

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2013
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NAME OF PROVIDER OR SUPPLIER  EVANSVILLE SURGERY CENTER ASSOCIATES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4133 GATEWAY BLVD STE 100 NEWBURGH, IN 47630
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002666</p> <p>Survey Date: 10/7/2013 through 10/9/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/22/13</p>	S000000		
S000010	<p>410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a)</p> <p>Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules.</p>			

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

TITLE

(X6) DATE

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

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	<p>Based on employee file review and interview, the facility failed to comply with all applicable state laws for 2 of 2 unlicensed Nursing Assistant employee files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. IC 16-28-13-4: a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</li> <li>2. Review of employees #18 and #19 employee files indicated that he/she was hired on 5/24/04 and 9/6/05 respectively as Nursing Assistants. Both employee files lacked documentation of a nurse aide registry report verification. The two Nursing Assistants were</li> </ol>	S000010	S010- On 10/30/2013 Human Resources Director accessed and requested copies of all employees State Nurse Aid Registry Report with no findings noted. The Human Resources Director has added this requirement to all future hires employed as nurse aids.	10/30/2013			

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S000432	<p>not certified and provide direct patient care.</p> <p>3. At 1:15 PM on 10/8/2013, staff member #16 indicated he/she was unaware that a state nurse aide registry report was to be obtained on all unlicensed and non-certified health care personnel that have direct patient contact.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, policy and procedure review, manufacturer's directions, and interview, the infection control committee failed to ensure all supplies, equipment, and surfaces were cleaned according to policy to prevent cross-contamination between patients</p>	S000432	S432- Tourniquets used for IV starts will be treated as "single patient use" items and disposed of after one patient use. Charge nurses will be made aware of these changes by the Director of Operations and Material Management will order sufficient supplies to allow for this new	12/31/2013

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	<p>and failed to ensure manufacturer recommendations for high level disinfection were followed in the operative area.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. During the pre-operative patient observation at 9:10 AM on 10/08/13, staff member #P5 used a tourniquet on the patient's arm while starting the IV (intravenous) line. At the completion of the task, staff member #P5 put the tourniquet back in the little basket with other supplies, then placed the basket back in a cabinet for future use.</li> <li>2. During the tour of the surgical area at 10:10 AM on 10/08/13, a container of Resert XL HLD for disinfection of the laryngoscope blades was observed at the scrub sink. A timer was on the shelf along with a log book. The entries in the log book indicated blades had been soaked in the disinfectant 18 times between 09/13/13 and 10/08/13. The soaking time was not documented for 13 of the times and 4 of the 5 documented times indicated the blades soaked longer than 8 minutes.</li> <li>3. During the observation of the terminal cleaning of operating room 3 at the completion of a surgical case at</li> </ol>		<p>practice effective 11/1/2013. On 10/8/2013 the Director Of Operations notified Gateway OR charge nurse of ISDH observations of incomplete Resert XL HLD log sheet with instructions to inform staff. OR staff in-services will be performed by the Education Coordinator regarding the use of Resert XL High Level Disinfectant based on manufacturers recommendations, Policy 3229 (High Level Disinfection-Resert XL HLD), and completing the log sheet correctly beginning 10/28/2013 and to be completed by 12/31/2013. OR staff in-services will be performed by the Education Coordinator regarding cleaning in the OR between cases and revisions to Policy 5028 (Cleaning in the OR between cases). Staff in-services to begin 10/28/2013 and be completed by 12/31/2013. Follow up infection control observations will be conducted on a monthly basis beginning 11/1/2013 using the Infection Control Practices Audit tool by the Infection Control Officer or their designee. Any observed deficiencies will be addressed and corrected on the spot. Results of audits will be reported to the QAPI Committee quarterly, and reviewed by the Medical Executive Committee.</p>				

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	<p>10:45 AM on 10/08/13, staff member P9 did not wipe the intravenous pole, rolling stool, or the flat surface of the anesthesia cart before the room was mopped and deemed ready for the next case.</p> <p>4. At 10:45 AM on 10/08/13, the operating room manager, staff member #P10, was questioned regarding the Resert XL while he/she was mopping the operating room. He/she indicated the timer should be set for 8 minutes while the blades were soaking, but they could remain in the solution longer than that. He/she indicated the time in and time out should be documented in the log book. He/she indicated the blades were rinsed for approximately 30 seconds under running water at the scrub sink.</p> <p>5. The facility policy "Cleaning Laryngoscope Blades", last reviewed Feb. 20, 2013, indicated, "1. Utilizing universal precautions, the laryngoscope blade is washed by the circulating RN with scrub soap and water after intubation. It is dried prior to placing in disinfectant. 2. The blade is then immersed in the high-level disinfectant per the manufacturer's guidelines. 3. The blade is rinsed with tap water, and dried."</p>				

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	<p>6. Manufacturer's information taped on the lid of the container of disinfectant at the scrub sink indicated, "Once the instrument has been immersed and all surfaces in contact with the disinfectant solution, soak the instrument for 8 minutes. Track the soak time using a timer. It is not recommended to reprocess instruments for longer than 8 minutes."</p> <p>7. Manufacturer's literature regarding rinsing instructions indicated, "5. Following removal from Resert XL, HLD solution, thoroughly rinse the medical device by immersing it completely in water. ...6. Keep the instrument or medical device immersed for a minimum of 1 minute in duration, unless longer is specified by the instrument manufacturer. "</p> <p>8. The facility policy "Cleaning in the OR Between Cases", last reviewed Feb. 20, 2013, indicated. "Procedure: All equipment and environmental surfaces will be cleaned and decontaminated after contact with blood or other potentially infectious materials."</p> <p>9. At 11:45 AM on 10/08/13, staff member #P1 confirmed the manufacturer's guidelines were not</p>			

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S000444	<p>followed regarding the high level disinfectant and the facility policy was not specific regarding the procedures. He/she also confirmed all equipment and surfaces in the OR should be disinfected between cases.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks.</p> <p>Findings included:</p> <p>1. While observing in the pre-op area between 9:10 AM and 9:55 AM on 10/08/13, five different staff members were observed coming out of the surgical area, going to the nurses'</p>	S000444	S444- OR staff in-services will be performed by the Education Coordinator regarding Policy 3245 (Surgical Dress Code), and specifically wearing of the surgical mask. In-services will begin 10/28/2013 and be completed by 12/31/2013. Observation of anesthesia provider with mask hanging from his/her neck by ISDH observer was reported to Medical Director on 10/30/2013, at Medical Staff meeting on 11/4/2013 and will be reported to Medical Executive Committee meeting on	12/31/2013			

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	<p>station, and talking with patients with their surgical masks either covering their nose and mouth, covering only their mouths, or hanging around their necks, then returning to the surgical area. At 9:40 AM, the anesthesiologist, staff member #P7 with a surgical mask hanging around his/her neck, went in to check the case observation patient prior to surgery.</p> <p>2. The facility policy "Surgical Dress Code", last reviewed Feb. 20, 2013, indicated, "Masks must be donned before beginning procedure. Masks should be changed between cases and not left dangling around neck or in scrub suit pockets."</p> <p>3. At 2:45 PM on 10/08/13, staff member #P1 confirmed the facility followed AORN recommendations which indicated surgical masks were to be changed between cases and not worn around the neck or stored in pockets.</p>		<p>11/11/2013. Follow up infection control observations will be conducted on a monthly basis beginning 11/1/2013 using the Infection Control Practices Audit tool by the Infection Control Officer or their designee. Any observed deficiencies will be addressed and corrected on the spot. Results of audits will be reported to the Chief of Anesthesia, QAPI Committee quarterly, and reviewed by the Medical Executive Committee.</p>		

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S000612	<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 medical record review, policy and procedure review, and interview, the facility failed to ensure the "Physician Progress Notes" form was completed accurately and timely for 10 of 25 patients having procedures at the center (#N6, N8, N14, N15, N17, N18, N21, N22, N23, and N24).</p> <p>Findings included:</p> <p>1. The medical record for patient #N6 indicated surgery started at 0910 and ended at 1000 on 03/05/13, but the "Physician Progress Notes" form indicated both the pre-surgical assessment and the postoperative assessment were signed by the physician at 0715 on 03/05/13.</p> <p>2. The medical record for patient #N8 indicated surgery started at 0752 and ended at 0850 on 08/06/13, but the</p>	S000612	S612- In order to increase accuracy and completeness of the entire medical record, a monthly audit of one day's charts to number at least 30 will be completed by the Medical Records Coordinator or their designee. The start date for the auditing will be 11/1/2013. The plan for the audits and the gathered data will be presented to the Medical Executive Committee (MEC) beginning 11/11/2013. The Performance Improvement Coordinator and the Facility Administrator will be responsible for communication with the governing body. Ultimately, the Facility Administrator and Medical Director will be responsible for addressing physician compliance with completion of the medical record. Incremental improvement is expected until a compliance rate of 95% is achieved. Target date of completion is 3/1/2014.	03/01/2014			

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	<p>"Physician Progress Notes" form indicated both the pre-surgical assessment and the postoperative assessment were signed by the physician at 0720 on 08/04/13.</p> <p>3. The medical record for patient #N14 indicated surgery started at 1419 and ended at 1439 on 03/13/13, but the "Physician Progress Notes" form indicated both the pre-surgical assessment and the postoperative assessment were signed by the physician at 1400 on 03/13/13.</p> <p>4. The medical record for patient #N15 indicated surgery started at 1147 and ended at 1154 on 04/15/13, but the "Physician Progress Notes" form indicated the pre-surgical assessment was signed by the physician at noon on 04/15/13 which was after surgery had started.</p> <p>5. The medical record for patient #N17 indicated surgery started at 0614 and ended at 0725 on 07/12/13, but the "Physician Progress Notes" form indicated the pre-surgical assessment was incomplete and the postoperative assessment was signed at 0720 on 07/12/13.</p> <p>6. The medical record for patient #N18</p>						

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	<p>indicated surgery was performed on 07/05/13, but the "Physician Progress Notes" form lacked times for both the pre-operative and post-operative assessments.</p> <p>7. The medical record for patient #N21 indicated surgery was performed on 08/06/13, but the "Physician Progress Notes" form lacked times for both the pre-operative and post-operative assessments.</p> <p>8. The medical record for patient #N22 indicated surgery started at 0844 and ended at 0943 on 03/18/13, but the "Physician Progress Notes" form indicated the pre-surgical assessment was incomplete and lacked a time with the physician's signature.</p> <p>9. The medical record for patient #N23 indicated surgery was performed on 03/29/13, but the "Physician Progress Notes" form lacked a time for the post-operative physician assessment.</p> <p>10. The medical record for patient #N24 indicated surgery was performed on 06/05/13, but the "Physician Progress Notes" form lacked a time for the post-operative physician assessment.</p> <p>11. The facility policy "History and</p>				

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	<p>Physical", last reviewed Feb. 20, 2013, indicated, "Pre-surgical Assessment: A pre-surgical assessment will be performed on each patient by the surgeon or operating practitioner. This assessment will be performed immediately before surgery."</p> <p>12. The facility policy "Maintenance of Medical Records", last reviewed Feb. 20, 2013, indicated, "E. State the current date and time of the entry, and if different, the date and time of the event that is the subject of the entry. F. Be complete such that all lines of a particular entry are either filled or a single line is drawn through the remainder of the line, and all blanks of a particular form are either completed or marked 'N/A'."</p> <p>13. At 10:00 AM on 10/09/13, staff member #P1 confirmed the discrepancies with the "Physician Progress Notes" forms in the medical records reviewed.</p>			

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S001146	<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 observation, AORN recommendations, and interview, the facility failed to ensure a safe environment for patients with regard to warmed fluids.</p> <p>Findings included:</p> <p>1. During the tour of the surgical area at 10:05 AM on 10/08/13, accompanied by staff member #P1, a Logiquip Warmer was observed registering 104 degrees F. (Fahrenheit) for the top cabinet and 126 degrees F. for the bottom cabinet. The bottom cabinet contained only blankets, but the top cabinet contained 13 bags of Lactated Ringers intravenous fluid (IV), 5 bags of 0.9% Normal Saline IV fluid, and 2 containers of 0.9% Normal Saline irrigation fluid. The 2 containers of irrigation fluid had a date sticker of 1</p>	S001146	S1146- Policy developed for fluid and blanket warmers indicating rules for the storage, use, and monitoring of fluids and blankets that are warmed prior to patient use. Manufacturer guidelines will be followed regarding temperature and length of storage time for IV and irrigation solutions. All fluids stored in warmer will be labeled with date they were placed in warmer, cabinet will bear label that indicates manufacturer recommended length of stay in warmer and manufacturers recommended temperature. Daily monitoring of the fluid warmer will continue. The blanket warmer daily temperature monitoring will begin 11/11/2013. The Physical Plant Manager or his/her designee will be responsible for monitoring the daily fluid and blanket warmer temperatures. In-servicing for	12/31/2013

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	<p>Oct. 13, but the IV fluids were not dated. The temperature monitoring logs indicated only the top cabinet of the warming unit was monitored and was consistently at 104 degrees F.</p> <p>2. AORN recommendations indicated both fluid and blanket warmers should be monitored regularly with blanket cabinets not above 130 degrees F. and fluids warmed and stored according to manufacturer guidelines.</p> <p>3. At 2:45 PM on 10/08/13, staff members #P1 and P2 confirmed the facility followed AORN recommendations, but did not have a policy regarding the warmers. They indicated only the fluid cabinets were monitored and they did not have the manufacturer directions regarding warming and storing the fluids.</p>		<p>staff regarding the above changes will be completed by the Education Coordinator no later than 12/31/2013.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001106		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/09/2013	
NAME OF PROVIDER OR SUPPLIER  EVANSVILLE SURGERY CENTER ASSOCIATES LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4133 GATEWAY BLVD STE 100 NEWBURGH, IN 47630			
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S001156	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(D)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(D) Maintenance and repairs must be carried out in accordance with applicable codes, rules, standards, and requirements of local jurisdictions, administrative building council, the state fire marshal, and the department.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the facility was being inspected by whomever has local jurisdiction over the state fire marshal inspections in the previous 4 years and 9 months.</p> <p>Findings included:</p> <p>1. The last Compliance Inspection Report/Fire and Building Code</p>	S001156	S1156- Deficiency Corrected. Contact was made with Division OF FIRE AND BUILDING SAFETY INDIANA DEPARTMENT OF HOMELAND SECURITY on 10/28/2013 to request survey by State Fire Marshall. Facility was inspected on 10/30/2013. Noted violations will be corrected within 30 days (11-30-2013) or sooner and contact made with Fire Marshall for re-inspection of facility. Annual follow up inspections will be scheduled by ESC Safety Officer through the DIVISION OF FIRE AND BUILDING SAFETY	10/30/2013			

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S001164	<p>Enforcement was conducted on 1/22/09.</p> <p>2. At 2:15 PM on 10/8/13, staff member #11 indicated the surgery center has not been inspected to make sure the facility was in compliance of code enforcement for over 4 years.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</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>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on documentation review and staff interview, the facility</p>	S001164	<p>INDIANA DEPARTMENT OF HOMELAND SECURITY to ensure future compliance.</p> <p>S1164- Preventive Maintenance Log has been developed for auxiliary air compressor to</p>	11/01/2013			

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	<p>failed to perform required preventive maintenance inspections on the Portable Air Compressor as per manufacturer's manual.</p> <p>Findings included:</p> <p>1. Portable Air Compressor Manual Preventive Maintenance section states, "Daily Maintenance - Check and maintain oil level, Drain condensate from receiver, check for unusual noise or vibration; Weekly Maintenance - Clean Air Filters, Clean all external parts of the compressor, Check the safety valve manually; Monthly Maintenance - Inspect the entire system for leaks, Inspect condition of oil and change if necessary, check drive belt tension and tighten if necessary; Every 3 months or 1000 hours of operation - Change oil, Inspect valves, Check and tighten bolts if necessary, check Unloader operation."</p>		<p>facilitate and document preventive maintenance performed at manufacturer's specified intervals effective 11/1/2013. Pol. 111 (Safety Program/ Routine Maintenance Checks) was revised on 10/30/2013 to reflect addition of Auxiliary Air Compressor to list of routinely inspected equipment. Physical Plant Manager will be responsible for performing routine preventative maintenance at specified intervals and maintaining maintenance log.</p>		

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	<p>2. At 12:30 PM on 10/8/2013, the house keeping closet was inspected. The room was observed with a portable air compressor that opens the washer drawers in Central Sterile. The drawers need 80 lbs psi for them to open. On the compressor was a yellow maintenance inspection sign. The sign summarized the maintenance inspections that were required for daily, weekly, monthly, and quarterly. The room did not have a maintenance manual that notes the required preventive maintenance inspections were performed.</p> <p>3. At 1:00 PM on 10/8/2013, staff member #11 indicated he/she does not preformed the maintenance inspections that were required by the manufacturer's operation manual. The staff member indicated the reason the periodical maintenance inspections were not performed as required was he/she thought the manual was for compressor that work with paint.</p>			

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	Staff member #11 indicated the oil was changed annually and the filters have never been cleaned. The staff member indicated he/she does not maintain a log book on the compressor.			