheet currently maintained by the HR Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0166 Bldg. 00	<p>the Center will provide BLS, ACLS, and PALS instruction through the American Heart Association or any other recognized service every two years. B. If the employee is unable to attend the courses provided by this center, it is the employee's responsibility to obtain certification at another location...".</p> <p>4. Review of employee files for three pre/post RNs indicated that the ACLS certification for RN N8 had expired 4/2015.</p> <p>5. At 1:15 PM on 6/3/15, interview with staff member #50, the facility administrator, indicated:</p> <p>a. The AHA ACLS trainer has not replied to requests by this staff member as to how much elapsed time they will allow for renewing the ACLS certification for staff member N8.</p> <p>b. It is a standard of practice to have ACLS certification renewed prior to the expiration date.</p> <p>c. The ACLS certification for staff member N8 expired on 4/2015, as noted in the employee's file.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on document review and interview, the CEO (chief executive officer), failed to implement the blanket warmer policy for 1 of 1 blanket warmers.</p> <p>Findings:</p> <p>1. Review of the "Blanket and Fluid Warmer" policy, number ASC-CL-129, dated 10/22/13, indicated:</p> <p>a. Under "Procedure", it reads: "A. Fluid Warmer - Lower Chamber...The temperature in the lower chamber with parenteral fluids should not exceed 104 [degrees] F. If over 104 [degrees] the fluids should not be used..."</p> <p>b. Under "Procedure", in section B., it reads: "B. Blanket warmer - Upper & Lower Chambers...The temperature for the upper chamber with blankets should not exceed 110 [degrees] F."</p> <p>c. Under "Procedure", in section D., it reads: "D. If chamber temperature exceeds 104 [degrees] F for the lower chamber or 110 [degrees] F for the upper chamber, the following actions will be taken to return the temperature to an</p>	S 0166	<p>The policy "Blanket and Fluid Warmer", ASC-CL-129, will go to the Board for their approval on July 29, 2015 with the following changes: "The temperature of the upper chamber with blankets should not exceed 130 degrees F" per ECRI recommendations. The current policy temperature requirements for the lower chamber of 104 degrees F, with parenteral fluids, will not change. The log sheet for the blanket and fluid warmer will also go to the Executive Committee of the Board for their approval on July 29, 2015 with the following changes: Additional columns have been added to the log sheet to allow for documentation of actions taken and recording additional temperatures for the upper and/or lower chambers every 4 hours if indicated. The current policy was reviewed with the pre-post staff on June 4, 2015 following the IN State re-licensure survey. The Pre-Post Lead RN is responsible for assuring that proper documentation and adherence to the policy is maintained. The log sheet will be</p>	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2015	
NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514			
(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			
	<p>acceptable range: A second reading will be taken and documented within (4) hours. If temperature remains high, a second adjustment will be made and the temperature will be rechecked in (4) hrs. (hours). If the temperature cannot be brought to within an accepted range, the blanket warmer will be turned off and the Maintenance Coordinator will be notified. All actions taken will be documented."</p> <p>2. At 12:40 PM on 6/3/15, the May 2015 "Blanket and Fluid Warmer Temperature Log" was reviewed and indicated that 17 of 29 days on the log were documented as being higher than the 110 degrees required per facility policy for the upper cabinet (temperatures ranged from 111 to 115 degrees), and the lower cabinet was higher than 104 degrees on 13 of 29 days (temperatures ranged from 105 to 107 degrees).</p> <p>3. At 12:45 PM on 6/3/15, interview with staff member #50, the facility administrator, indicated:</p> <p>a. Temperatures were outside the range required per facility policy as listed in 1. and 2. above.</p> <p>b. Staff failed to make notations in the column provided for "COMMENTS (ADJUSTED TEMPERATURE, CALLED FOR REPAIR, ETC)".</p>		monitored on a monthly basis per the ASC Director and also through the QA process.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0172 Bldg. 00	<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 document review and interview, the CEO (chief executive officer) failed to ensure the implementation of the TB (tuberculosis) policy for 1 of 3 housekeeping staff members, N3; and 1 of 4 RNs (registered nurses), staff member N7.</p> <p>Findings: 1. Review of the policy "Tuberculosis Infection Control Program", policy number ASC-EC-105, last dated 8/21/12, indicated: a. On page two under "C. Employees", it reads: "1. All new employees will receive a baseline TB screening upon</p>	S 0172	The Infection Control Committee will meet to review the TB Standards and update the current policy. The updated "Tuberculosis Infection Control Program Policy" will then be presented to the Executive Committee of the Board on July 29, 2015 for their approval. Staff member N7 received the two step PPD (purified protein derivative) and their negative results have been documented and placed in the employee's file. Due to an active case of Poison Ivy upon hire, staff member N7's TB test had been postponed. The manager of the contracted housekeeping service will be required for	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2015
NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514		
(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	
	<p>hire; unless they have documentation of a recent (12 months) negative Mantoux...test results...2. PPD (purified protein derivative) status will be updated annually...".</p> <p>2. Review of employee health files indicated:</p> <p>a. Housekeeping staff member N3 had:</p> <p>A. No supplied/documented date of hire, but had annual training/education done on 2/18/15, which would indicate employee status.</p> <p>B. No documentation of having had a TB test within 12 months of hire at the facility.</p> <p>C. No documentation of having had a TB test while working at the facility.</p> <p>b. RN N7 was hired 5/15/14 and had no documentation of having had a TB test after being hired.</p> <p>3. At 11:30 AM on 6/3/15, interview with staff member #50, the facility administrator, indicated:</p> <p>a. The hire date for staff member N3 is not known, but they were in attendance at the 2/18/15 training.</p> <p>b. It is unknown if staff member N3 had cleaned on the surgery center side of the facility prior to their termination on 3/19/15.</p> <p>c. Staff member N3 should have had a TB test at the time of hire.</p>		<p>notifying the ASC Director of new hires to include employee name and date of hire to assure that TB testing is done upon hire per policy. The ASC Director will monitor this on a monthly basis with the manager of the contracted housekeeping service. The ASC Director and The Director of Human Resources will be responsible for assuring that new hires, current employees, and contracted employees adhere to the TB standards set forth in the policy on an ongoing basis.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0226 Bldg. 00	<p>d. Staff member N7 had "poison ivy" at the time of hire and was "skipped", or was missed, in following up to receive the TB test, as required at the time of hire, per facility policy.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</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>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the center failed to maintain its list of all contracted services, including the scope and nature of services provided, for 4 contracted services (laundry, medical waste, and fire systems inspection/testing/certification and monitoring).</p> <p>Findings:</p> <p>1. On 6-02-15 at 1630 hours, a list of contracted services was identified in the contracted services (CS) agreements</p>	S 0226	The Materials Manager will update the Contracted Services binder demonstrating current contracts, effective date of contract; expired contracts with dates of service, as well as the scope and nature of services for each contract. The Materials Manager will then update the list of Contracted Services currently located in the front of the Contracted Services Binder. The ASC Director agrees that the UR/QA Minutes did not reflect the activities regarding the termination of one linen contract, initiation of a new linen contract, then termination of the	07/30/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2015
NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514		
(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	
	<p>binder. The list included the names of two laundry service providers CS1 and CS2, a medical waste disposal service CS5, and a fire systems inspection service CS7 and no supporting documentation indicated the center was under current agreement and/or currently receiving services from the four providers.</p> <p>2. CS binder documentation dated 10-8-14 indicated a 30 day termination of agreement notice [letter] from the center to a commercial laundry service CS3.</p> <p>3. Utilization Review/Quality Assurance (UR/QA) committee meeting minutes dated 11-12-14 failed to indicate a comment and/or discussion about the laundry service provider CS3 and the IR/QA meeting minutes dated 2-11-15 indicated only that laundry provider CS4 began providing services on 11-10-14.</p> <p>4. CS binder documentation indicated a current agreement with medical waste disposal service CS6.</p> <p>5. Center documentation dated 4-10-15 indicated fire alarm system maintenance including testing of all detectors by CS8.</p> <p>6. Center documentation indicated fire/security system monitoring by CS9.</p>		<p>new linen contract and return to the prior linen service. However, multiple discussions occurred at multiple levels including the Infection Control Committee, the UR/QA Meeting as well as the ASC Board of Managers. The ASC Director will document those activities in the appropriate minutes going forward. The ASC Director will ultimately be responsible to assure that the Contracted Services Binder is maintained per regulation and that minutes accurately reflect all activity.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0310 Bldg. 00	<p>7. During an interview on 6-3-15 at 1230 hours, the surgery director A2 confirmed that the list of contracted services had not been maintained.</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. Based on document review and interview, the Quality Assurance (QA) program failed to ensure that all contracted services were evaluated and reviewed by the program for one contracted (laundry) service.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance (approved 12-14) indicated the following: "The board of managers has delegated responsibility for integration of the various quality assurance functions to a multi-disciplinary committee." The QA plan failed to indicate a requirement for evaluating contracted services through</p>	S 0310	The Quality Assurance Program has been updated to include a requirement for evaluating contracted services through the QA Program. The policy will go to the Executive Committee of the Board for their approval on July 29, 2015. The ASC Director will present the Contracted Services to be evaluated and/or reviewed as indicated at the August 12, 2015 UR/QA Committee Meeting. The 2014 Contracted Services report presented to the Board of Managers on January 20, 2015 have been added to the board minutes. The ASC Director agrees that the UR/QA Minutes did not reflect the activities between the two linen companies. However, multiple discussions occurred at multiple	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>the QA program.</p> <p>2. Utilization Review/Quality Assurance (UR/QA) committee meeting minutes dated 11-12-14 failed to indicate a comment and/or discussion about the laundry service provider CS3 and the UR/QA meeting minutes dated 2-11-15 indicated only that laundry provider CS4 began providing services on 11-10-14. The UR/QA committee meeting minutes for 2014 and 2015 lacked documentation to indicate that any contracted services were evaluated and/or reviewed by the UR/QA committee.</p> <p>4. The board of managers meeting minutes dated 1-20-15 indicated a 2014 contracted services report was presented for board review and approval and a copy of the report documentation was not present with the board minutes. The surgery director A2 was requested to provide the contracted services report for review and a copy was not available until the time of exit from the center.</p> <p>5. The 2014 contracted services report indicated that the service provided by the commercial laundry CS3 was terminated on 11-7-14 and no documentation indicated that the commercial laundry provider CS4 was evaluated or reviewed during the remaining 8 weeks of the year.</p>		<p>levels including the UR/QA meeting. The ASC Director will document those activities in the appropriate minutes going forward. The ASC Director will be responsible for assuring that minutes accurately reflect all activity.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0612 Bldg. 00	<p>6. During an interview on 6-3-15 at 1410 hours, the surgery director A2 indicated that the laundry services provided since 11-14 by the laundry service CS4 had been unsatisfactory and indicated that the center had resumed services with laundry service CS3 in 2015. The surgery director A2 confirmed that no UR/QA committee meeting documentation indicated that the contracted services including the commercial laundry services of CS3 and CS4 were evaluated and/or reviewed through the QA program.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on document review and interview, the facility failed to ensure that medical records were accurately documented for 9 of 12 records reviewed (Records #1, #2, #3, #4, #5, #6, #10, #11 and #12).</p>	S 0612	The Medical Director will be presenting the findings from the monthly internal electronic health record audits, the quarterly external electronic health record audits, as well as the findings from the State Licensure Survey	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>Findings:</p> <p>1. Review of the policy "Charting Standards", policy number ASC-MR-112, last revised on April 2013, indicated:</p> <p>a. Under "Procedure", it reads in the "1. General Instructions" section: "...b. Charting should be clear, concise, factual objective and accurate...g. Record notations after the care is given...".</p> <p>2. Review of the policy "Medical Records", policy number ASC-MR-111, last reviewed/revised July 2013, indicated:</p> <p>a. Under "Procedure", it reads: "An electronic health record (EHR) shall be maintained for each patient, which is accurate, legible, complete and comprehensive to ensure adequate patient care,...".</p> <p>b. Under Electronic Health Record, it reads in section 3. "Electronic Data Entry": "...Entries should never be made in advance...".</p> <p>3. Review of medical records indicated:</p> <p>a. Pt. #1 had authentication on the form "Anesthesia Record" prior to the end of the surgery. CRNA #57 (certified registered nurse anesthetist) authenticated the record at 11:05 AM on 9/9/14 and the Surgeon,</p>		<p>to the Executive Committee of the Board on July 29, 2015 as well as to the individual Medical Staff members by August 7, 2015. The Medical Director will be presenting the electronic health record findings on a monthly basis as well as following up with each Medical Staff member as necessary. The Medical Director, ASC Director and ultimately each Medical Staff Member will be responsible for assuring compliance and accuracy of the electronic health records.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>#58, authenticated the record at 10:40 AM while the surgery start time was 10:59 AM and the surgery end time was 11:42 AM on 9/9/14.</p> <p>b. Pt. #2 had authentication by the CRNA on the form "Anesthesia Record" prior to the end of the surgery. CRNA #59, authenticated the record at 8:58 AM while the surgery end time was 9:29 AM, and the anesthesia end time was 9:52 AM on 4/9/14.</p> <p>c. Pt. #3 had authentication on the form "Anesthesia Record" at 12:52 PM by CRNA #61, with a second procedure performed that had a "2nd Anesthesia Start" time of 12:40 PM and an anesthesia ending time of 4:14 PM on 4/13/15. The surgeon, physician #60, had yet to authenticate the 4/13/15 electronic form for surgery performed on that date.</p> <p>d. Pt. #4 had:</p> <p>A. Authentication on the form "Anesthesia Record" at 10:52 AM by CRNA #62, and at 10:41 AM by surgeon #63 when the surgery didn't end until 12:35 PM, and the anesthesia didn't end until 12:49 PM on 2/16/15.</p> <p>B. Inaccurate documentation on the PACU (post anesthesia care unit) Record form in the area "Discharge to" where staff wrote that the patient was transferred to a "...Critical Access Hospital (CAH)", when they were transferred instead to a large acute care</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>facility.</p> <p>e. Pt. #5 had authentication on the "Anesthesia Record" form by CRNA #57 at 3:29 PM and the Surgeon, #64, at 2:39 PM when the surgery end time on 11/25/14 was 4:11 PM and the anesthesia end time was 4:23 PM.</p> <p>f. Pt. #6 had authentication on the "Anesthesia Record" form by CRNA #59 at 3:55 PM and by surgeon #65 at 3:31 PM with the surgery end time noted at 4:45 PM and the anesthesia end time noted at 5:22 PM on 12/12/14.</p> <p>g. Pt. #10 had authentication on the "Anesthesia Record" form by CRNA #59 at 4:15 PM on 5/6/14, but the surgery end time was not until 4:53 PM, and the anesthesia end time was 5:07 PM. The surgeon, #66, had not yet authenticated the record.</p> <p>h. Pt. #11 had:</p> <p>A. Documentation in the "RN (registered nurse) NOTES" section that Versed 2 mg and 10 ml (milliliters) of Xylocaine 1% and 10 ml Marcaine 0.25 % with epinephrine 16 ml was "injected in left wrist per..." surgeon #60 at 9:53 AM in the pre op area.</p> <p>B. An operative note that read: "...[pt] was brought to the operating room where he/she was given a wrist block into his/her left hand. His/her left hand was then prepped and draped in the usual fashion. IV (intravenous sedation) was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0676	<p>used for patient comfort during placement of the wrist block...".</p> <p>i. Pt. #12 had authentication on the "Anesthesia Record" form by CRNA #62 at 11:23 AM on 4/28/15 and the surgeon, #58, authenticated the form on 4/28/15 at 10:14 AM which was prior to the end of surgery at 11:49 AM, and the anesthesia end, which was 11:56 AM on 4/28/15.</p> <p>4. At 3:00 PM on 6/2/15 and 12:45 PM on 6/3/15, interview with the facility administrator, staff member #50, indicated:</p> <p>a. The CRNA and/or surgeon noted confirmation of the "Anesthesia Record" form documentation/information prior to the end of either the surgery procedure, or the end of anesthesia time, or both, for the patients as listed in 3. above.</p> <p>b. Documentation prior to the care being completed is not allowed, as per the policies listed in 1. and 2. above.</p> <p>c. Pt. #11 had documentation that IV medication/sedation was given prior to the injection of a local anesthetic while the patient was in the pre op area, making the operative report inaccurate with documentation reading that this was done in the operative suite.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2015
NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514		
(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>MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or legally reproduced medical records must be maintained by the center for a period of seven (7) years in accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure.</p> <p>Based on observation and interview, the center lacked a departmental waiver for off-site storage of medical records (MR).</p> <p>Findings:</p> <ol style="list-style-type: none"> During a tour on 6-2-15 at 1510 hours, the maintenance coordinator A3 indicated that surgery center MR were moved in August or September of 2014 to an off-site business office property for storage away from the surgery center building. During an interview on 6-2-15 at 1610 hours, surgery director A2 confirmed that surgery center MR were being stored in a secure location away from the surgery center and confirmed that a waiver for off-site MR storage had not been requested or obtained from the Indiana State Department of Health. 	S 0676	ASC Director scanned and e-mailed a letter to the attention of John Lee, ISDH Program Director Hospitals/ASCs on July 17, 2015, requesting a waiver for off-site storage of medical records. The ASC Director will be responsible for maintaining the waiver once received.	07/31/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0736 Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based upon document review and interview, the medical staff failed to conduct a quarterly medical staff meeting for 1 of 4 meetings in 2014 and 2015.</p> <p>Findings:</p> <p>1. The Medical Staff Bylaws, Rules and Regulations (approved 7-22-13) indicated the following: "Regular meetings of the medical staff will be held. The annual meeting will be held in April." The bylaws failed to indicate a requirement for medical staff meetings at least quarterly.</p> <p>2. Medical staff meeting minutes indicated that the medical staff met on 5-15-14, 8-26-14, 9-24-14, 12-15-14 and 5-14-15. The medical staff meeting minutes dated 5-14-15 indicated an</p>	S 0736	<p>Quarterly Medical Staff Meetings have been added to the Bylaws, ASC-AD-100, and will be presented to the Executive Committee of the Board for their approval on July 29, 2015. The organization modified its Governance structure in the last quarter of 2014, causing OSMC to miss the Medical Staff meeting during the first quarter of 2015. However the Medical Staff is comprised of the same members that serve on the Board of Directors that met on January 20, 2015; February 25, 2015; and April 13, 2015. The meeting schedule has been established for the remainder of the year to ensure that all Medical Staff meetings are held. This meeting schedule will be ongoing in subsequent years. The CEO will be responsible for assuring that Medical Staff Meetings are held at least quarterly.</p>	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0772 Bldg. 00	<p>approval of the medical staff minutes dated 12-15-14 and no other documentation indicated that a meeting was held during the first quarter (January, February, March) or in April, 2015.</p> <p>3. During an interview on 6-3-15 at 1405 hours, the chief executive officer A1 confirmed that the medical staff failed to have a meeting during the first quarter of 2015 and confirmed that no annual medical staff meeting was conducted in April 2015.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy. Based on document review and interview, the medical staff failed to follow facility policy, and failed to implement their rules and regulations, related to history and physicals for 3 of 12 patients (Patients #1, #6, and #12).</p> <p>Findings:</p> <p>1. Review of the policy "History and Physical Documentation", policy number ASC-MR-125, with a revision date of October 22, 2013, indicated:</p> <p>a. Under "Policy", it reads: "A complete History and Physical Examination (H&P) shall be completed no more than 30 days before a patient undergoes a surgical or pain management procedure...H&P's will be updated the day of surgery..."</p> <p>2. Review of the "Rules and Regulations", policy number ASC-AD-101, with a revision/approved date of 4/25/13, indicated:</p> <p>a. Under "Section 5 Patient Admission Requirements", it reads: "...E. A history</p>	S 0772	<p>The current "History and Physical Documentation Policy" ASC-MR-125 does state that "H&P's will be updated the day of surgery", however the Rules and Regulations, policy ASC-AD-101, does not currently incorporate that statement. The Rules and Regulations have been updated to reflect that statement and will be presented to the Executive Committee of the Board for their approval on July 29, 2015. The current H&P form does have an area at the end of each document stating: "updated H&P with changes" and "updated H&P no changes". The physician is to date, time and sign his/her name and include changes if indicated following exam. The requirement will be reviewed with the Board, the Medical Staff and the clinical staff since the H&P is to be on the chart, signed, dated and time stamped with/without changes prior to any surgery/procedure. The ASC Director will be responsible for ensuring that the clinical staff and Medical Staff adhere to the policy. This will be accomplished by doing an internal daily monitor</p>	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>and physical examination will be performed on all patients within thirty (30) days of the date of surgery...".</p> <p>b. The Rules and Regulations do not address the need for updating the H & P on the day of surgery.</p> <p>3. Review of medical records indicated:</p> <p>a. Pt. #1 had surgery on 9/9/14 and had a H & P with a note: "H & P reviewed with no change" checked, but dated by surgeon #58 on 9/10/14 (the day after surgery), with a time that is illegible.</p> <p>b. Pt. #6 had a H & P that was performed by surgeon #65 on 12/3/14, prior to surgery on 12/12/14, that was not updated the day of surgery when a general anesthetic with an axillary block was to be given.</p> <p>c. Pt. #12 had a H & P dated 4/14/15 for surgery on 4/28/15 with an update noted by surgeon #58 with a date that is illegible, but looking like 4/25/12.</p> <p>4. At 12:45 PM on 6/3/15, interview with the facility administrator, staff member #50, indicated :</p> <p>a. The surgeon wrote the wrong date when updating the H & P for patient #1.</p> <p>b. Pt. #6 lacked an update the day of surgery on the H & P form.</p> <p>c. Pt. #12 had an illegible date by the surgeon in updating the H & P for that</p>		per the clinical staff assuring that H&P's are completed per policy prior to the patient leaving the pre-operative area.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0780 Bldg. 00	<p>patient.</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 document review and interview, the medical staff failed to implement facility policy, and medical staff rules and regulations, related to the authentication of orders for 5 of 12 patients (Patients #3, #4, #8, #10, and #11).</p> <p>Findings: 1. Review of the policy "Authentication of Medical Records", policy number ASC-MR-126, last reviewed/revised February 2014, indicated: a. On page two under "Acceptable Methods for Valid Authentication",</p>	S 0780	The Rules and Regulations, policy ASC-AD-101, has been changed to require authentication of verbal orders not to exceed thirty (30) days. A read back and verify process has also been added to the policy pending approval of the Executive Committee of the Board. The Policy will be presented to the Executive Committee of the Board for their approval on July 29, 2015. The "Authentication of Medical Records" policy will also be reviewed at the July 29, 2015 Executive Committee of the Board Meeting. Compliancy with this requirement will be stressed with both the Medical Staff	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>indicated: "...Handwritten signatures with date and time. Electronic signature using a date and timestamp...Physician authentication on verbal orders which includes date and time."</p> <p>2. Review of the policy "Medical Records", policy number ASC-MR-111, last reviewed/revised July 2013, indicated under "Procedure": "...All entries must be legible, complete, and authenticated with a dated and timed signature..."</p> <p>3. Review of the medical staff "Rules and Regulations", policy number ASC-AD-101, signed 4/25/13, indicated: a. In section 9, "Physician Orders", it reads: "A...1. A standing order may be prescribed verbally to a Registered Nurse in the Center and signed by the surgeon prior to patient discharge. 2. A standing order may be prescribed in writing and signed by the physician and delivered prior to surgery...B. Verbal orders may be given...The prescribing physician will have 10 business days to sign off on the order; to include signature, date and time..."</p> <p>4. Review of medical records indicated: a. Pt. #3 had the following orders without authentication by physician #60: A. Pre operative orders on 4/13/15 for</p>		<p>and clinical staff, and monitored through ongoing monthly internal electronic health record audits as well as quarterly external electronic health record audits. The clinical staff will be more diligent in assuring that the ordering physician authenticates all written and verbal orders (or read back and verify verbal orders) in a legible manner per policy, prior to the patient going to the next peri-operative phase of care. The ASC Director will be responsible for oversight of this process.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>2 mg Versed IV (intravenous), and Kefzol 1 gm IV that were not signed, dated, and timed on the day of surgery, or since.</p> <p>B. PACU (post anesthesia care unit) orders hand written on 4/13/15 for Narcan 0.4 mg IVP (intravenous push) that were not signed, dated, and timed on the day of surgery, or since.</p> <p>C. Discharge orders written on 4/13/15 to "Discontinue IV, discharge, Prescriptions are ordered, and confirm appointment", that were not signed, dated, and timed on the day of surgery, or since.</p> <p>b. Pt. #4 had an authentication of the PACU orders by physician #63, without a date and time of authentication.</p> <p>c. Pt. #8 had:</p> <p>A. Pre operative orders on 7/15/14 by physician #66 that were not authenticated until 9/2/14 at 1:17 PM.</p> <p>B. Discharge orders on 7/15/14 by physician #66 that were not authenticated until 9/2/14 at 1:17 PM.</p> <p>d. Pt. #10 had Pre op orders to: initiate IV with 1000 ml Lactated Ringers...Kefzol 1 gm IVP written on 5/6/14 that lacked a date and time of authentication by physician #66.</p> <p>e. Pt. #11 lacked a date and time with the authentication by physician #60 of the "Discharge" orders for a day of surgery 4/27/15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0832 Bldg. 00	<p>5. At 12:45 PM on 6/3/15, interview with the facility administrator, staff member #50, indicated:</p> <p>a. The physicians failed to authenticate, or date and time authentication, of orders for the patients, as listed in 4. above.</p> <p>b. Physician #66 failed to authenticate orders for pt. #8, who had surgery on 7/15/14, until 9/2/14, which is not per medical staff rules and regulations.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(ii)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and postanesthesia as follows:</p> <p>(ii) The completion by the practitioner administering anesthesia of intra-operative anesthesia monitoring and notations, to include vital signs, on each patient in accordance with the center policy. Based on document review and</p>	S 0832	"Rules and Regulations" policy ASC-AD-101, under Anesthesia	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>interview, the medical staff failed to implement their rules and regulations, related to anesthesia evaluations prior to surgery, for 5 of 12 patients (Patients #3, #6, #8, #9, and #10).</p> <p>Findings:</p> <p>1. Review of the medical staff "Rules and Regulations", policy number ASC-AD-101, signed 4/25/13, indicated in section 6., "Anesthesia Requirements": "...C...The administration of pre-op medications and/or intraoperative medications for local anesthesia cases will be the responsibility of the surgeon, regardless of route of administration. Surgeons administering local anesthetics will evaluate the anesthetic risk of the patient prior to surgery and provide appropriate documentation in the patient's chart. D. The anesthesiologist will maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation performed by a physician...".</p> <p>2. Review of medical records indicated:</p> <p>a. Pt. #3 lacked:</p> <p>A. Evidence of of a pre anesthesia evaluation by surgeon #60 as there was no authentication, date, or time on the "Anesthesia Evaluation" form for a date of service of 4/13/15.</p> <p>B. Authentication by surgeon #60 of the CRNA (certified registered nurse</p>		<p>Requirements, indicate that the surgeon is responsible for the anesthetic eval. The findings of the State survey will be presented to the Executive Committee of the Board on July 29, 2015. The Medical Director will be reviewing this policy with all physicians that have privileges in the surgery center. Compliance with this policy will be monitored through monthly internal electronic health record audits and quarterly external electronic health record audits and those findings will be reported to the Medical Director. The Medical Director will be responsible for the ongoing compliance with this regulation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>anesthetist) documentation on the "Anesthesia Record" form with documentation of the events of the operating suite as relates to anesthesia.</p> <p>b. Pt. #6 lacked documentation of physician #65 having checked the patient's "Heart", "Lungs", and "Abdomen" in the area provided, in the history and physical section of the chart, for surgeons to note this information prior to surgery.</p> <p>c. Pt. #8, with a surgery date of 7/15/14, had:</p> <p>A. A blank "Anesthesia Evaluation" form that was signed on 9/2/14 at 1:16 PM.</p> <p>B. The "Anesthesia Record" form authenticated on 9/2/14 at 1:16 PM.</p> <p>d. Pt. #9 had surgery on 9/30/14, with anesthesia that included an axillary block, who lacked a date and time of authentication by surgeon #67 on the "Anesthesia Evaluation" form and on the "Anesthesia Record" form.</p> <p>e. Pt. #10 had MAC (monitored anesthesia care) for surgery on 5/6/14 that lacked documentation that:</p> <p>A. The physician (#66) completed the "Anesthesia Evaluation" (no signature, date, time on form--signed off only by the CRNA).</p> <p>B. Physician #66 agreed with the CRNA by failing to sign, date and time the "Anesthesia Record" form.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 0836 Bldg. 00	<p>3. At 12:45 PM on 6/3/15, interview with the facility administrator, staff member #50, indicated anesthesia evaluations for patients #3, #6, #8, #9, and #10 lacked completion of the anesthesia evaluation forms and/or the anesthesia records, as noted in 2. above.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(iv)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and postanesthesia responsibilities as follows:</p> <p>(iv) The requirement that all postoperative patients shall be discharged from the postanesthetic care unit by the practitioner described in clause (C) as responsible for the patient's care in accordance with center policy.</p> <p>Based on document review and interview, the medical staff failed to ensure that an order for discharge was given and authenticated for 1 of 2 patients for surgeon #60 (Patient #3).</p>	S 0836	"Rules and Regulations" policy ASC-AD-101 states that "patients will be discharged only on written order of the anesthesiologist or attending physician". The findings during the State survey will be presented to the Executive	07/29/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/03/2015	
NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514			
(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			
S 1168 Bldg. 00	<p>Findings:</p> <ol style="list-style-type: none"> Review of the medical staff "Rules and Regulations", policy number ASC-AD-101, signed 4/25/13, indicated in section 12. "Discharge": "A. Patients will be discharged only on written order of the anesthesiologist or attending physician...". Review of medical records indicated Pt. #3 lacked authentication of the "Discharge" orders for 4/13/15. At 12:45 PM on 6/3/15, interview with the facility administrator, staff member #50, indicated the discharge orders for patient #3 were not authenticated by surgeon #60. <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p>		<p>Committee of the Board on July 29, 2015 per the Medical Director. The Medical Director will be reviewing this policy with all physicians that have privileges in the surgery center. Compliance with this policy will be monitored through monthly internal electronic health record audits and quarterly external electronic health record audits. Those findings will be reported to the Medical Director. The Medical Director will be responsible for assuring ongoing compliance with this regulation.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review, observation, and interview, the center failed to ensure that preventive maintenance (PM) including regular inspection and repair was performed on all patient care equipment at the center for one infusion pump.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Preventive Maintenance (approved 12-14) indicated the following: "Preventive maintenance in the form of regular inspection and repair will be conducted so as to assure ...the safety of patients and employees...Results of the inspections will be recorded and maintained on file." During a tour of the center on 6-2-15 at 1430 hours with maintenance coordinator A3, the following condition was observed in the pre-op and post-op area of the surgery center: an intravenous (IV) infusion pump (asset ID OSMC265) with a label indicating that PM was last performed on 3-2014 and due to be completed on 3-2015. Review of PM records for patient care equipment failed to indicate the IV pump (OSMC265) was inspected by the biomedical engineering provider during routine service visits conducted during March, 2015. 	S 1168	The contracted service that performs scheduled PM's had his own equipment out for repair that he would have used to check the IV Infusion Pump, so he was unable to complete the PM at the scheduled interval. The IV Infusion Pump PM was completed on June 8, 2015. The ASC Director will monitor the contracted biomedical engineering's monthly service reports to assure that all equipment PM's have been performed per biomedical engineering's schedule and manufacturer's recommendations.	06/08/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
S 1182 Bldg. 00	<p>4. During an interview on 6-3-15 at 1405 hours, the surgery director A2 confirmed that the center lacked documentation of an annual PM inspection for an IV pump (OSMC265) observed during a tour of the center.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based on document review and interview, the center failed to document the safety committee recommendation and follow-up action in response to a safety concern identified through the safety management program.</p> <p>Findings:</p> <p>1. The policy/procedure Safety Management Plan (approved 2-15) indicated the following: "The safety officer and the safety committee are appointed by the chief executive officer. Administration has delegated to the safety committee the authority to take action when hazardous conditions or potential hazardous conditions exist that could result in personal injury to individuals or damage to equipment or buildings. This delegated authority has been approved by the administration and the governing body...the safety committee will meet quarterly, or more often when necessary, and record the</p>	S 1182	<p>Clarification of State Response: Safety Committee Meetings and Infection Control Committee Meetings are held separate from Utilization Review/ Quality Assurance (UR/QA) Committee Meetings. However, the information from the Safety Committee and Infection Control Committee are reported to the UR/QA Committee. I do not desire to complete an IDR for the above clarification. I agree that the Safety Committee minutes did not reflect the concerns and actions taken regarding the safety of a medical device or equipment. The information was discussed with the Medical Director who is one of the two physician members on the Safety Committee. Due to the nature of the concern, immediate action</p>	06/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001067	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER OSMC OUTPATIENT SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2310 CALIFORNIA ROAD, SUITE B ELKHART, IN 46514
--	---

(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
	<p>activities...minutes will be forwarded to the Quality Assurance (QA) committee and the governing body."</p> <p>2. During an interview on 6-2-15 at 1605 hours, the surgery director and safety officer A2 indicated the safety committee meets as a subcommittee during the Utilization Review/ Quality Assurance (UR/QA) committee meetings.</p> <p>3. The UR/QA committee minutes dated 5-7-14 and 8-13-14 indicated a concern involving a medical device or equipment (asset ID OSMC024) including service on 2-3-14 and 5-20-14 by a qualified provider and no subcommittee minutes dated 5-7-14, 8-13-14 or 11-12-14 indicated documentation of a safety committee recommendation or action in response to the real or potential safety concerns.</p> <p>4. Center documentation dated 6-24-14 indicated an initial inspection for (2) medical devices or equipment identified as OSMC348 AND OSMC349 and documentation dated 9-18-14 indicated the (2) medical devices or equipment identified as OSMC024 AND OSMC036 were no longer in service.</p> <p>5. During an interview on 6-3-15 at 1410 hours, the surgery director and safety officer A2 confirmed that the (2) medical devices or equipment identified as OSMC024 and OSMC036 had been replaced and confirmed the UR/QA minutes failed to indicate documentation of a safety subcommittee action or recommendation in response to the reported concerns.</p>		<p>was taken. The incident reports were reported to the UR/QA Committee. The ASC Director will be responsible for thorough documentation of minutes for Safety, Infection Control and UR/QA Committee Meetings.</p>	