

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER FOR PAIN OF SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2920 MCINTIRE DR STE 150 BLOOMINGTON, IN 47403
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 008901</p> <p>Survey Date: June 19, 2013</p> <p>Surveyors: Billie Jo Fritch, RN, MBA, MSN Public Health Nurse Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/24/13</p>	S000000		

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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S000010	<p>410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a)</p> <p>Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules. Based on document review and staff interview, the facility failed to comply with all applicable state laws for 2 of 2 unlicensed staff members providing direct patient care.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of IC 16-28-13-4, a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law. Review of staff member #N3 personnel file indicated that he/she was hired on 11/2/12 as a medical assistant. The file lacked documentation of a nurse aide registry report. Review of staff member #N4 personnel 	S000010	<p>A report for all current unlicensed employees will be obtained from the state's nurse aide registry. The report will be placed in each employees personal file. To avoid this in the future, this will be completed at the time of employment for all future employees. The Nursing Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	08/01/2013

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	<p>file indicated that he/she was hired on 1/2/13 as a medical assistant. The file lacked documentation of a nurse aide registry report.</p> <p>4. Staff member N1 verified in interview at 4:00 p.m. on 6/19/13 that the facility had not checked the nurse aide registry for staff members #N3 and N4.</p>			

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S000132	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(8)</p> <p>The governing body shall do the following:</p> <p>(8) Ensure surgical procedures are performed only by a physician, dentist, or podiatrist who is privileged to perform such procedures according to medical staff bylaws, regulations, and/or policies and procedures.</p> <p>Based on document review, observation, and staff interview, the facility failed to ensure procedures were performed by a practitioner with privileges to perform such procedures for 10 of 32 patients and failed to schedule patients for procedures that the practitioner had privileges to perform for 2 of 32 patients.</p> <p>Findings include:</p> <p>1. Professional staff bylaws last approved 12/7/11 states on page 7 states "Appointment to the Professional Staff shall confer on the appointee only such privileges granted in accordance with these Bylaws and shall be reviewed at each reappointment." and states on page 12: "6.1.A Every Practitioner providing clinical services at this Center by virtue of Professional Staff membership shall, in connection with such practice, be entitled to exercise only those clinical privileges</p>	S000132	<p>This deficiency has already been corrected. Physicians will supply a current list of any procedures they will be performing in the ASC. All current physicians will supply an updated list. The list of procedure list will be placed in the physician's personal file once approved by the board. In the future, this will be completed at the time any new physicians are granted privileges in the ASC to avoid any further deficiencies. Current physicians will have their personal file reviewed on a yearly basis and prn to keep them updated. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	06/27/2013			

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	<p>granted to him by the Board of Directors....." and</p> <p>2. Patient #1 had a release of right stenosing tenosynovitis of the flexor long profundus and sublimis and a tenosynovectomy right long flexor on 1/30/13.</p> <p>3. Patient #5 had a lipomectomy in the lumbar paraspinal area on 1/30/13.</p> <p>4. Patient #12 had an excision of a hypertrophic neuromatous scar with advancement of flap on 3/13/13.</p> <p>5. Patient #13 had excision of Squamous Cell Carcinoma of his/her had with advancement of flap for reconstruction on 3/20/13.</p> <p>6. Patient #14 had excision of a right STSG with neuroma and advancement flap on 4/10/13.</p> <p>7. Patients #16 and #17 had an excision of a neoplastic area with advancement flap on 4/10/13.</p> <p>8. Patient #18 had a right foot release of intermeta tarsal ligament on 4/17/13.</p> <p>9. Patient #19 had a release of right long stenosing teno synovitis of the flexor</p>			

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	<p>longus profundus and tenosynovectomy of right long flexor on 4/17/13.</p> <p>10. Patient #20 had an excision of sebaceous cyst on scalp with advancement flap on 4/17/13.</p> <p>11. The above procedures were performed by M.D. #1.</p> <p>12. Patients #N31 and N32 were observed leaving the facility at 9:15 a.m. on 6/19/13.</p> <p>13. Review of M.D. #1 credential file indicated he/she did not have privileges to perform the procedures on patients #1, 5, 12, 13, 14, 16, 17, 18, 19, 20, 31, and 32.</p> <p>14. Staff member #N2 indicated in interview at 1:15 p.m. on 6/19/13 that patient #N31 was to have Carpal Tunnel surgery and patient #N32 was to have a lesion removal. He/she stated that the procedures were canceled due to time limits.</p> <p>15. Staff member #N1 verified in interview at 4:00 p.m. on 6/19/13 that M.D. #1 did not have privileges for the above.</p>						

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S000230	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(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.</p> <p>Based on document review and interview, governing body failed to provide a Utilization Review (UR) Committee of physicians with none having financial interest in the facility.</p> <p>Finding included:</p> <ol style="list-style-type: none"> 1. Review of the committee membership list on 6-19-13 indicated MD#1, owner of the surgical facility, is a member of the UR Committee. 2. Review of the UR Committee meeting minutes for 12-18-12 and 3-28-13 on 6-19-13 indicated MD#1, owner of the surgical facility, is a member of the UR Committee. 3. Review of ownership documents on 6-19-13 indicated MD#1 is the owner of the surgical facility. 	S000230	<p>This deficiency has already been corrected. The ASC will update its Utilization Review (UR) Committee to include at least three physicians without any financial interest in the ASC and remove Dr. Tristan Stonger from the committee. This will be monitored more closely and updated by the nursing administrator on a yearly basis and prn to avoid deficiencies in this area in the future. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	06/27/2013

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	<p>4. Review of the Quality Assurance Program on 6-19-13 indicated the following on page 23: UTILIZATION REVIEW COMMITTEE; membership includes three or more professionals from the community who may or may not be members of the Professional Staff (none of whom have any financial interest in the Center).</p> <p>5. An interview was conducted with MD#1 on 6-19-13 at 0920 hours and confirmed he/she is the owner of the surgical facility.</p> <p>6. An interview was conducted with B#1 on 6-19-13 at 1545 hours and confirmed MD#1 owns the surgical facility and is a member of the UR Committee.</p>				

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S000310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include three services (nursing, transcription, and laundry) in the facility's Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's QAPI documentation on 6-19-13 lacked evidence the services of nursing, transcription, and laundry were included in the facility's QAPI program. 2. An interview was conducted with B#1 on 6-19-13 at 1525 hours and confirmed the services of nursing, transcription, and laundry are not included in the facility's QAPI program. 	S000310	<p>This deficiency has already been corrected. The ASC will include nursing, transcription, and laundry services in the center's Quality Assurance & Performance Improvement (QAPI) program. QA's will be completed on these services on a yearly basis and prn to maintain compliance. The Nurse Administrator will monitor the QAPI program more closely to avoid any services being omitted from the program. QA's will be used for all services to maintain compliance. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	06/27/2013			

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S000332	<p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the center:</p> <p>(A) The following surgical events:</p> <p>(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</p> <p>(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.</p> <p>(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</p> <p>(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.</p>			

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	<p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(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.</p> <p>(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.</p> <p>(B) The following product or device events:</p> <p>(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.</p> <p>(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:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(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.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide</p>			

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	<p>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.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>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.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(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:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p>			

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	<p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(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.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(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.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on</p>			

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	<p>the grounds of the center.</p> <p>(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.</p> <p>Based on document review and interview, the facility failed to include serious adverse events in the facility Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of facility QAPI documents on 6-19-13 lacked evidence serious reportable events, those reportable to the Indiana State Department of Health (ISDH), were included in the facility's QAPI program. An interview was conducted with B#1 on 6-19-13 at 1525 hours and confirmed serious reportable events, those reportable to the ISDH, are not included in the facility's QAPI program. 	S000332	<p>This deficiency has already been corrected. The ASC will include serious reportable events in the center's Quality Assurance & Performance Improvement (QAPI) program. QA's will be completed on a yearly basis and prn to maintain compliance. The Nurse Administrator will monitor the QAPI program more closely to avoid any services being omitted from the program. QA's will be used for all services to maintain compliance. Serious reportable events will be covered at each quarterly meeting. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	06/27/2013			

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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER FOR PAIN OF SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2920 MCINTIRE DR STE 150 BLOOMINGTON, IN 47403
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S000400	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review and observation, the facility failed to use disinfectant according to manufacturer recommendations, failed to remove expired items from patient stock in 2 of 2 procedure rooms and failed to follow the facility's hand hygiene policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "ENVIRONMENTAL DISINFECTION AND STERILIZATION" last reviewed/revised 12/7/11 states on page 10: "7. Disinfect non-critical surfaces with an EPA registered and hospital disinfectant according to the labels's safety precautions and use directions." Page 13 states "The Center shall clean the operating rooms between each patient." 2. Facility policy titled "HAND HYGIENE" last reviewed/revised 12/7/11 states on page 17: "2. The staff of the Center must wear gloves in an effort to promote improved hand hygiene and as follows:.....d. When anticipating direct 	S000400	<p>Research for a new disinfectant with a shorter disinfectant time will be completed. The ASC will change disinfectants if one is found to be comparable with a shorter disinfectant time. Staff will complete an in-service on appropriate use of disinfectants. The ASC will adhere to the current disinfectant's label until a new product is found. Staff will complete an in-service on the handling and disposal of expired items. Staff will complete an in-service on the current hand hygiene policy of the ASC. These deficiencies will be avoided in the future by monitoring the staff in-service log more closely and making sure all staff stay current on all policies and in-services for the ASC. All new employees will complete all required in-services at time of hire. The nurse administrator will monitor the staff and observe that they are following the proper protocols with regard to the above policies to maintain compliance. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	08/01/2013

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	<p>contact with blood and bloody fluids....."</p> <p>3. Label instructions for LPH se states "Use a 10 minute contact time for disinfection against all organisms claimed."</p> <p>4. During observations beginning at 9:25 a.m. on 6/19/13 the following observations were made:</p> <p>(A) Staff member #N1 sprayed a bedside stand with LPH se, allowed it to dry for 35 seconds and placed supplies on the stand for the patient in the room.</p> <p>(B) Staff member #N3 cleaned the procedure room between patients using the LPH se. He/she sprayed surfaces and immediately wiped it with a disposable cloth. He/she reapplied a disposable sheet on the bed and set up for the next patient after just 2 minutes.</p> <p>(C) Staff member #N3 removed a disposable sheet from the bed after a procedure. The sheet had a large area of blood on it. He/she had removed his/her gloves prior to removing the soiled sheet.</p> <p>(D) Two (2) sterile bags for the C-arm with an expiration date of 3/13 were observed in procedure room #1</p> <p>(E) A staple removal kit with an expiration date of 3/13 was observed in procedure room #2.</p> <p>(F) Three (3) Tegaderm dressings with an expiration date of 4/06 were observed in</p>						

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	procedure room #2. (G) One (1) Tegaderm dressing with an expiration date of 5/07 was observed in procedure room #2.			

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S000426	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)</p> <p>The infection control committee responsibilities must include, but not are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: Based on document review, it could not be determined that the infection control committee was an active committee reviewing and recommending changes in policies and procedures for one infection control program reviewed.</p> <p>Findings include:</p> <p>1. Review of the typed infection control meeting minutes for 4/19/12, 5/17/12, 6/28/12, 9/27/12, and 12/18/12 indicated that the exact same information was documented each month including, but not limited to, "An issue of having surgical scrubs laundered and provided by the ASC by an outside source has been brought up by the ISDH....."</p>	S000426	This deficiency has already been corrected. The ASC will update its infection control committee and more thorough meeting notes will be taken at the infection control meetings. The Nurse Administrator will monitor the infection control meetings to avoid any future deficiencies. The meeting notes will be presented to the board at each quarterly meeting for approval. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.	06/27/2013	

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S000444	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on document review and observation, the facility failed to ensure staff members changed mask between patients for one day of observations made.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "PERSONAL HYGEINE (known spelling error) AND ATTIRE" last reviewed/revised 12/7/11 states under attire: "a. The masks are to be changed between each patient. b. Each mask is for one procedure use." 2. Facility mask were stored on a table outside the procedures rooms and within site of surveyor work area. 3. M.D. #1 and staff member #N3 were observed throughout the day leaving the 	S000444	<p>All current employees (including physicians) will be in-serviced on the "personal hygiene and attire" policy. The in-service will cover the importance of personal changing their masks with each patient to follow infection control guidelines. The policy will be fully reviewed as well. This in-service will be completed on a yearly basis and prn as the need arises to avoid any future deficiencies. The nurse administrator will monitor the staff and observe that they are following the proper protocols with regard to the above policies to maintain compliance. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	08/01/2013

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	<p>procedure room with a mask around their neck and re-entering the room. Their masks were not being changed.</p> <p>4. During observations of 2 patients within the procedure room beginning at 9:30 a.m., M.D. #1 and staff member #N3 did not change their mask between the patients.</p>			

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S000622	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(6)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(6) The center shall have a system of coding and indexing medical records which allows for timely retrieval of records by diagnosis and procedure, physician, and condition on discharge, in order to support continuous quality assessment and improvement activities. Based on document review and interview, the facility failed to have a system to allow the timely retrieval of records by diagnosis and the patients' condition on discharge.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility surgical procedure log for patient medical record selection on 6-19-13 lacked evidence of documentation of the patient diagnosis and their condition on discharge. 2. An interview was conducted with B#1 on 6-19-13 at 1410 hours and confirmed the surgical procedure log does not include the patient diagnosis or their condition on discharge. 	S000622	The patient diagnosis and patient condition upon discharge from the ASC will be added to the daily procedure log. This change will be made to the permanent template of the procedure log to avoid it being a deficiency in the future. The Nurse Administrator will complete a QA within the quarter to monitor that this has been completed and maintained. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.	08/01/2013			

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S000658	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(6)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(6) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and observation, the facility failed to ensure the patient was informed of the procedure they were to receive and signed an informed consent prior to the procedure for 2 of 2 patients observed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "TREATMENT CONSENTS" last reviewed/ revised 12/7/11 states on page 29: "All patients must have a signed Informed Consent for Treatment" and "B. The consent must include the name of the practitioner performing the treatment and the procedures to be performed." 2. During observations beginning at 9:25 a.m. on 6/19/13, the following observations were made: 	S000658	<p>All staff will be in-serviced on the correct procedure of completing paperwork for the ASC properly and accurately. This will be added to the yearly in-services and completed with all new staff members. The Nurse Administrator will continue to monitor the in-services for the ASC. The nurse administrator will monitor the staff and observe that they are following the proper protocols with regard to the above policies to maintain compliance. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	08/01/2013

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	(A) Patients #3 and #4 were asked to sign a consent. The consent did not have the type of procedure to be performed marked nor was this explained to them. (B) Staff member #N1 marked what procedure was to be performed after the patient arrived in the procedure room and was on the table. The patient had no involvement in the consent at that point.			

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S000676	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or legally reproduced medical records must be maintained by the center for a period of seven (7) years in accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure.</p> <p>Based on observation and interview, the facility failed to maintain patient medical records within the surgery center.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the facility with B#1 on 6-19-13 at 1350 hours, it was observed that patient medical records are not all stored in the surgery center. 2. An interview was conducted with B#1 on 6-19-13 at 1400 hours and confirmed some patient medical records are stored in the surgery center and others are stored in MD#1's physician office; B#1 confirmed the surgery center does not have a waiver from the Indiana State Department of Health to store the patient medical records at a site outside the surgery center. 	S000676	The ASC will apply for a wavier from the Indiana State Department of Health (ISDH) to store the ASC's archived patient records off site (cabinets in front of the physician's office). The archived patient records currently stored there will be moved to the storage bay of the ASC until the wavier is obtained. Once obtained, the ASC will maintain the wavier to avoid any future deficiencies. If the wavier is not obtained, the archived patient records will remain in the ASC. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.	08/01/2013	

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S000772	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on observation and document review, the facility failed to ensure the physician updated the history and physical (H&P) according to policy for 2 of 2 patients observed (patients #3 and #4).</p> <p>Findings include:</p>	S000772	The physician performing a procedure in the ASC will complete a history and physical the day of the procedure or update an existing history and physical if it is within two weeks of the procedure prior to each procedure. Each physician will be in-serviced on the ASC's current	08/01/2013			

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	<p>1. Facility policy titled "REQUIRED DOCUMENTATION" last reviewed/revised 12/7/11 states on page 4: "A history and physical examination shall be recorded prior to surgery. The H&P must be dated within 2 weeks of the scheduled procedure date. The MD must review and update the H&P on the day of the scheduled procedure."</p> <p>2. During observations beginning at 9:25 a.m. on 6/19/13, the following observations were made: (A) M.D. #1 did not see patients #3 or 4 prior to the procedure. Staff member #N1 wrote "No changes as of 6/19/13" on the H&P form. M.D. #1 initialed the "no changes" line after the procedure. (B) M.D. #1 did not review or obtain information to update the H&P on the day of the procedure as required by policy.</p>		<p>policy for performing a history and physical prior to procedures. This will be completed at the time of employment for any new physicians. The nurse administrator will monitor this with all current and new hires. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>		

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S001142	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)</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>(1) No condition in the center or on the grounds may be maintained which may be conducive to the harboring or breeding of insects, rodents, or other vermin.</p> <p>Based on observation and interview, the facility maintained a condition conducive to the harboring of insects.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the facility with B#1 on 6-19-13 at 1350 hours, multiple bugs were observed in six light fixtures. 2. An interview was conducted with B#1 on 6-19-13 at 1420 hours and confirmed there were multiple bugs in six light fixtures. 	S001142	<p>This deficiency has already been completed. The building maintenance department was called and a work order was placed to have the light fixtures cleaned immediately. The cleaning company was called and notified to add this to their regular cleaning duties to avoid any future deficiencies. The nurse administrator will continue to complete QA's on the cleaning company to maintain compliance. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	06/21/2013

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S001146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the surgery center created/maintained a conditions which may result in a hazard to patients, the public, and surgery center employees.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. While touring the facility with B#1 on 6-19-13 at 1350 hours, 3 stained ceiling tiles were observed above the patient procedure chair in the main patient care area which could effect the safety and well-being of patients, the public, and facility staff. 2. An interview was conducted with B#1 on 6-19-13 at 1420 hours and confirmed 3 stained ceiling tiles are above the patient procedure chair in the main patient care area. 	S001146	<p>This deficiency has already been completed. The building maintenance department was called and a work order was placed to have the ceiling tiles replaced immediately. The maintenance department was requested to monitor this issue on a regular basis. The nurse administrator will also monitor this weekly to avoid any future deficiencies. The nurse administrator will complete QA's on the maintenance department to maintain compliance. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	07/10/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001061		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2013	
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER FOR PAIN OF SOUTHERN INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 2920 MCINTIRE DR STE 150 BLOOMINGTON, IN 47403			
(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			
S001164	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on observation, document review, and interview, the facility failed to provide preventative maintenance (PM) on 1 piece of equipment.</p> <p>Findings included:</p> <p>1. While touring the facility with B#1 on 6-19-13 at 1350 hours, the emergency call alarm in the patient restroom was activated by B#1; the alarm did not provide an audible alarm when activated and the light outside the door did not illuminate.</p>	S001164	<p>This deficiency is currently being worked on by the building maintenance department. The building maintenance department was called and a work order was placed to have the patient restroom emergency call light repaired immediately. The maintenance department is currently working on correctly repairing or replacing the emergency call light. If the call light cannot be repaired by 08/15/2013, it will be replaced. The nurse administrator will complete preventative maintenance checks on the</p>	08/15/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001061	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2013
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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER FOR PAIN OF SOUTHERN INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2920 MCINTIRE DR STE 150 BLOOMINGTON, IN 47403
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	<p>2. Review of facility documents on 6-19-13 lacked evidence preventative maintenance was conducted on the emergency call alarm in the patient restroom.</p> <p>3. An interview was conducted with B#1 on 6-19-13 at 1545 hours and confirmed the emergency call alarm in the patient restroom did not work when activated; B#1 confirmed preventative maintenance was not provided for this piece of equipment to ensure patient safety if using the emergency alarm.</p>		<p>emergency call light to avoid any future deficiencies. The Nurse Administrator (MaryAnn Jacobs, RN) will be responsible to maintain compliance.</p>	