

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001158	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/12/2014
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NAME OF PROVIDER OR SUPPLIER ST VINCENT SURGERY CENTER OF TERRE HAUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E MCCALLISTER DR TERRE HAUTE, IN 47802
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005650</p> <p>Survey Date: 6/11/14 through 6/12/2014</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Carol Laughlin, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/23/14</p>	S000000		
S000056	<p>410 IAC 15-2.3-2 POSTING OF LICENSE 410 IAC 15-2.3-2 (a)</p> <p>Sec.2.(a) The license must be conspicuously posted on the premises. Based on observation and staff interview, the facility failed to ensure the posting of</p>	S000056	S-0056The state license was hung in a frame along with AAAHC Accreditation Certificate,	07/08/2014

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

TITLE

(X6) DATE

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

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S000328	<p>a copy of the current license in an area conspicuously open to the patients and public.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Upon entering the facility on 06/11/14 at 0930, it was observed that there was no license posted in the entry/lobby/waiting area or at or near the glass registration window. The license was posted on a bulletin type board on the wall to the right behind the registration person, who was behind the glass window. The license could only be viewed by standing directly in front of the open glass window. 2. The posting of the license on the wall behind the registration person and glass window was confirmed by A2 on 06/11/14 at 1315. <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p>		<p>Notice of Compliance for Radiation Machines, Radiation Machine Registration, and Certificate of Occupancy in the patient registration area. Upon the recommendation of the state surveyors the framed license has been relocated to the main entrance lobby/waiting room. The administrator will ensure the license continues to hang in the public area. The relocation was completed on July 8, 2014</p>	

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	<p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on documentation review and staff interview, the facility failed to take appropriate action to address the opportunities for improvement for contracted housekeeping and contracted radiology services.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. St. Vincent Surgery Center of Terre Haute Quality Improvement Plan policy #2.1.14 (last approved 1/24/2013) stated, "Evaluate the level of Quality of Care provided and the establishment of mechanisms for change and/or improvement when needed." 2. The St. Vincent Surgery Center of Terre Haute Monthly Housekeeping Audits were reviewed for the 4th quarter of 2013 and the 1st quarter of 2014. The reports identified spot checks 	S000328	S-0328The meeting minutes of the March 2014 Quality Meeting have been revised to appropriately reflect the discussion of the issues with contracted services (housekeeping and radiology) along with the plan of correction, actions and resolution. (Attached)The administrator will be responsible to ensure that the detailed discussion of plans of correction, actions and resolutions will be documented in the meeting minutes in order to properly demonstrate the quality improvement opportunities and resolutions. The minutes were updated on July 3, 2014.	07/03/2014

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	<p>revealed the same housekeeping issues. The response to the identified housekeeping issues of the contracted service was the cleanliness of the molding. The quality assurance audits did not address the opportunities to resolve the issue.</p> <p>3. The 2014 St. Vincent Surgery Center of Terre Haute Criteria for Evaluation of Efficacy on Radiology contracted service identified they did not meet Response to Urgent Calls. The response to this lack of expectations was the reason the contracted service did not meet the expectations. The Quality Assurance process did not address opportunities for improvement in quicker response to urgent calls.</p> <p>4. At 11:45 AM on 6/12/2014, staff member #1 confirmed the quality assurance documentation does not provide action plans to address lacking performance of the contracted services.</p>			

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S000400	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the humidity and temperature of the Operating Rooms are maintained according to policies and procedures.</p> <p>Findings included:</p> <p>1. Room Temperature and Humidity policy #2.2.243 (last approved 1/24/2013) stated, "The center will monitor the operating/procedure rooms for compliance of temperature and humidity levels according to code. Acceptable temperature range: 68 to 73 degrees F; Acceptable humidity range: 20% to 60%."</p>	S000400	<p>S-0400HVAC preventative maintenance for June was conducted on June 24, 2014. The technician made adjustments that were directed at lower the humidity. A new log was created to assist with the identification of recommended ranges for both temperature and humidity. (attached)The staff have been informed about the recommended ranges and new log in a staff meeting held on July 8, 2014. A sign has been created for each OR room to inform the physician of the recommended ranges. The Clinical Director will track any requests by surgeons to lower temperatures. If such requests do occur within the next 60 days then a review of the recommended practices will be conducted to evaluate if a policy change will be appropriate to accomodate such requests. The administrator is responsible to ensure recommended ranges are maintained on an ongoing basis. The clinical director or</p>	07/08/2014
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	<p>2. The St. Vincent Surgery Center of Terre Haute Room Temperature & Humidity Logs were reviewed between February 1, 2014 through April 1, 2014. The surgery center has two operating rooms and 1 procedure room. The logs revealed 96% of the time, both Operating Rooms 1 & 2 did not meet the required temperatures while the humidity in Operating Room 1 and 2 did not meet the required humidity levels, 13% and 9% respectively. The Procedure Room did not meet the required temperature and humidity levels, 30% and 9% of the time respectively.</p> <p>3. At 2:00 PM on 6/11/2014, staff member # 1 confirmed the operating rooms' temperature and humidity are not maintained to the levels defined by the facility's policies. The staff member indicated there are physicians that want the temperature lower than the requirements.</p>		<p>administrator will be notified when ranges are not appropriate. When any area fails to meet the recommended range for three consecutive days, the materials manager will contact the HVAC contractor for appropriate action. As of July 1 through July 8, the temperature and humidity for each OR is at recommended levels. (attached logs)</p>				

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S000850	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4 (d)</p> <p>(d) Surgical services must be organized according to scope of the services offered, to meet the needs of the patient, in accordance with acceptable standards of practice and safety. Requirements for surgical services include:</p> <p>Based on observation, policy review and staff interview, the facility failed to ensure implementation of its policy regarding attire in patient care areas.</p> <p>Findings:</p> <p>1. During tour of the operating rooms area (OR) with A2 on 06/11/14 at 1442, A3, a circulating nurse, was observed in OR 1 with a bouffant cap behind his/her ears, exposing both hair on the sides and at the neck and hoop earrings. A3 was also wearing a necklace and a bracelet unconfined. In OR 2, A4, a scrub nurse, was observed wearing a bouffant cap behind his/her ears, exposing both hair on the sides and at the neck and stud earrings.</p> <p>2. Review of facility policy on 06/12/14, # 2.1.67, Attire in Patient Care Area (Restricted, Semi-Restricted,</p>	S000850	S-0850The staff clearly failed to follow the policy on proper attire in the operating room as it relates to hair and jewelry.The clinical manager reviewed the policy in detail at a staff meeting on July 8, 2014 to ensure proper education and ongoing compliance.The clinical manager will be responsible to ensure compliance with policy through daily observation. Infection control nurse will assist clinical director with survelience and ongoing staff education as appropriate.	07/08/2014

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S001164	<p>Non-Restricted), revised September 2012, Page 1 of 2, II., <u>Proper Dressing Attire</u>; b., "All possible head and facial hair, including sideburns and necklines, should be covered while in the restricted areas of the surgical suite: i. The surgical hat or hood should be clean, lint free, and confine hair". Page 2 of 2, V., <u>Other</u>; c. "Jewelry: All personnel entering the restricted areas of the surgical suite should have jewelry confined or removed".</p> <p>3. A2 confirmed the observation of hair and jewelry on 06/11/14 at 1450.</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</p>						

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	<p>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. Based on documentation review and staff interview, the facility failed to provide documentation that the wheelchairs and patient emergency call systems are having preventive maintenance performed on them.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The preventive maintenance reports were reviewed and lacked evidence that the center's patient emergency call systems and patient wheelchairs had routine preventive maintenance performed on them. At 2:22 PM on 6/11/2014, staff member #1 indicated the facility does not have documented evidence that preventive maintenance was performed on the 	S001164	<p>S-1164Materials Manager performs the required preventative maintenance/safety checks yearly on both wheelchairs and nurse call system.Safety checks had been performed but we could not produce the required documentation.A log which includes both items has been developed and tab made for the maintenance log book so that the documentation is readily available upon request and not forgotten by the Materials Manager. Safety checks were performed on July 2, 2014 and properly documented (attached).The administrator and/or clinical director will be responsible for ongoing documentation of yearly checks. The checks will be noted at the Quality Meeting on a yearly basis.</p>	07/02/2014

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S001188	<p>emergency call systems and the wheelchairs.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on documentation review and staff interview, the facility failed to evaluate 1 of 4 fire drills as required per policy and procedures.</p> <p>Findings included:</p> <p>1. St. Vincent Surgery Center of Terre Haute Fire - Code Red Plan policy #3.3.2 (last approved 1/24/2013) stated, "The procedure</p>	S001188	S-1188Safety Officer failed to complete the evaluation section of the fire drill form for the fire drill conducted on March 31, 2014.Safety Officer was informed on June 16, 2014 of his failure to complete evaluation section on the above drill along with the importance of the evaluation section. On June 30, 2014, the quarterly fire drill was conducted with proper completion of the form by the Safety Officer (attached).The administrator and/or clinical director will be responsible for ensuring form completion by reviewing and	06/30/2014
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	<p>for a fire drill will be identical to those actions taken in the event of a real fire. Fire drills will be evaluated to identify any areas for improvement."</p> <p>2. Fire Drill held 3/31/2014 had survey questions that evaluate the response of the fire drill. The personnel that participate in the fire drill respond to the survey questions and at the end of the questions, the fire drill was to be evaluated for effectiveness. The March 31, 2014 Fire Drill Survey Form was incomplete and the fire drill was not evaluated as required per surgery center's policies and procedures.</p> <p>3. At 1:00 PM on 6/11/2014, staff member #1 confirmed the 3/31/2014 fire drill was not evaluated as required per policy.</p>		initially the form prior to placing in the appropriate log book.				