STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001133	A. BUILDING 00 B. WING	01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000000	The visit was for a Federal recertification survey. Facility #: 003633 Date: 1-22-13 through 1-23-13 Surveyors: Billie Jo Fritch RN, MSN, MBA Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor QA: claughlin 01/30/13	O000000	no plan of correction needed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
Q000101	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on observation and document review, the facility failed to keep the operating room (OR) doors closed except for movement of the patient into the room for 1 procedure observed. Findings include: 1. At 1:50 p.m. on 1/22/13, the operating room door was left opened for an extended period of time with surgical instruments opened on the back table. The staff were observed positioning the patient and adding equipment (stored in the room) to the table as well as performing the time out procedure while the door was left open. 2. AORN standards, recommended practices, and guidelines 2007 edition states on page 704: "2. Doors to the operating or procedure rooms should be closed except during movement of patients, personnel, supplies, and equipment. The air pressure within each operating or procedure room should be	O000101	1.OR door will remain closed except during movement of patients, personnel, supplies and equipment. 2.The OR door will remain closed except during movement of patients, personnel, supplies and equipment effective immediately. 3. C. Lim, MD-Administrator 4. Staff was educated and corrected this deficiency on 01/29/2013.Changed to: 1.OR doorwill remain closed except during movement of patients, personnel, supplies andequipment.2.The OR door will remain closed except during movement of patients, personnel,supplies and equipment effective immediately. There will periodic surpriseinspections of OR Suite Doors to enforce that they are being kept closed asrequired.3. M. Bedwell, DON and C. Lim, MD- Administrator 4. Staff was educated and corrected thisdeficiency on 01/29/2013	01/29/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	greater than in the semirestricted area. The air in the OR should be maintained under positive pressure with a minimum of 15 total room air exchanges per hour. When the doors are left open, the heating, ventilation, and air conditioning system is unable to maintain these critical environmental parameters. Leaving the door open can disrupt pressurization and cause turbulent airflow that could increase airborne contamination....."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000106	416.44(d) EMERGENCY PERSONNEL Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC. Based on document review and interview, the facility failed to follow the approved policy for Cardiopulmonary Resuscitation (CPR) training for one of three physicians (MD#3) and one of one surgical technicians (H#3). Findings included: 1. Review of credential files and personnel files on 1-22-13 and 1-23-13 lacked evidence one of three physicians (MD#3) and one of one surgical technicians (H#3) had documentation of current CPR competency. 2. Review of facility policy #1200.02, last reviewed 2-11-10, titled CARDIOPULMONARY RESUSCITATION TRAINING indicated the following: All staff will be trained in CPR and will follow proper procedure in case of cardiopulmonary emergency; all physicians with privileges will maintain current CPR certification; all physicians will provide proof of current certification in CPR; failure to provide proof of CPR certification may result in termination of employment and physicians not being permitted to schedule procedures; a copy	O000106	1.CPR training is scheduled for 3/06/13 at Terre Haute Regional Hospital for H#3 and MD#3.2.Healthcare workers providing direct patient care will have current CPR training and a current CPR card will be kept in the employee/physician file in the personnel office.3. C. Lim, MD-Administrator4. Class will be 3/06/13.	03/06/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	of current CPR card will be kept in employee/physician files in the personnel office. 3. Interview with B#1 on 1-23-13 at 1550 hours confirmed the facility policy requires all staff, including physicians, maintain current CPR competency and documentation; B#1 confirmed one of three physicians (MD#3) and one of one surgical technicians (H#3) lacked documentation of current CPR competency as required by facility policy.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000122	416.45(b) REAPPRAISALS Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. Based on document review and interview, the medical staff failed to periodically reappraise the medical staff privileges for three of three (MD#1 - MD#3) physicians. Findings included: 1. Review of physician medical staff credential files on 1-22-13 and 1-23-13 indicated the following: a.) MD#1, most recent reappraisal 4-8-2008. b.) MD#2, most recent reappraisal 4-8-2008. c.) MD#3, most recent reappraisal 5-9-2008. 2. Review of the Medical Staff ByLaws/Rules and Regulations on 1-22-13 and 1-23-13 indicated the following: 2.4.2 Reappointment to any category of the Staff shall be for a period of two (2) years. 3. Interview with B#1 on 1-23-13 at 1550 hours confirmed the Medical Staff ByLaws/Rules and Regulations require members of the medical staff to be reappraised/reappointed every two years;	Q000122	1. The physicians will be reappointed/reappraised on 3/01/13 as required. 2. The physicians will be reappointed/reappraised every two years as required. A spreadsheethas be implemented to insure that all meeting, annual check of staff filesincluding medical doctors, reappointed of physicians, review of medicalrecords, pharmacy checks, utilization review, HVAC inspections , policies and proceduresreview every 3 years. Reappointed/reappraised physicians every two years 3. C. Lim, MD - Administrator 4. 3/01/13	03/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	B#1 confirmed MD#1 was most recently reappraised/reappointed 4-8-2008; MD#2 was most recently reappraised/reappointed 4-8-2008; MD#3 was most recently reappraised/reappointed 5-9-2008.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15C0001133		01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. Based on document review and staff interview, the facility failed to ensure the medical record contained an operative report for 1 of 1 patient who had surgery performed by M.D. #2 (patient #N11). Findings include: 1. Patient #N11 had surgery on 11/28/12 by M.D. #2. The medical record lacked documentation of an operative report. 2. Staff member #N2 verified the above at 3:45 p.m. on 1/23/13.	O000162	1. MD#2 faxed the correct Operative Report to our facility and it was placed in the patient file (N#11) 2. Charts will be reviewed for Operative Reports before filed in medical record storage. 3. C. Lim, MD - Administrator 4. 1/24/13	01/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on staff interview, the facility failed to ensure multi dose vials were destroyed after 28 days once opened. Findings include: 1. Staff member #N1 indicated in interview at 2:00 p.m. on 1/23/13 that multi-dose vials are destroyed 30 days after they are opened. 2. Joint Commission article titled "Clarification Expiration of Multi dose Vials" states: "USP1 and APIC2 now recommend that opened or punctured multi-dose vials be used for no more than 28 days...."	O000181	1. 1/28/13 Each multi-dose vial will be initialed and dated when opened and will be destroyed after 28 days. 2. All mult-dose vials will be initialed and dated. They will be destroyed after 28 days once opened. 3. Dr. C. Lim, MD - Administrator 4. 1/28/13 1/28/13 Eachmulti-dose vial will be initialed and dated when opened and will be destroyedafter 28 days.2. All multi-dose vials will be initialed and dated. They will be destroyedafter 28 days once opened. The multi-dose vials will be checked periodically byDr. C. Lim, Administrator. Nathan Propst, Pharmaceutical Consultant, will alsocheck quarterly.3. Dr. C. Lim, MD - Administrator4. 3/14/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000221	416.50(a)(1) NOTICE OF RIGHTS The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands. Based on document review and staff interview, the facility failed to ensure patients received verbal and written notice of rights in advance of the current procedures performed for 6 of 20 patients (patients #3, 4, 5, 13, 14, and 15). Findings include: 1. Patient #N3 had surgery on 3/6/12. His/her notice of patient rights was signed as received on 7/26/11. 2. Patient #N4 had surgery on 5/2/12. His/her notice of patient rights was signed as received on 3/27/12. 3. Patient #N5 had surgery on 10/2/12. His/her notice of patient rights was signed as received on 2/28/12. 4. Patient #N13 had surgery on 9/11/12. His/her notice of patient rights was signed as received on 8/28/12. 5. Patient #N14 had surgery on 9/11/12. His/her notice of patient rights was signed	O000221	1. 1/28/13 Patients are receiving verbal and written notice of rights in advance of each procedure instead of annually. 2. Patients will be given verbal and written notice of rights in advance of each procedure instead of annually. 3. C. Lim, MD - Administrator 4. 1/28/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	as received on 8/2/11. 6. Patient #N15 had surgery on 12/14/12. His/her notice of patient rights was signed as received on 11/30/12. 7. Staff member #A1 indicated in interview at 3:15 p.m. on 1/23/13 that he/she thought the notice had to be presented on an annual basis only.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000222	4166.50(a)(1)(i) NOTICE - POSTING In addition, the ASC must - Post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. Based on observation, document review, and interview, the facility failed to include the web site for the Office of the Medicare Beneficiary Ombudsman in the posted notice of patients rights. Findings included: 1. While touring the facility lobby on 1-23-13 at 1005 hours, it was observed that the posted Patients' Rights did not contain the web site for the Office of the Medicare Beneficiary Ombudsman. 2. Interview with B#1 on 1-23-13 at 1005 hours confirmed that the posted Patients' Rights did not contain the web site for the Office of the Medicare Beneficiary Ombudsman.	O000222	1. The posted Bill of Patients Rights now has the Medicare Beneficiary Ombudsman website link included as of 1/28/13. 2. The Medicare Beneficiary Ombudsman website link will remain posted on the Bill of Patients Rights as required.3. C. Lim, MD - Administrator4. 1/28/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000223	416.50(a)(1)(ii) NOTICE - PHYSICIAN OWNERSHIP The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure. Based on document review and staff interview, the facility failed to ensure patients received notice of financial ownership or physician financial interest in advance of the current procedure performed for 6 of 20 patients (patients #3, 4, 5, 13, 14, and 15). Findings include: 1. Patient #N3 had surgery on 3/6/12. His/her notice of physician ownership was signed as received on 7/26/11. 2. Patient #N4 had surgery on 5/2/12. His/her notice of physician ownership was signed as received on 3/27/12. 3. Patient #N5 had surgery on 10/2/12. His/her notice of physician ownership was signed as received on 2/28/12. 4. Patient #N13 had surgery on 9/11/12. His/her notice of physician ownership was signed as received on 8/28/12. 5. Patient #N14 had surgery on 9/11/12.	Q000223	1. Patients are being notified prior to each procedure of physician ownership. Effective 1/28/13. 2. Patients will be notified prior to each procedure of physician ownership. The form that is given to show this, will be signed and placed in patient chart. 3. Dr. C. Lim, MD - Administrator 4. 1/28/13 Changed: Patients are being notified prior to each procedure ofphysician ownership. Effective 1/28/13. 2. Patients will be notified prior to each procedure of physician ownership.The form that is given to show this, will be signed and placed in patientchart. Tammy Siner, Medical Records Consultant, will ensure this is being doneduring her quarterly chart reviews. 3. Tammy Siner, Medical Records Consultant and C. Lim, MD, Administrator 4. 3/14/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	His/her notice of physician ownership was signed as received on 8/2/11. 6. Patient #N15 had surgery on 12/14/12. His/her notice of physician ownership was signed as received on 11/30/12. 7. Staff member #A1 indicated in interview at 3:15 p.m. on 1/23/13 that he/she thought the notice had to be presented on an annual basis only.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000224	416.50(a)(2) ADVANCE DIRECTIVES The ASC must comply with the following requirements: (i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms. (ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. Based on document review and staff interview, the facility failed to ensure patients received the facility policy on advance directives in advance of the current procedures performed for 6 of 20 patients (patients #3, 4, 5, 13, 14, and 15). Findings include: 1. Patient #N3 had surgery on 3/6/12. His/her notice of facility policy on advance directives was signed as received on 7/26/11. 2. Patient #N4 had surgery on 5/2/12. His/her notice of facility policy on advance directives was signed as received on 3/27/12.	O000224	1. Patients are being notified prior to each procedure of the facility policy on advanced directives. Effective 1/28/13. 2. Patients will be notified prior to each procedure of facility policy on advanced directives. The form that is given to show this, will be signed and placed in patient chart. 3. Dr. C. Lim, MD - Administrator 4. 1/28/13 Changed to Patients arebeing notified prior to each procedure of physician ownership. Effective1/28/13.2. Patients will be notified prior to each procedure of physician ownership.The form that is given to show this, will be signed and placed in patientchart. Tammy Siner, Medical Records Consultant, will ensure this is	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	3. Patient #N5 had surgery on 10/2/12. His/her notice of facility policy on advance directives was signed as received on 2/28/12. 4. Patient #N13 had surgery on 9/11/12. His/her notice of facility policy on advance directives was signed as received on 8/28/12. 5. Patient #N14 had surgery on 9/11/12. His/her notice of facility policy on advance directives was signed as received on 8/2/11. 6. Patient #N15 had surgery on 12/14/12. His/her notice of facility policy on advance directives was signed as received on 11/30/12. 7. Staff member #A1 indicated in interview at 3:15 p.m. on 1/23/13 that he/she thought the notice had to be presented on an annual basis only.		being doneduring her quarterly chart reviews.3. Tammy Siner, Medical Records Consultant and C. Lim, MD, Administrator4. 3/14/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
Q000225	416.50(a)(3)(i), (v), (vi), (vii) SUBMISSION AND INVESTIGATION OF GRIEVANCES (i) The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC. (v) The grievance process must specify timeframes for review of the grievance and the provisions of a response. (vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished. (vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed. Based on document review and interview, the facility failed to provide a procedure for grievances communicated verbally or by telephone, a procedure to provide the patient/representative with the steps taken to investigate the grievance, or the results of the grievance process. Findings included: 1. Review of the facility policy #1000.21 titled GRIEVANCE POLICY on 1-22-13 indicated the following: Any patient with a complaint or grievance shall address it to the Grievance Director, MD#1, in	Q000225	1. Patients are being notified prior to each procedure of facility grievance policy. The policy has been changed to indicate grievance can be written or verbal. Patient will be notified of an investigation and outcome once resolved within 5 days. Effective 1/28/13. 2. Patients will be notified prior to each procedure of facility grievance policy. The policy has been changed to indicate grievance can be written or verbal. Patient will be notified of an investigation and outcome once resolved within 5 days. The form that is given to show this,	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	writing; the Grievance Director will notify the filer by mail and will be given a phone number to talk to the Director about additional problems or questions. 2. Interview with B#1 on 1-23-13 at 1550 hours confirmed the Grievance Policy does not address grievances communicated verbally or by telephone, providing the patient/representative with the steps taken to investigate the grievance, or the results of the grievance process.		will be signed and placed in patient chart. 3. Dr. C. Lim, MD - Administrator 4. 1/28/13 Changed to: 1. Patients are being notifiedprior to each procedure of facility grievance policy. The policy has beenchanged to indicate grievance can be written or verbal. Patient will benotified of an investigation and outcome once resolved within 5days. Effective 1/28/13.2. Patients will be notified prior to each procedure of facility grievancepolicy. The policy has been changed to indicate grievance can be writtenor verbal. Patient will be notified of an investigation and outcome onceresolved within 5 days. The form that is given to show this, will be signed andplaced in patient chart. Tammy Siner, Medical Records, Consultant will ensurethis is being done during the quarterly chart reviews.3. Tammy Siner, Medical Records, Consultant and C. Lim, MD, Administrator4. 1/28/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on observation, document review, and staff interview the facility failed to provide a safe and healthful environment that minimized risks to patients and staff. Findings include: 1. During survey, the following breaches in infection control were observed: (A) CRNA #1 was observed starting an I.V. on patient #N1 at 1:30 p.m. on 1/22/13. He/she removed his/her gloves and failed to perform hand hygiene after the procedure. He/she went to the nurse station and began talking on a cell phone and then proceeded to the operating room. (B) At 2:00 p.m. on 1/22/13, M.D. #1 was observed recapping a syringe after injecting medication into patient #N1. (C) At 2:05 p.m. on 1/22/13, staff member #N3 was observed recapping a syringe after it had been used to injection medication into patient #N1. (D) Two of Two (2/2) boxes of expired 5 cc syringes were observed in supply room #217. The expiration date of the syringes was 4/12. (E) The facility had alcohol foam hand	Q000241	1. 1/30/13 Policy was written on handwashing after gloves are removed. It has been reviewed and implemented by all staff. Policy was written on recapping needles. It has been reviewed and implemented by all staff. All expired items were moved to storage room for Mission Use Only. On 2/01/13 hot water heater temperature was increased to 160 degrees. 1/30/12 Operating Rooms will be cleaned according to Infection Control and Operating Room Sanitation Policies. 2. Employees will wash hands when removing gloves. Employees will no longer recap needles. Expired items will be moved to Mission Use Only storage room. Laundry will now be done at 160 degrees or hotter. Operating Rooms will be cleaned according to Infection Control and Operating Room Sanitation Policies. 3. C. Lim, MD - Administrator 4. 1/30/13 Changed to: 1. 1/30/13 Policy was written on handwashingafter gloves are removed. It has been reviewed and implemented by all staff. Policy was written on recapping needles. It has been reviewed and	01/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	sanitizer in the nutrition pantry and the patient pre-operative area observed at 1:45 p.m. on 1/23/13, however the foam was expired. The expiration dates on the foam were 2010 and 2011. (F) Observation of operating room cleaning after the last procedure at 3:00 p.m. on 1/22/13 indicated that staff member #N3 wiped horizontal surfaces and mopped the floor only. He/she did not clean kick buckets, cabinets, doors, scrub sinks or carts. (G) Tour of bulk supplies beginning at 10:30 a.m. on 1/23/13 indicated there were numerous outdated supplies including thirty four (34) 5 cc syringes with an expiration date of 11/2010, eighteen (18) 5 cc syringes with an expiration date of 4/2012, and thirteen (13) 9 oz. containers of Alcare foam antiseptic handrub with an expiration date of 11/11. 2. Review of facility policy titled "Infection Control in Surgery" last reviewed/revised last reviewed/revised 5/19/11 states on page 1: "1.4.1.....Hands shall be washed:.....1.4.1.8 After removing gloves...." Page 4 states: "1.16.5 Supplies are checked weekly for outdating." 3. Review of facility policy titled		implementedby all staff.All expired items were moved to storage room for Mission Use Only.On 2/01/13 hot water heater temperature was increased to 160 degrees.1/30/12 Operating Rooms will be cleaned according to InfectionControl and Operating Room Sanitation Policies. We adopted a policy onrecapping needles. Infection Control Officer will observe surgery casesrandomly to ensure that no employees are recapping needles. 2. Employees will wash hands when removing gloves. Employees will nolonger recap needles. Expired items will be moved to Mission Use Only storageroom. Laundry will now be done at 160 degrees or hotter. Operating Rooms willbe cleaned according to Infection Control and Operating Room SanitationPolicies.3. Infection Control Officer and C. Lim, MD - Administrator4. 1/30/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	"Operating Room Sanitation" last reviewed/revised 2/15/11 states on page 2: "2.5 End of the day cleaning includes, but is not limited to, ...2.5.2 Cleaning and disinfection of kick buckets 2.5.3 Cleaning of cabinet doors and operating room doors 2.5.4 Cleaning of scrub sink 2.5.5 Cleaning of transport and utility carts....." 4. Facility policy titled "Infection Control In Surgery" last reviewed/revised 5/19/11 states on page 2: "1.8.1: Operating rooms shall be terminally cleaned at the end of each day and made ready for the next days use....." Page 3 states: "1.11 Terminal Cleaning (at end of day) 1.11.1 Remove all removable items from the room after disinfecting 1.11.2 Completely wash with disinfectant all remaining furniture and equipment on all surfaces, including wheels, legs, casters and conductive tips....." 5. Staff member #N3 indicated in interview at 3:00 p.m. on 1/22/13 that he/she cleans the room at the end of the day including wiping the operating room table, horizontal surfaces, and mopping the floor. He/she indicated that staff member #N4 terminally cleans the operating rooms on Saturdays. 6. Staff member #N4 indicated in phone			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	interview at 1:00 p.m. on 1/23/13 that he/she works on Saturdays and mops and buffs the floors as needed. He/she indicated the operating rooms are already cleaned prior to Saturday and he/she only cleans something if a note is left, but does not have a lot of extra time. 7. Review of facility policy #900.39 titled INFECTION CONTROL IN HOUSEKEEPING/LINEN, on 1-23-13 indicated the following: All linen will be washed following CDC guidelines, with reference to an attachment. 8. Review of the attachment to policy #900.30 on 1-23-13 indicated the following: a temperature of at least 160 degrees for a minimum of 25 minutes is commonly recommended for hot-water washing; chlorine bleach becomes activated at water temperature of 135-145 degrees. 9. While touring the facility on 1-23-13 with B#1 and B#3, it was observed that the facility's laundry is done at the facility which included the linens/gowns for patients and the scrubs for staff; the water temperature log was attached to the cabinet next to the washer/dryer. 10. Review of the laundry water temperature log on 1-23-13 indicated the water temperature for facility laundry was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	between 122 degrees and 129 degrees during January through December 2012 and January 2013. 11. Interview with B#1 on 1-23-13 at 1542 hours confirmed the facility's laundry for patient linens/gowns and staff scrubs is done at the facility; B#1 confirmed the policy indicates the facility will follow CDC guidelines of 160 degrees for laundry water temperature; B#1 confirmed the laundry water temperatures for January through December 2012 and January 2013 were between 122 degrees and 129 degrees and did not follow the approved facility policy.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. Based on document review and staff interview, the facility failed to have a system in place to track infections. Findings include: 1. Review of document titled "Infection Control Log" indicated for the months of June-October 2012 and also December 2012 were blank. 2. Staff member #N2 indicated in interview at 3:45 p.m. on 1/23/13 that there was not a system that is kept current to track infections.	O000242	1. Effective 1/28/13, Infection Control Committee has established a system for identifying, reviewing and reporting infections in the center. 2. Infections will be noted in the Patient Log Book next patient's name and date of surgery. Infections will be followed up by surgeon as necessary until infection free. 3. C. Lim, MD - Administrator 4. 1/28/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000261	416.52(a)(1) ADMISSION ASSESSMENT Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. Based document review and observation, the facility failed to ensure the physician performed a history & physical (H&P) exam prior to the surgical procedure for 1 patient observed (patient #N1). Findings include: 1. Facility policy titled "MEDICAL STAFF COVERAGE AND RESPONSIBILITIES" last reviewed/revised 5/19/11 states "Required responsibilities OUTPATIENT SURGERIES" will include: 6.1 Histories and physicals (Medical Clearance) 6.1.1 An H&P may be written or dictated up to 7 days prior to surgery but must have an updated progress note documented upon admission." 2. During observation of patient #N1's visit to the facility beginning at 12:00 p.m. on 1/22/13 indicated the following: (A) The patient presented for a varicose vein ligation and stripping and was	O000261	1. History and Physicals are being done on the date of surgery if not they are being done within 7 days prior and include an updated progress note on the date of surgery, effective 1/28/13. 2. Patient will not have surgery unless a History and Physical is done immediately prior or within 7 days prior with a progress note done on the date of surgery. 3. C. Lim, MD - Administrator 4. 1/28/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	observed from the point of registration to the post operative phase (B) M.D. #1 did not perform an H&P on the patient prior to the surgical procedure. 3. Review of the medical record for patient #N1 on the following day (1/23/13) indicated the following: (A) There was a signed and completed H&P examination indicating that HEENT, neck, cardiac, lungs, abdomen, genitalia & rectal, and neurological were all within normal limits. The H&P was dated 1/22/13.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15C0001133		01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
Q000262	416.52(a)(2) PRE-SURGICAL ASSESSMENT Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals. Based on document review and observation, the facility failed to ensure a physician or other qualified practitioner completed a pre-surgical assessment for 1 of 1 patient observed (patient #N1). Findings include: 1. Facility policy titled "MEDICAL STAFF COVERAGE AND RESPONSIBILITIES" last reviewed/revised 5/19/11 states "Required responsibilities OUTPATIENT SURGERIES" will include: 6.1 Histories and physicals (Medical Clearance) 6.1.1 An H&P may be written or dictated up to 7 days prior to surgery but must have an updated progress note documented upon admission." 2. During observation of patient #N1's visit to the facility beginning at 12:00	O000262	1. Pre-surgical assessments are being done on all patients by a physician or other qualified practioner. Effective 1/28/132. Pre-surgical assessments will be done on all patients by a physician or other qualified practioner.3. C. Lim, MD - Administrator4. 1/28/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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.m. on 1/22/13 indicated the following: (A) The patient presented for a varicose vein ligation and stripping and was observed from the point of registration to the post operative phase (B) M.D. #1 did not perform a pre-surgical assessment of the paitent prior to the surgical procedure. 3. Review of the medical record for patient #N1 on the following day (1/23/13) indicated the following: (A) There was a signed and completed H&P examination indicating that HEENT, neck, cardiac, lungs, abdomen, genitalia & rectal, and neurological were all within normal limits. The H&P was dated 1/22/13.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000000	The visit was for a State licensure survey. Facility #: 003633 Date: 1-22-13 through 1-23-13 Surveyors: Billie Jo Fritch RN, MSN, MBA Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor QA: claughlin 01/30/13	S000000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000106	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3) The governing body shall do the following: (3) Review the bylaws at least triennially. Based on document review and interview, the governing body failed to review their bylaws at least triennially. Findings included: 1. Review of the governing body bylaws, titled OPERATING AGREEMENT, indicated the document was reviewed/updated 4-8-2008. 2. Interview with B#1 on 1-23-13 at 1535 hours confirmed the governing body bylaws, titled Operating Agreement, were last reviewed/updated 4-8-2008.	S000106	1.Governing Board reviewed and revised the bylaws on 2/01/13 and will do so every 3 years.2. Bylaws will be reviewed at least every 3 years3. Responsible Dr. C. Lim Administator 4. Reviewed 2/1/2013	02/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000110	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5) The governing body shall do the following: (5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up. Based on document review and interview, the governing body failed to hold meetings to review, at least quarterly, reports of management operations including Quality Assessment and Performance Improvement (QAPI) activities and patient services provided at the facility. Findings included: 1. Review of facility documents on 1-22-13 and 1-23-13 indicated the Board of Directors met 12-28-11; the facility documents reviewed lacked documentation that the Board of Directors met in 2012. 2. Interview with B#1 on 1-23-13 at 1535 hours confirmed the Board of Directors did not meet during 2012 to review QAPI activities or patient care services provided at the facility.	S000110	1. As of 2/01/13, Governing Board will meet quarterly (April, July, Oct. and Jan) and discuss management operations of facility. 2. Governing Board will meet quarterly. 3. C.Lim, MD-Administrator 4. 2/01/13	02/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000122	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3) The governing body shall do the following: (3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body. Based on document review and interview, the governing body failed to ensure that the medical staff had ByLaws/Rules and Regulations that were reviewed and approved at least triennially by the governing body. Findings included: 1. Review of the Medical Staff ByLaws/Rules and Regulations on 1-22-13 and 1-23-13 indicated the ByLaws/Rules and Regulations were last revised and approved on 4-8-2008. 2. Interview with B#1 on 1-23-13 at 1535 hours confirmed the Medical Staff ByLaws/Rules and Regulations were last revised and approved on 4-8-2008.	S000122	1.Governing Board reviewed and revised the bylaws on 2/01/13 and will do so every 3 years. 2. Bylaws will be reviewed at least every 3 years 3. Responsible Dr. C. Lim Administator 4. Reviewed 2/1/2013	02/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000162	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 facility failed to follow the approved policy for Cardiopulmonary Resuscitation (CPR) training for one of three physicians (MD#3) and one of one surgical technicians (H#3). Findings included: 1. Review of credential files and personnel files on 1-22-13 and 1-23-13 lacked evidence one of three physicians (MD#3) and one of one surgical technicians (H#3) had documentation of current CPR competency. 2. Review of facility policy #1200.02, last reviewed 2-11-10, titled CARDIOPULMONARY RESUSCITATION TRAINING indicated the following: All staff will be trained in CPR and will follow proper procedure in	S000162	1.CPR training is scheduled for 3/06/13 at Terre Haute Regional Hospital for H#3 and MD#3. 2.Healthcare workers providing direct patient care will have current CPR training and a current CPR card will be kept in the employee/physician file in the personnel office. 3. C. Lim, MD-Administrator 4. Class will be 3/06/13.	03/06/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	case of cardiopulmonary emergency; all physicians with privileges will maintain current CPR certification; all physicians will provide proof of current certification in CPR; failure to provide proof of CPR certification may result in termination of employment and physicians not being permitted to schedule procedures; a copy of current CPR card will be kept in employee/physician files in the personnel office. 3. Interview with B#1 on 1-23-13 at 1550 hours confirmed the facility policy requires all staff, including physicians, maintain current CPR competency and documentation; B#1 confirmed one of three physicians (MD#3) and one of one surgical technicians (H#3) lacked documentation of current CPR competency as required by facility policy.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000164	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H) Require that the chief executive officer develop and implement policies and programs for the following: (H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program. Based on document review and staff interview, the facility failed to ensure post offer physicals were completed for 1 of 2 Registered Nurses (RN) working at the facility. Findings include: 1. Staff member #N1 (RN) was hired 9/18/12. His/her personnel file lacked documentation of a post offer physical. The form was blank. 2. Facility policy titled "Pre-employment Physicals" last reviewed/revised 10/7/08 states "A physical exam is to be obtained by the newly hired employee prior to work within the first week of employment....." 3. Staff member #N2 verified at 12:45 p.m. on 1/23/13 that the physical form in the personnel file of staff member #N1	S000164	1.#N1 Physical form completed.2. Physical will be performed on all new employees prior to work and will be kept in personnel file.3. C.Lim, MD - Administrator4. 2/05/13	02/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	was blank.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000166	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I) Require that the chief executive officer develop and implement policies and programs for the following: (I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and interview, the chief executive officer (CEO) failed to ensure policies and procedures are updated and reviewed at least triennially. Findings included: 1. Review of Administrative Policies and Procedures on 1-22-13 and 1-23-13 indicated the most recent review/revision of the Administrative polices was 10-30-2008. 2. Review of the facility policy #1000.08 titled TRACKING THE REVIEW/REVISION OF POLICIES AND PROCEDURES on 1-22-13 and 1-23-13 indicated the following: Policies and procedures shall be reviewed on a bi-annual basis with revisions made as needed to reflect current information. 3. Interview with B#1 on 1-23-13 at 1535 hours confirmed the Administrative policies and procedures are documented	S000166	1. The CEO reviewed and updated the policies and procedures on 2/07/132. The CEO will ensure policies and procedures are updated and reviewed at least every three years.3. C. Lim, MD-Administrator4. 2/07/13	02/07/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	as last reviewed/revised 10-30-2008.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000172	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L) Require that the chief executive officer develop and implement policies and programs for the following: (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. Based on document review and interview, the facility failed to ensure annual TB skin testing for 4 of 4 (B#2, B#3, B#4, and H#3) staff member's personnel files reviewed. Findings included: 1. Review of personnel files on 1-22-13 and 1-23-13 indicated the following: a.) B#2 most recent TB skin test 3-22-2011. b.) B#3 most recent TB skin test 4-13-2011. c.) B#4 most recent TB skin test 3-19-2011. d.) H#3 most recent TB skin test 3-22-2011. 2. Review of facility policy #1600.03	S000172	1. TB skin testing will be performed on facility employees on 2/12/13 and results will be placed in personnel files. 2. TB skin testing will be performed on all new employees and annually on all other employees. Paula will over see all employee files and will check them on an annually bases to insure all files are up to date. A spreadsheethas be implemented to insure that all meeting, annual check of staff filesincluding medical doctors, reappointed of physicians, review of medicalrecords, pharmacy checks, utilization review, HVAC inspections , policies and proceduresreview every 3 years. Reappointed/reappraised physicians every two years 3.Paula Huffman Office	02/13/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	titled PRE-EMPLOYMENT PHYSICALS on 1-23-13 indicated the following: All new employees will have a TB skin test on employment and yearly. 3. Interview with B#1 on 1-23-13 at 1552 hours confirmed the facility requires annual TB skin testing per facility policy; B#1 confirmed B#2's most recent TB skin test was 3-22-2011, B#3's most recent TB skin test was 4-13-2011, B#4's most recent TB skin test was 3-19-2011, and H#3's most recent TB skin test was 3-22-2011.		Administrator and C. Lim, MD-Administrator 4. 2/12/13 and 3/14/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15C0001133		01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000230	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5) 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: (5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility. Based on document review and interview, the governing body failed to provide for a periodic review of the center and its operations by a Utilization Review Committee comprised of three or more duly licensed physicians having no financial interest in the facility. Findings included: 1. Review of the Utilization Review Committee documents/reviews on 1-22-13 and 1-23-13 indicated the committee was comprised of two (2) physicians (MD#2 and MD#4). 2. Interview with B#1 on 1-23-13 at 1538 hours confirmed the Utilization Review Committee is comprised of two (2) physicians (MD#2 and MD#4).	S000230	1. March 1, 2013,Utilization Review will be performed by a 3rd licensed physician along with the two that we currently have. 2. Ensure Utilization Review is done semi annually by 3 licensed physicians. 3. C. Lim, MD - Administrator 4. 3/01/13 Changed to: 1. March 1, 2013, Utilization Review will be performed by a3rd licensed physician along with the two that we currently have. Dr. Gonzale will be the 3rd physician and has no personal financial interest in the facility. 2. Ensure Utilization Review is done semi annually by 3 licensed physicians that have no personal financial interest in the facility.. 3. C. Lim, MD - Administrator 4. 3/01/13	03/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15C0001133		01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000300	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a) (a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the facility failed to maintain an effective Quality Assessment and Performance Improvement (QAPI) committee by not providing ongoing review and approval of the QAPI plan. Findings included: 1. Review of the QAPI plan on 1-22-13 and 1-23-13 indicated the QAPI plan was last reviewed/approved 4-8-2008. 2. Interview with B#1 on 1-23-13 at 1535 hours confirmed the QAPI plan was last reviewed/approved 4-8-2008.	S000300	1. QAPI plan was reviewed on 2/07/13.2. We will maintain and implement an effective QAPI plan with written implementation.3. C. Lim, MD- Administrator4. 2/07/13	02/07/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001133	A. BUILDING 00 B. WING	01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000332	410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1) Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the center: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	(BB) Objects present before surgery that were intentionally retained. (CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws. (v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. (B) The following product or device events: (i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product. (ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators. (iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism. (C) The following patient protection events: (i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center. (D) The following care management events: (i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability. (ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products. (iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy. (iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates. (vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar. (vii) Patient death or serious disability resulting from joint movement therapy performed in the center. (viii) Artificial insemination with the wrong donor sperm or wrong egg. (E) The following environmental events: (i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion. (ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient: (AA) contains the wrong gas; or (BB) is contaminated by toxic substances. (iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center. (iv) Patient death or serious disability associated with a fall while being cared for in the center. (v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center. (F) The following criminal events: (i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider. (ii) Abduction of a patient of any age. (iii) Sexual assault on a patient within or on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	the grounds of the center. (iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center. Based on document review and interview, the facility's Quality Assurance and Performance Improvement (QAPI) program failed to establish a policy/procedure/process to determine the occurrence of serious reportable events, those reportable to the Indiana State Department of Health (ISDH). Findings included: 1. Review of facility policies and procedures on 1-22-13 and 1-23-13 lacked evidence that the facility's QAPI program had developed a policy/procedure/process to determine the occurrence of serious reportable events, those reportable to the ISDH. 2. Interview with B#1 on 1-23-13 at 1546 hours confirmed the facility's QAPI program had not developed a policy/procedure/process to determine the occurrence of serious reportable events, those reportable to the ISDH.	S000332	1. Policy #1000.03 aka Policy #1300.20 was located and reviewed on 2/07/13. 2. Educate staff on existing policies and procedures in our manuals. 3. C. Lim, MD - Administrator 4. 2/07/13Changed to 1. Policy #1000.03 aka Policy #1300.20 was located andreviewed on 2/07/13.2. All sentinel events will be reported immediately to the facilityadministrator. An investigation will begin within 24 hours. Acute Care Divisionof the State Board of Health will be notified by telephone.3. M. Bedwell, DON and C. Lim, MD, Administrator4.3/14/13	02/07/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000334	410 IAC 15-2.4-2.2(a)(2) QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(2) (2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center. (b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner. (c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following: (1) The report shall: (A) be made to the department; (B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program; (C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any: (i) patient; (ii) individual licensed under IC 25; or (iii) center employee involved; or any other information. (2) A potential reportable event may be identified by a center that:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	(A) receives a patient as a transfer; or (b) admits a patient subsequent to discharge; from another health care facility subject to a reportable event requirement. In the event that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program. (3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures. (4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law. (d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually. (e) Any serious reportable listed in subsection (a)(1) that: (1) is determined to have occurred within the center between: (A) January 1, 2009; and (B) the effective date of this rule; and (2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	Based on document review and interview, the facility's Quality Assurance and Performance Improvement (QAPI) program failed to establish a policy/procedure/process to report the occurrence of serious reportable events to the Indiana State Department of Health (ISDH). Findings included: 1. Review of facility policies and procedures on 1-22-13 and 1-23-13 lacked evidence that the facility's QAPI program had developed a policy/procedure/process to report the occurrence of serious reportable events to the ISDH. 2. Interview with B#1 on 1-23-13 at 1546 hours confirmed the facility's QAPI program had not developed a policy/procedure/process to report the occurrence of serious reportable events to the ISDH.	S000334	1. Policy #1000.03 aka Policy #1300.20 was located and reviewed on 2/07/13. 2. Educate staff on existing policies and procedures in our manuals. 3. C. Lim, MD - Administrator 4. 2/07/13 changed to: 1. Policy #1000.03 aka Policy #1300.20 was located and reviewed on 2/07/13. 2. All sentinel events will be reported immediately to the facility administrator. An investigation will begin within 24 hours. Acute Care Division of the State Board of Health will be notified by telephone. 3. M. Bedwell, DON and C. Lim, MD, Administrator 4. 3/14/13	02/07/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000400	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation and document review, the facility failed to provide a safe and healthful environment that minimized risks to patients and staff. Findings include: 1. During survey, the following breaches in infection control were observed: (A) CRNA #1 was observed starting an I.V. on patient #N1 at 1:30 p.m. on 1/22/13. He/she recapped a syringe of lidocaine after injecting it into the patients arm. Additionally, the provider removed his/her gloves and failed to perform hand hygiene after the procedure. He/she went to the nurse station and began talking on a cell phone and then proceded to the operating room. (B) At 1:50 p.m. on 1/22/13, the operating room door was left opened for an extended period of time with surgical instruments opened on the back table. The staff were observed positioning the patient and adding equipment to the table as well as performing the time out procedure while the door was left open.	S000400	1. 1/30/13 Policy was written on handwashing after gloves are removed. It has been reviewed and implemented by all staff. Policy was written on recapping needles. It has been reviewed and implemented by all staff. All expired items were moved to storage room for Mission Use Only. On 2/01/13 hot water heater temperature was increased to 160 degrees. 2. Employees will wash hands when removing gloves. Employees will no longer recap needles. Expired items will be moved to Mission Use Only storage room. Laundry will now be done at 160 degrees or hotter. 3. C. Lim, MD - Administrator 4. 1/30/13 Changed to 1. 1/30/13 Policy was written on handwashing after glovesare removed. It has been reviewed and implemented by all staff. Policy was written on recapping needles. It has been reviewed andimplemented by all staff. All expired items were moved to storage room for Mission Use Only. On 2/01/13 hot water heater temperature was increased to 160 degrees.2.	01/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	(C) At 2:00 p.m. on 1/22/13, M.D. #1 was observed recapping a syringe after injecting medication into patient #N1. (D) At 2:05 p.m. on 1/22/13, staff member #N3 was observed recapping a syringe after it had been used to injection medication into patient #N1. (E) Two of Two (2/2) boxes of expired 5 cc syringes were observed in supply room #217. The expiration date of the syringes was 4/12. (F) The facility had alcohol foam hand sanitizer in the nutrition pantry and the patient pre-operative area observed at 1:45 p.m. on 1/23/13, however the foam was expired. The expiration dates on the foam were 2010 and 2011. (G) Tour of bulk supplies beginning at 10:30 a.m. on 1/23/13 indicated there were numerous outdated supplies including thirty four (34) 5 cc syringes with an expiration date of 11/2010, eighteen (18) 5 cc syringes with an expiration date of 4/2012, and thirteen (13) 9 oz. containers of Alcare foam antiseptic handrub with an expiration date of 11/11. 2. Review of facility policy titled "Infection Control in Surgery" last reviewed/revised last reviewed/revised 5/19/11 states on page 1: "1.4.1.....Hands shall be washed:.....1.4.1.8 After removing		Employees will wash hands when removing gloves. We adopted a policy andemployees will no longer recap needles. Infection Control Officer will observesurgery cases randomly to ensure that noemployees are recapping needles. Expired items will be moved to Mission UseOnly storage room. Laundry will now be done at 160 degrees or hotter.3. Infection Control Officer and C. Lim, MD - Administrator4. 3/14/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	gloves...." Page 4 states: "1.16.5 Supplies are checked weekly for outdating." 3. Review of facility policy #900.39 titled INFECTION CONTROL IN HOUSEKEEPING/LINEN, on 1-23-13 indicated the following: All linen will be washed following CDC guidelines, with reference to an attachment. 4. Review of the attachment to policy #900.30 on 1-23-13 indicated the following: a temperature of at least 160 degrees for a minimum of 25 minutes is commonly recommended for hot-water washing; chlorine bleach becomes activated at water temperature of 135-145 degrees. 5. While touring the facility on 1-23-13 with B#1 and B#3, it was observed that the facility's laundry is done at the facility which included the linens/gowns for patients and the scrubs for staff; the water temperature log was attached to the cabinet next to the washer/dryer. 6. Review of the laundry water temperature log on 1-23-13 indicated the water temperature for facility laundry was between 122 degrees and 129 degrees during January through December 2012 and January 2013.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	7. Interview with B#1 on 1-23-13 at 1542 hours confirmed the facility's laundry for patient linens/gowns and staff scrubs is done at the facility; B#1 confirmed the policy indicates the facility will follow CDC guidelines of 160 degrees for laundry water temperature; B#1 confirmed the laundry water temperatures for January through December 2012 and January 2013 were between 122 degrees and 129 degrees and did not follow the approved facility policy.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000418	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(A) (2) The infection control committee responsibilities must include, but are not limited to the following: (A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the center. Based on document review and staff interview, the facility failed to have a system in place to track infections for 1 infection control program. Findings include: 1. Review of document titled "Infection Control Log" was left blank for the months of June-October 2012 and also December 2012. 2. Staff member #N2 indicated in interview at 3:45 p.m. on 1/23/13 that there was not a system that is kept current to track infections.	S000418	1. Effective 1/28/13, Infection Control Committee has established a system for identifying, reviewing and reporting infections in the center.2. Infections will be noted in the Patient Log Book next patient's name and date of surgery. Infections will be followed up by surgeon as necessary until infection free.3. C. Lim, MD - Administrator4. 1/28/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000424	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.4-1(f)(2)(D) The infection control committee responsibilities must include, but are not limited to: (D) Written reports of quarterly meetings. Based on document review and staff interview, the facility failed to ensure quarterly infection control meetings were held for 1 infection control program reviewed. Findings include; 1. Review of infection control meeting minutes lacked evidence that the facility conducted quarterly infection control meetings. A meeting was held on 3/12/12 and 6/12/12 only. 2. Staff member #N2 verified the above beginning at 3:45 p.m. on 1/23/13.	S000424	1. Infection Control Meetings will be held quarterly. Next quarterly meeting is due in March 2013. Infection control program will then be reviewed. 2. Meetings for Infection Control will be held quarterly. 3. C. Lim, MD - Administrator 4. 1/28/131. Infection Control Meetings will be held quarterly. Next quarterly meeting is due in March 2013. Infection control program will then be reviewed. 2. Meetings for Infection Control will be held quarterly. A spreadsheethas be implemented to insure that all meeting, annual check of staff filesincluding medical doctors, reappointed of physicians, review of medicalrecords, pharmacy checks, utilization review, HVAC inspections , policies and proceduresreview every 3 years. Reappointed/reappraised physicians every two years 3. C. Lim, MD - Administrator 4. 3/14/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000428	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i) The infection control committee responsibilities must include, but are not limited to: (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: (i) Sanitation. Based on observation, document review, and staff interview the facility failed to ensure the operating rooms were cleaned per policy for 3 of 3 operating rooms. Findings include: 1. Observation of operating room cleaning after the last procedure at 3:00 p.m. on 1/22/13 indicated that staff member #N3 wiped horizontal surfaces and mopped the floor only. He/she did not clean kick buckets, cabinets, doors, scrub sinks or carts. 2. Review of facility policy titled "Operating Room Sanitation" last reviewed/revised 2/15/11 states on page 2: "2.5 End of the day cleaning includes, but is not limited to, ...2.5.2 Cleaning and disinfection of kick buckets 2.5.3 Cleaning of cabinet doors and operating	S000428	1. Reeducated N#3 and N#4 on 1/29/13 on the Infection Control in Surgery Policy for cleaning in the Operating Room. 2. All staff involved in Operating Room cleaning will be educated on the Infection Control in Surgery Policy and will clean according to policy. 3. C. Lim, MD - Administrator 4. 1/29/13 Changed to 1. Reeducated N#3 and N#4 on 1/29/13 on the Infection Control in Surgery Policy for cleaning in the Operating Room. 2. All staff involved in Operating Room cleaning will be educated on the Infection Control in Surgery Policy and will clean according to policy. Random unannounced checks will be preformed to insure that N#3 and N#4 are cleaning according to policy. 3. Infection Control officer. and C. Lim, MD - Administrator 4.3/14/13	01/29/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	room doors 2.5.4 Cleaning of scrub sink 2.5.5 Cleaning of transport and utility carts....." 3. Facility policy titled "Infection Control In Surgery" last reviewed/revised 5/19/11 states on page 2: "1.8.1: Operating rooms shall be terminally cleaned at the end of each day and made ready for the next days use....." Page 3 states: "1.11 Terminal Cleaning (at end of day) 1.11.1 Remove all removable items from the room after disinfecting 1.11.2 Completely wash with disinfectant all remaining furniture and equipment on all surfaces, including wheels, legs, casters and conductive tips....." 4. Staff member #N3 indicated in interview at 3:00 p.m. on 1/22/13 that he/she cleans the room at the end of the day including wiping the operating room table, horizontal surfaces, and mopping the floor. He/she indicated that staff member #N4 terminally cleans the operating rooms on Saturdays. 5. Staff member #N4 indicated in phone interview at 1:00 p.m. on 1/23/13 that he/she works on Saturdays and mops and buffs the floors as needed. He/she indicated the operating rooms are already cleaned prior to Saturday and he/she only cleans something if a note is left, but does			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	not have a lot of extra time.			
S000664	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(9) All patient records must document and contain, at a minimum, the following: (9) A written or dictated report describing techniques, findings, and tissue removed or altered. Based on document review and staff interview, the facility failed to ensure the medical record contained an operative report for 1 of 1 patient who had surgery performed by M.D. #2 (patient #N11). Findings include: 1. Patient #N11 had surgery on 11/28/12 by M.D. #2. The medical record lacked documentation of an operative report. 2. Staff member #N2 verified the above at 3:45 p.m. on 1/23/13.	S000664	1. MD#2 faxed the correct Operative Report to our facility and it was placed in the patient file (N#11) 2. Charts will be reviewed for Operative Reports before filed in medical record storage. 3. C. Lim, MD - Administrator 4. 1/24/13Change to: 1. MD#2faxed the correct Operative Report to our facility and it was placed in thepatient file (N#11)2. Charts will be reviewed for Operative Reports before filed in medical recordstorage. Tammy Siner, Medical Records Consultant, will do a medical recordaudit to ensure Operative Reports are placed in charts.3. Tammy Siner, Medical Records Consultant and C. Lim, MD, Administrator4. 3/14/13	01/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000708	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(3) The medical staff shall do the following: (3) Make recommendations to the governing body on the appointment or reappointment of the applicant for a period not to exceed two (2) years. Based on document review and interview, the medical staff failed to make recommendations to the governing body on the reappointment of three of three (MD#1 - MD#3) physicians not to exceed two years. Findings included: 1. Review of physician medical staff credential files on 1-22-13 and 1-23-13 indicated the following: a.) MD#1 most recent reappointment 4-8-2008. b.) MD#2 most recent reappointment 4-8-2008. c.) MD#3 most recent reappointment 5-9-2008. 2. Review of the Medical Staff ByLaws/Rules and Regulations on 1-22-13 and 1-23-13 indicated the following: 2.4.2 Reappointment to any category of the Staff shall be for a period of two (2) years.	S000708	1. The physicians will be reappointed on 3/01/13 as required. 2. The physicians will be reappointed every two years as required. 3. C. Lim, MD - Administrator 4. 3/01/13 1. The physicians will be reappointed on 3/01/13 as required. 2. The physicians will be reappointed every two years as required. A spreadsheethas be implemented to insure that all meeting, annual check of staff filesincluding medical doctors, reappointed of physicians, review of medicalrecords, pharmacy checks, utilization review, HVAC inspections , policies and proceduresreview every 3 years. Reappointed/reappraised physicians every two years 3. C. Lim, MD - Administrator 4. 3/14/13	03/01/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	3. Interview with B#1 on 1-23-13 at 1550 hours confirmed the Medical Staff ByLaws/Rules and Regulations require members of the medical staff to be reappointed every two years; B#1 confirmed MD#1 was most recently reappointed 4-8-2008; MD#2 was most recently reappointed 4-8-2008; MD#3 was most recently reappointed 5-9-2008.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000710	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4) The medical staff shall do the following: (4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following: (A) A completed, signed application. (B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A current copy of the individual's: (i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board. (ii) Indiana controlled substance registration showing number as applicable. (iii) Drug Enforcement Agency registration showing number as applicable.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	(iv) Documentation of experience in the practice of medicine. (v) Documentation of specialty board certification as applicable. (vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C). (D) Category of medical staff appointment and delineation of privileges approved. (E) A signed statement to abide by the rules of the center. (F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements. (G) Other items specified by the center and medical staff.			
	Based on document review and interview, the facility failed to maintain complete credential files for 2 of 3 physicians (MD#2 and MD#3). Findings included: 1. Review of the medical staff credential file for MD#2 on 1-22-13 lacked a current Drug Enforcement Agency (DEA) registration (expired 9-30-12) and no signed statement to abide by the rules of the center. 2. Review of the medical staff credential	S000710	1. 2/07/13 MD#2 and MD#3 files are updated with DEA numbers.2. All physical files will have a current DEA card.3. C. Lim, MD - Administrator4. 2/07/13	02/07/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	file for MD#3 on 1-22-13 lacked any evidence of a current DEA registration. 3. Interview with B#1 on 1-23-13 at 1550 hours confirmed the DEA registration for MD#2 contained in the credential file expired 9-30-12 and the credential file of MD#3 lacked evidence of a DEA registration.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S000772	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (M) A requirement that a medical history and physical examination be performed as follows: (i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed. (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 of the medical staff. (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 document review and observation, the facility failed to ensure the physician performed a history & physical (H&P) exam prior to the surgical procedure for 1 patient observed (patient #N1). Findings include:	S000772	1. History and Physicals are being done on the date of surgery if not they are being done within 7 days prior and include an updated progress note on the date of surgery, effective 1/28/13. 2. Patient will not have surgery unless a History and Physical is done immediately prior or within 7	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013
NAME OF PROVIDER OR SUPPLIER SULLIVAN SURGICENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 320 N SECTION ST SULLIVAN, IN 47882	

(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
	1. Facility policy titled "MEDICAL STAFF COVERAGE AND RESPONSIBILITIES" last reviewed/revised 5/19/11 states "Required responsibilities OUTPATIENT SURGERIES" will include: 6.1 Histories and physicals (Medical Clearance) 6.1.1 An H&P may be written or dictated up to 7 days prior to surgery but must have an updated progress note documented upon admission." 2. During observation of patient #N1's visit to the facility beginning at 12:00 p.m. on 1/22/13 indicated the following: (A) The patient presented for a varicose vein ligation and stripping and was observed from the point of registration to the post operative phase (B) M.D. #1 did not perform an H&P on the patient prior to the surgical procedure. 3. Review of the medical record for patient #N1 on the following day (1/23/13) indicated the following: (A) There was a signed and completed H&P examination indicating that HEENT, neck, cardiac, lungs, abdomen, genitalia & rectal, and neurological were all within normal limits. The H&P was dated 1/22/13.		days prior with a progress note done on the date of surgery. 3. C. Lim, MD - Administrator 4. 1/28/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15C0001133		01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S001012	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(B) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (B) Drug administration according to established center policies and acceptable standards of practice. Based on observation and document review, the facility failed to follow acceptable standards of practice for recapping needles. Findings include: 1. At 1:30 p.m. on 1/22/13, CRNA #1 was observed starting an I.V. on patient #N1. He/she recapped a syringe of lidocaine after injecting the medication into the patients arm. 2. At 2:00 p.m. on 1/22/13, M.D. #1 was observed recapping a syringe after injecting medication into the leg of patient #N1. 3. At 2:05 p.m. on 1/22/13, staff member #N3 was observed recapping a syringe after it had been used to inject medication	S001012	1. 1/28/13 Policy #1300.33 was written on recapping needles. All staff have been educated and are no longer recapping needles. 2. Recapping needles will not be performed by any medical staff member. 3. C. Lim, MD - Administrator 4. 1/28/13 Changed to: 1. 1/28/13Policy #1300.33 was written on recapping needles. All staff have beeneducated and are no longer recapping needles.2. We adopted a policy on recapping needles. Recapping needles will notbe performed by any medical staff member. Infection Control Officer willobserve random surgery cases unannounced to ensure that no employees arerecapping needles.3. Infection Control Officer and C. Lim, MD - Administrator4. 3/14/13	01/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	into patient #N1. 4. CDC guidelines for needle recapping states: "Health care workers should take the following steps to protect themselves and their fellow workers from needlestick injuries: .....Avoid recapping needles."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
S001152	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(B) (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: (3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plan and equipment by qualified personnel as follows: (B) All mechanical equipment (pneumatic, electric, sterilizing, or other) 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 document review and interview, the facility failed to provide preventative maintenance services for the heating, ventilation, and air conditioning (HVAC) system of the physical structure. Findings included: 1. Review of facility documents on 1-22-13 and 1-23-13 lacked evidence that preventative maintenance services had been provided for the HVAC system. 2. Review of facility documents on	S001152	1. Heady's Heating and Cooling (812-696-2396) were here on 1/29/13 to provide preventative maintenance services for the heating, ventilation, and air conditioning system of the facility. 2. Heady's Heating and Cooling will be here every odd year to provide preventative maintenance on the heating, ventilation, and air conditioning system of the facility. A spread sheet has be implemented to insure that all meeting, annual check of staff files including medical doctors, reappointed of physicians, review	01/29/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST SULLIVAN, IN 47882

(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
	1-23-13 indicated the maintenance personnel maintains a log of the building temperature when the facility is open, but lacked evidence of preventative maintenance of the HVAC system. 2. Interviews with B#1 and B#2 on 1-23-13 at 1410 hours confirmed there is no preventative maintenance service provided for the HVAC system; B#1 and B#2 indicated the facility will call for service only if there is a problem.		of medical records, pharmacy checks, utilization review, HVAC inspections , policies and procedures review every 3 years. Reappointed/reappraised physicians every two years 3. C. Lim, MD - Administrator 4. 1/29/13	