

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001114	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2014
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NAME OF PROVIDER OR SUPPLIER SOUTH CENTRAL SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5002 E SR 44 FRANKLIN, IN 46131
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 003073</p> <p>Survey Date: 4/30/2014 thru 5/2/2014</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 05/13/14</p>	S000000		
S000300	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is</p>			

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

TITLE

(X6) DATE

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

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	<p>not limited to, the following: Based on documentation review and staff interview, the facility failed to ensure there was an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The South Central Surgery Center has two Quality Improvement Programs. Quality Assurance Plan #1 was approved with all surgery center policies, Medical Staff and Governing Board Bylaws on 10/24/2012. Plan #1 indicates that all areas are to report to Quality Assurance Committee. 2. The South Central Surgery Center Quality Assurance Plan #2 was last reviewed 4/16/2014. The plan focused on infection control and lacked a comprehensive program that included all areas of the facility. 	S000300	<p>The Quality Assurance Committee and the Governing board have reviewed both Quality Assurance Plan #1 and #2 and have agreed and approved to keep Plan #1. The Governing board approved this plan on June 2, 2014. The Quality Assurance Plan will include Personnel meetings, Nursing Standards and Philosophy Review, Incident reports, Complaint-Patients and Physicians, Discharge Planning Review, Safety Review-Environmental, Equipment, Disaster, Orientation Program Evaluation, In-service Programs/Continuing Education Profile, Policy and Procedures Manual, Reappraisal of Staff Privileges, Patient surveys, Infection Control, Various Committee Meetings (as needed), contracts, and any new devices or supplies that are brought to the facility. The Quality Assurance Committee will review these reports quarterly and report it finding to the Director of Nursing who will then report it to the Governing Board. The Director of Nursing will keep a QA on the Quality Assurance committee to make sure they are doing the reviews quarterly. and report these findings to the Governing Board. Quarterly All Quality Assurance Committee meeting minutes will be placed in each Quality Assurance and Improvement Book.</p>	06/02/2014	

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S000320	<p>3. South Central Surgery Center Quality Improvement Meeting minutes were reviewed for: 2/14/13; 5/5/13; 8/6/13; and 11/16/13. The committee meeting minutes only listed 7 indicators with two word results for each indicator listed. The minutes did not address the issues as defined in Plan #1 agenda criteria.</p> <p>4. At 10:45 AM on 5/1/2014, staff member #1 indicated the surgery center was utilizing two quality assurance programs. The staff member confirmed the two programs are in conflict with each other and are confusing.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p>			

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	<p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and staff interview, the facility failed to ensure 2 surgery center functions were part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> South Central Surgery Center's Quality Improvement Program (last reviewed 10/24/2012) indicated all services with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. Review of the facility's QA&I data indicated it did not include the functions of Infection Control and Response to Patient Emergency. The 4 Quality Assurance Committee reports identified Infection Control with "no 	S000320	<p>The Quality Assurance Committee has revised the Infection Control QA to include Type of Infection, Physician, Time frame from of infection occuring to surgery, Sterile records on instruments. Treatment used, results and Actions taken to prevent this. The Director of Nursing will complete these QAs and report to the Quality Assurance Committee who will report the findings to the Governing Board quarterly. The Response to Patient Emergency QA has been revised it includes Type of Emergency, Actions taken to correct, Time to respond to emergency, and Actions taken to prevent this happening again. The Director of Nursing will complete this QA monthly and give the findings to the Quality Assurance Committee quarterly who will then report the findings to the Governing Board Quarterly.</p>	06/02/2014			

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S000328	<p>infections" attached to it. The minutes nor quality assurance data identified how the function "Infection Control" was being evaluated. Neither the minutes nor quality assurance data identified function "Response to Patient Emergencies" as being monitored and evaluated by the surgery center.</p> <p>3. At 1:50 PM on 5/1/2014, staff member #1 confirmed Infection Control and Response to Patient Emergencies are not being monitored and evaluated by the Quality Assurance Committee.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p>			

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	<p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and staff interview, the facility failed to ensure 3 services (Pharmacy, Laundry/Linen, Bioengineering) were evaluated and monitored as specified by the Quality Assurance Program.</p> <p>Findings included:</p> <p>1. The 2013 Quarterly QA Reports were reviewed. The goal for the pharmacy supplier was to have supplies arrive in 2 days after ordered and medications arrive 1 day after ordered. The document provided was last evaluated by the quality assurance committee in 2009. The Linen Quality Assurance report provided indicated the goals using universal precaution when washing laundry internally; sanitize after each cycle; and bleach in each cycle. The report identified three quality</p>	S000328	<p>The Quality Assurance Committee has developed a new QA form for Medication and Supplies. This will include which Supplier is used. The date ordered and the date delivered. If the supplies are medication. If they are delivered in good condition and not expired. Any back orders will be noted with date to be sent. Actions taken to correct any problems. The director of nursing will be completing this form monthly and reporting the findings to the Quality Assurance Committee who then will report the findings to the Governing board at the quarterly meeting. The Quality Assurance Committee has developed a new QA for Laundry process in house. This will include if the person wore protective gear, gown glasses and gloves, if hands are washed before any laundry is handled, Water temperature, Results, action taken for correction if any problems, This will be completed by the Director of Nursing monthly with the findings sent to the Quality Assurance Committee who will then take the findings to the Governing board quarterly. The Quality Assurance Committee has developed a form</p>	06/02/2014

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	<p>indicators on it: Appearance of Linen; Arrival Time; and Received Correct Amount. The three quality indicators were for contracted Laundry/Linen services. The report did not identify the goals for Linen Quality Assurance being evaluated for meeting their threshold. The goal for the Bioengineering was to ensure quarterly and yearly maintenance was conducted on time. The 2013 Biomed Quality Assurance Report identified there were only three quarterly bioengineering maintenance recorded for 2013. The report identified quarterly preventive maintenance was meeting their goals; however, the log identified the contracted Bioengineering service did not meet the goal specified by the Quality Assurance Committee and there was no action taken for not meeting the goals specified by the committee.</p> <p>2. On 5/1/2014 at 2:05 PM, staff member #1 confirmed three</p>		<p>to follow the Bioengineering company that does are maintenance. This form will include the date it was done, what was included on this check if it was a quarterly or an annual check, it will compare to see if it was done at the appropriate time. It will have the results and any action taken if it was not done on time. The Director of Nursing will maintain this form on a quarterly basis. The Director of Nursing will give her results to the Quality Assurance Committee and they will report the findings to the governing board quarterly.</p>	

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S000400	<p>services did not meet their goals in 2013 and the surgery center did not take action: Pharmacy, Laundry/Linen, Bioengineering.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, policy review, nationally recognized guidelines review, and interview, the facility failed to provide a safe patient environment by ensuring areas were inspected and free of outdated patient supplies and by monitoring the temperature and humidity of the OR (operating room) suites.</p> <p>Findings included:</p> <p>1. During the tour of the pre/post op area at 1:45 PM on 04/30/14, accompanied by staff member A1, the following observations were made:</p> <p>A. One of one 250 ml. (milliliter) bag of 5% Dextrose IV (intravenous) fluid, with an expiration date of 05/2013, in the crash cart.</p> <p>B. In the bottom of the warming cabinet:</p>	S000400	<p>All expired medication has been removed and placed in boxes marked outdated not to use see Director of Nursing. All outdated fluids have been removed and discarded in appropriate containers. All outdated supplies have been removed and disposed of in appropriate containers. The Director of Nursing is now accompanying the person that checks out dates in all areas. The Director of Nursing will complete the form and report the findings to the Quality Assurance committee quarterly who will then report the findings to the Governing Board quarterly. The Director of Nursing has spoken to the Johnson Controls about regulating the Temperature and Humidity in the operating rooms. A policy for temperature and humidity has been developed and approved by the Governing Board. It states</p>	06/02/2014

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	<p>1. One of one 500 ml. 0.9% normal saline for irrigation expired June 2012.</p> <p>2. One of one 500 ml. sterile water for irrigation expired May 2009.</p> <p>C. In the top of the warming cabinet:</p> <p>1. One of one 500 ml. 0.9% normal saline for irrigation expired June 2012.</p> <p>2. During the tour of the surgical area at 2:25 PM on 04/30/14, accompanied by staff member A1, the following observations were made in OR 2:</p> <p>A. One packaged sterile gown, laying on a table, with an expiration date of 01/2014.</p> <p>B. One box of 7.5 sterile gloves with an expiration date of 03/2010.</p> <p>C. Three boxes of Vicryl 4.0 sutures packages with an expiration date of 07/2013.</p> <p>D. One box of Vicryl 4.0 sutures packages with an expiration date of 01/2009.</p> <p>E. Four boxes of Vicryl 3.0 sutures packages with an expiration date of 01/2012.</p> <p>F. One box of Vicryl 3.0 sutures packages with an expiration date of 01/2014.</p> <p>G. The room felt warm upon entering and the temperature control device on the wall did not register any temperature, but only had a "warm/cool" switch.</p>		<p>that the Operating room temperature is to stay between 68 degrees to 73 degrees F. Humidity is to stay between 30 to 60%. This is according to AORN Standards. The Quality Assurance Committee has developed a QA to monitor the temp and humidity in the operating rooms daily. It will also have what was done if the temperature or humidity was not in this range. This form will be maintained by the Director of Nursing and the findings will be reported to the Quality Assurance Committee and they will report the findings to the Governing board quartely.</p>	

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	<p>3. During the tour of the sterile supply room at 2:45 PM on 04/30/14, accompanied by staff member A1, the following observations were made:</p> <p>A. A box of 22 French catheters with an expiration date of 01/2005.</p> <p>B. A box of 14 French catheters with an expiration date of 11/2006.</p> <p>C. A box of 16 French catheters with an expiration date of 04/2006.</p> <p>D. Another box of 16 French catheters with an expiration date of 04/2009.</p> <p>E. One 16 gauge catheter with an expiration date of 04/2006.</p> <p>4. During the tour of the OR clean room at 3:00 PM on 04/30/14, accompanied by staff member A1, the following observations were made:</p> <p>A. Two of two Single use Specimen Pouches with an expiration date of 03/2010.</p> <p>B. Three of three Versaport single use obturators with an expiration date of 10/2006.</p> <p>C. One box of disposable fixation devices with an expiration date of 07/2010.</p> <p>D. A box of vaginal packing containers with an expiration date of 06/2006.</p> <p>5. The facility policy "Checking Supplies", last reviewed 10/24/12, indicated, "All supplies will be checked</p>			

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	<p>monthly for expiration dates. If any supplies are expired or holes or packages open, they are to be taken to the Director of Nursing and she will place them in an area with a note on them. These supplies include: Medication, Suture, Fluids, Needles, Custom Packs, IV tubing, any packaging that will come in contact or be used on the patient. These areas to be checked are all Operating Rooms, Procedure Room, Pre-Post-op, Sterile Supply, Cast Room, Supply Room, Decontamination Room."</p> <p>6. The facility Infection Control Policy indicated, "All resources for infection control has been obtained from Infection Control Tech, Eagle Advisor, CDC, APIC, and AORN."</p> <p>7. A copy of the AORN (Association of periOperative Registered Nurses) 2012 guidelines for surgical centers, provided by staff member A1, indicated, "Temperature and humidity controls: AORN and the American National Standards Institute (ANSI), the American Society of Heating, Refrigeration, and Air-Conditioning Engineers (ASHRAE), and the American Society for Healthcare Engineering (ASHE) support the guidelines on temperature, humidity, and air exchanges in a perioperative setting published by the Facility Guidelines</p>			

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S000442	<p>Institute in the Guidelines for Design and Construction of Health Care Facilities and suggests that the following parameters be maintained. Operating Room: Temperature- 68 to 73 degrees F. (Fahrenheit), Humidity- 30 to 60 %."</p> <p>8. At 11:25 AM on 05/01/14, staff member A1 indicated the supplies were to be checked monthly by the surgical tech, but confirmed there was no documentation of this process. He/she indicated a lot of the outdated supplies were items not used anymore because many of the surgeons no longer come to the facility, but confirmed they were stored alongside supplies that were currently used. He/she also indicated OR 2 was warm when toured, but the whole facility was set at 70 degrees F. and could only be adjusted by 2 degrees either way. He/she indicated the facility followed AORN standards, but they did not monitor the temperature or humidity of the OR suites.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p>						

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	<p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on policy review, employee medical file review, and interview, the facility failed to ensure all of their employees had documentation of immunization status in 3 of 5 employee medical files reviewed (A1, A3, and A5).</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Employment Application and Record", last reviewed 10/24/12, indicated, "...3. The personnel health record shall contain: a. Results of employee physical examination, b. Results of diagnostic tests, c. Hepatitis Vaccination record, d. Tuberculosis testing, e. Any other testing deemed appropriate by physician with the physicals." The medical file for staff member A1, with a hire date of 12/18/01, failed to indicate any documentation of the Rubella or Rubeola status other than the 	S000442	Both Staff members A1 and A3 have brought their immunization records in for their files. The Quality Assurance Committee has developed a QA form to monitor the employees health records on an annual basis. This will be maintained by the Director of Nursing and the findings will be reported to the Quality Assurance Committee and they will report the findings to the Governing Board annually. The Director of Nursing has made a new check list for new employees that will include the immunization history or a titer. This will have to be completed before the new employee can start working. Resume, Employee application, Photo ID, CPR current, Physical, License current, Job Description, Orientation Skills list, Immunization Record or Titer, Hepatitis Titer or record of Injection. The Quality Assurance Committee will review the list before the new employee starts to make sure the list is complete.	06/02/2014

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S000494	<p>self-reported history of the diseases. The file indicated self reporting of "No" for Varicella disease or immunization.</p> <p>3. The medical file for staff member A3, with a hire date of 09/23/10, failed to indicate any documentation of the Rubella, Rubeola, or Varicella status other than the self-reported history of the diseases.</p> <p>4. The medical file for staff member A5, with a hire date of 12/17/00, failed to indicate any documentation of the Rubella, Rubeola, or Varicella status other than the self-reported history of the diseases.</p> <p>5. At 3:00 PM on 05/01/14, staff member A1 confirmed the medical file findings and indicated he/she thought the self reporting was acceptable, but staff were all asked to bring in documentation of immunization status. He/she confirmed the documentation was not in the records and titers were not performed.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(2)(i)(2)(B)</p> <p>(B) If laundry is processed in the center:</p>						

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	<p>(i) a laundry processing room must be provided;</p> <p>(ii) clean linen storage and mending must be separated from soiled linen storage; and</p> <p>(iii) employee hand washing facilities shall be available in each room where clean or soiled linen is processed and handled.</p> <p>Based on document review, observation, and staff interview, the facility failed to ensure the clean and soiled laundry/linen internal service were processed keeping clean from dirty and failed to ensure there was a handwashing facility available in the Laundry/Line Room (Receiving Room).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. South Central Surgery Center Linen Policy and Procedure (Last reviewed 10/24/2014) stated, "Linen carts will be covered at all times. All clean laundry will be kept separate from soiled laundry. 2. South Central Surgery Center 	S000494	All paint and outdoor use weed and grass killer etc. have been removed from the Receiving room. The Quality Assurance Committee has developed a QA form to check the Receiving room monthly for any hazardous material in the Receiving room. This will have a plan of action if any of these are found in the Receiving room. A staff meeting has occurred to explain that these materials are not to be in the receiving room. The director of nursing will maintain this form and report the findings to the quality assurance committee and they will report the findings to the governing board at their quarterly meetings. A wall hand sanitizer has been purchased and is scheduled to be mounted on June 6, 2014 in the laundry room. The laundry room will also have a division marked to show division between the washer (dirty) and the dryer (clean). This was also included in staff meeting to use the hand sanitizer before handling the laundry and how the division	06/02/2014

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	<p>Laundry Policy (last reviewed 10/24/2012) stated, "Washer to dryer - Wash hands apply gloves take wet laundry into clean cart and then place laundry into dryer. Turn dryer on. Remove gloves. Wash hands; Dryer to linen closet - Wash hands. Fold linen on table place in covered cart. Then take cart to place linen to linen closet."</p> <p>3. At 10:00 AM on 5/1/2014, the Receiving Room was inspected. The room was observed storing assorted equipment, paint, housekeeping supplies, clean linen storage cart, washer/dryer, clean linen folding table, liquid bleach, liquid outdoor use weed and grass killer, etc. The west end of the room contained the dryer stored next to the south wall. The washer was located between the 5-foot clean linen folding table. There was no separation between clean linen handling and soiled linen. The clean linen storage cart was observed not completely cover and it was located against a rack that</p>		<p>between dirty and clean. The Quality Assurance committee has developed a form to make sure the hand sanitizer and the division is being used and maintained. This will be kept by the Director of Nursing on a monthly basis with the results being reported to the Quality Assurance Committee who will then report the findings to the Governing Board quarterly</p>				

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S000788	<p>contained paint, weed and grass killer, etc. The Receiving Room was also observed without a hand washing sink.</p> <p>4. At 10:30 AM on 5/1/2014, staff member #1 confirmed the handling of clean linen and soiled linen can intermingle while the surgery center is washing and drying assorted laundry.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(R)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(R) A requirement that a physician shall be available to the center during the period any patient is present in the center.</p> <p>Based on documentation review, the facility failed to ensure a physician shall be available to the</p>	S000788	The policy for a physician being available has been modified to include that the physician or the anesthesiologist will be available by phone and with in a 30 minute	06/02/2014

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S001010	<p>center during the period any patient is present in the center.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. South Central Surgery Center 23 Hour Stay Protocol (Last reviewed 10/24/2014) stated, "If a problem arises with a patient during a 23 hour stay, the surgeon shall be notified. If the surgeon is unavailable then the anesthesiologist will be called. The medical director also will be called along with director of nursing. If none of these people are available then 911 will be called." 2. At 1:15 PM on 4/30/2014, staff member #1 confirmed the 23 Hour Stay Protocol does mention the possibility a physician may not be available while a patient was still present at the surgery center. 		<p>arrival time to the Surgery Center. The Quality Assurance Committee has developed a QA form to make sure this is followed by all physician and anesthesiologist for every patient. It will include that we have a current phone number and pager (if applicable) and that the Physician will be in range of 30 minutes will his or her patient is at the surgery center. This will be maintained by the Director of Nursing and report the findings to the Quality Assurance committee who will then report their findings to the governing board quarterly.</p>				
	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)						

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	<p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, policy review, facility documentation, and interview, the facility failed to ensure all medications were stored, labeled, and discarded according to policy.</p> <p>Findings included:</p> <p>1. During the tour of the facility, beginning at 1:30 PM on 04/30/14, accompanied by staff member #A1, the following observations were made:</p> <p>A. A 100 ml. (milliliter) vial of Naropin 0.2%, open, but not dated, in the cabinet at the nurses' station.</p> <p>B. Eight 30 ml. vials of Marcaine 0.5%, with a manufacturer's expiration date of 1 Jan. 2014, in the cabinet in the nurses' station.</p> <p>C. One open, but not dated, 20 ml. vial of Propofol in the medication refrigerator.</p> <p>D. A syringe containing 1.5 ml. of a clear fluid, labeled with a piece of tape</p>	S001010	<p>I have spoken with our Pharmacists we have decided that the pharmacists and the Director of Nursing will do the quarterly checks together for outdated drugs, multi-dose vial drugs not marked correctly. The Quality Assurance Committee will develop a QA form that will include date checks were done any thing found that was out dated or mis-marked or not marked. and how these were disposed and what actions were taken. The form the Pharmacists marks when he/she does the quarterly checks will be signed by both the pharmacists and the Director of Nursing. The Director of Nursing will maintain these forms and report the findings to the Quality Assurance Committee who will then report the findings to the Governing Board quarterly.</p>	06/02/2014

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	<p>with "Toradol" written on it, in the medication refrigerator.</p> <p>E. Five 2 ml. vials of Clindamycin with an expiration date of 1 Apr. 2014 in the medication refrigerator.</p> <p>F. Three 1 ml. vials of Diphenhydramine, with an expiration date of 11/2013, in the crash cart.</p> <p>G. A package of 25 vials of Magnesium Sulfate, with an expiration date of 02/2013, in the crash cart.</p> <p>H. Two 5 ml. syringes of Lidocaine, with an expiration date of 1 Apr. 2014, in the crash cart.</p> <p>I. Eighteen vials of Dantrium, with an expiration date of 02/2013, in the crash cart.</p> <p>J. An open, but not dated, 20 ml. vial of Lidocaine 1%, with an expiration date of 1 Jan. 2014, in a basket at the nurses' station.</p> <p>2. The facility policy "Medication Control and Accountability", last reviewed 10/24/12, indicated, "Labeling: Drugs and biologicals are labeled with name, strength, quantity, expiration date, and appropriate accessory or cautionary information. Multiple use medications are dated and initialed on the outside of the container at the time of initial use. ...The drug storage and preparation areas shall be devoid of outdated, discontinued, recalled or otherwise unusable drugs. 1.</p>						

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	<p>The Director of Nursing or assigned RN inspects all drug supplies at least once per month for outdated medications. ...3. Discontinued and outdated drugs are disposed of or are returned to the purchasing agent. ...4. Multiple use medications shall be discarded within thirty days after initial use."</p> <p>3. The facility policy "Multi-Dose Vial", last reviewed 10/24/12, indicated, "All multi-dose vials will be dated and initialed when opened and only kept till the end of the day and then will be discarded."</p> <p>4. The facility's Quarterly Inspection Checklist by the consultant pharmacist, staff member A8, dated Feb. 14, 2014, indicated everything was okay, including checking expiration dates on drugs in the drug cabinet, crash cart, and anesthesia cart.</p> <p>5. The facility's list of backordered medications included only Magnesium Sulfate, Calcium Chloride, and Dopamine.</p> <p>6. At 3:00 PM on 04/30/14, staff member #A1 indicated the nurses working the specific areas were supposed to check monthly for outdated medications and let him/her know what</p>				

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S001146	<p>needed to be ordered. He/she also indicated the pharmacist was aware of the backordered medications and had indicated it was okay to use them for a year. He/she confirmed there was no documentation of the monthly checks or the pharmacist recommendations. He/she also confirmed there were other outdated medications that were not backordered and the multidose vial policy wasn't followed.</p> <p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, policy review, document review, and interview, the facility failed to maintain the surgery center environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in three (3) instances.</p>	S001146	.An eyewash station will be installed on June 6,2014 in the Receiving Room. After installation there will be an inservice with the staff on how to use it.The Quality Assurance Committee has developed a QA form to maintain the care and education of the eyewash station.	06/02/2014

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	<p>Findings included:</p> <ol style="list-style-type: none"> At 10:00 AM on 5/1/2014, the Receiving Room was toured. The room was observed storing bleach, outdoor use weed and grass killer, etc. The first aid requirement on the manufacturer's label indicates if eyes come in contact with the chemical; rinse the eyes out with a heavy stream of water for at least 15 minutes. The room was observed without any eyewash station that meets the first aid requirements of the chemicals. The nearest eye washing station was located in the decontamination room which was not easily accessible for a person that has a chemical in their eyes. The decontamination room has two self-closing entry doors between the rooms. The mechanical room located in the surgery center was observed with three red 5-gallon gasoline containers. One container was observed third filled with highly flammable gasoline. The containers were observed stored in middle of the room and not in a flammable cabinet. At 1:15 PM on 5/1/2014, staff member #1 indicated the gasoline cans belong to the contracted grounds crew. 		<p>An annual inservice will be done on all eyewash stations and checking that each station is in functioning properly will be done on a quarterly basis. The Director of Nursing will maintain this form and report the findings to the Quality Assurance Committee and the Quality Assurance Committee will report the findings to the Governing Board quarterly. The gasoline containers that were in the Mechanical Room were removed on May 29, 2014. The Director of Nursing has talked to the Grounds crew that they are not to leave them at the surgery center. The staff has also met and discussed that they are not to let the Grounds crew leave them at the surgery center. The Quality Assurance Committee has developed a QA to monitor the Grounds Crew. It will indicate if they have left any equipment or gasoline cans in or at the facility. Also if they have what actions are taken. The Director of Nursing will maintain this form and report the findings to the Quality Assurance Committee and they will report the findings to the Governing Board quarterly.</p>				

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	<p>The staff member confirmed the containers should not be in the facility.</p> <p>4. During the tour of the facility at 1:45 PM on 04/30/14, accompanied by staff member A1, the malignant hyperthermia supplies were observed in the crash cart. The standard of practice is to keep 36 vials of Dantrium on hand in case of an emergency, but the cart contained only 18 vials of Dantrium and the vials expired 02/2013. The Amsco Warmer was observed with one 1000 ml. (milliliter) bag of Lactated Ringers intravenous solution, outdated irrigation fluids, and blankets. The temperature of the warmer was unable to be determined because the control only indicated "low, medium, high".</p> <p>5. The facility policy "Malignant Hypothermia" [should be hyperthermia], last reviewed 10/24/12, indicated, "Standard protocol for patients with suspected malignant hypothermia is as follows: 1. Arrangements will be made for an ambulance to transfer the patient to the hospital. 2. A physician as well as a nurse will accompany the patient during the transfer to the hospital. Initial treatment upon waiting for the ambulances arrival includes: 1. Discontinuation of all anesthetic gases. 2. Begin appropriate drug therapy such and Dantrium, cold IV packs, etc."</p>			

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	<p>6. The facility policy "Warmer", last reviewed 10/24/12, indicated, "Blankets and fluids are to be kept in the warmer. The temperature control is to be set on low. The blanket warmer is to be wiped out once a week. The lower area of the warmer is to be used for storage of fluids."</p> <p>7. Review of the Drug Formulary list for the facility indicated 36 vials of Dantrium Sodium were on hand at the facility.</p> <p>8. AORN (Association of periOperative Registered Nurses) recommendations indicated both fluid and blanket warmers should be monitored regularly with blanket cabinets not above 130 degrees F. and fluids warmed and stored according to manufacturer guidelines.</p> <p>9. At 11:25 AM on 05/01/14, staff member A1 confirmed the facility followed AORN recommendations, but did not have a policy regarding the warmers. He/she indicated they did not have the manufacturer directions regarding warming and storing the fluids. He/she also indicated the facility had always only kept 18 vials of Dantrium since they would transfer a patient with an emergent situation.</p>			

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