

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001041	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2015
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NAME OF PROVIDER OR SUPPLIER  SAGAMORE SURGICAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2320 CONCORD ROAD, SUITE B LAFAYETTE, IN 47909
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Q 000  Bldg. 00	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 006126</p> <p>Survey Date: 3/23/2015 through 3/25/2015</p> <p>QA: cl 04/09/15</p>	Q 000		
Q 105  Bldg. 00	<p>416.44(c) EMERGENCY EQUIPMENT</p> <p>The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC' s operating room. The equipment must meet the following requirements:</p> <p>(1) Be immediately available for use during emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel.</p> <p>Based on documentation review and staff interview, the facility failed to ensure preventive</p>	Q 105	Sagamore Surgical Services has one blanket warmer and two Life Air 1000 patient warming units. The Lifepak 9 defibrillator and all 3 warming units will have	05/14/2015

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>maintenance inspections on a Lifepak 9P Defibrillator.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>Sagamore Surgical Services, Inc Preventive Maintenance policy (last approved 4/15/2013) indicated the preventive maintenance routine inspections shall be conducted accordingly to the facility's preventive maintenance checklist.</li> <li>The Lifepak 9P defibrillator/monitor/pacemaker operating manual recommends preventive maintenance in-depth tests and calibration to be conducted semi-annually by a qualified clinical engineer.</li> <li>Review of facility preventive maintenance documents on 3/24/2015 indicated lack of preventive maintenance on the Lifepak 9P Defibrillator.</li> <li>At 10:30 AM on 3/24/2015,</li> </ol>		<p>preventive maintenance on April 24, 2015. We currently have two bio medical companies reviewing the equipment list to submit a contract for all equipment. The policy has been reviewed and is being acted upon by the Administrator and Director of Nursing.</p>				

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Q 221 Bldg. 00	<p>staff member #1 (Director of Nursing) confirmed the Lifepak 9P Defibrillator was not on the preventive maintenance checklists. The staff member indicated electrical checks are performed annually on all electrical components only. The defibrillator never receives routine preventive maintenance inspections.</p> <p>416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.</p> <p>Based on documentation review and staff interview, the facility failed to provide to the patient the Indiana State Department of</p>	O 221	The ISDH phone number provided to patients as part of their Patient Right's packet was corrected along with the Web site for the office of the Medicare Beneficiary Ombudsman.	04/24/2015

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	<p>Health's correct phone number and the Web site for the Office of the Medicare Beneficiary Ombudsman to file a grievance as part of the patient's rights.</p> <p>Findings included:</p> <p>1. At 2:30 PM on 3/24/2015, Director of Nursing provided a brochure of the Patient Rights Document that was given to all patients prior to surgery. The document was titled: Sagamore Surgical Center Patient Information which includes Patient's Rights. The Complaints/Grievance section identified the Indiana State Department of Health (ISDH); however, the ISDH phone number was not the correct number that was suppose to be provided to the patients as part of their Patient Right's packet. The Web site listed in the brochure was not the Web site for the Office of the Medicare Beneficiary Ombudsman to file a grievance.</p>		<p>03/25/2015The Patient Right's hanging on the wall was corrected for the ISDH phone number and the Web site for the office of the Medicare Beneficiary Ombudsman. 0325/2015The patient brochure that is handed out in the physicians' office is at the printer and will be handed out April 24th, 2015</p>	

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Q 241 Bldg. 00	<p>2. At 1:00 PM on 3/25/2015, staff member #1 (Director of Nursing) confirmed the ISDH phone number provided to patients as part of their Patient Right's packet was incorrect and the packet also did not include the Web site for the Office of the Medicare Beneficiary Ombudsman. The staff member indicated the posted patient rights sign in the lobby was also incorrect with ISDH correct phone number and did not have the Web site for the Office of the Medicare Beneficiary Ombudsman to file a grievance.</p> <p>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 policy and procedure review, manufacturer's directions, observation, and interview, the infection control</p>	O 241	The Rapicide OPA/28 policy was reviewed and revised. Revisions: 10 minutes for soaking the device was added to the policy to clarify	03/26/2015

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	<p>committee failed to ensure the appropriate rinsing procedures for high level disinfection were followed in the operative area.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. The facility policy "Cleaning and High Level Disinfection of Esophagoscope and Bronchoscope", last revised 02/14, indicated, "D. Immerse scope, components, and biopsy forceps in high level disinfectant. Soak per manufacturer's recommendations (12 minutes). E. After disinfection, rinse scope, flushing all channels/lumens with tap water."</li> <li>2. The facility policy "High Level Disinfectant (Rapicide OPA)", last revised 02/14, indicated, "B. Usage and Maintenance: ...5. Instruments must be soaked in the disinfecting solution according to the manufacturer's directions. 6. Following disinfection, rinse the instruments thoroughly, flushing all channels and lumens. Repeat the rinsing process using a different water rinse."</li> <li>3. The manufacturer's directions for the Rapicide OPA/28 High Level Disinfectant indicated, "C. High Level Disinfection Procedure: 1. Manual Reprocessing: Place pre-cleaned medical</li> </ol>		<p>the "according to manufacture's directions." It now includes to rinse in three separate pans totally submerged for 1 minute each pan. The pans of water are to be changed after each device. The policy will be reviewed by each employee with an inservice to staff. There will be random monitoring and QA completed by the Infection Control Nurse this will be done in the 2nd quarter 2015. This report will go to the Infection Control Committee to act upon and then reported to the QAPI Committee. The Director of Nursing will be responsible for ensuring compliance</p>	

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	<p>device into compatible tray. Immerse device completely, filling all lumens, with Rapicide OPA/28 solution for a minimum of 10 minutes at room temperature. ...D. Rinsing Instructions and Procedure: Following removal from Rapicide OPA/28, thoroughly rinse the semi-critical device by immersing it in a large volume of water (e.g. 8 liters). ...Keep the device entirely submersed for a minimum of 1 minute in duration, unless a longer time is specified by the reusable device manufacturer. Manually flush all lumens with large volumes of rinse water unless otherwise noted by the device manufacturer. Remove the device from the water and discard the rinse water. Always use fresh volumes of water for each rinse. Do not reuse the water for rinsing for any other purpose. Repeat the procedure for rinsing manual devices TWO additional times for a total of THREE (3) RINSES with large volumes of fresh water to remove Rapicide OPA/28 HLD residues. Proper rinsing of devices is required, see warnings and precautions. Three (3) separate large volume water immersion rinses are required unless otherwise specified by device manufacturer's instructions."</p> <p>4. At 10:35 AM on 03/24/15, the nurse brought the laryngoscope blade, that was</p>			

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	<p>used for the surgical case, and placed it in a small pan of Rapiocide OPA solution located on the shelf of the scrub sink outside of the OR suite (Operating Room).</p> <p>5. At 10:35 AM on 03/24/15, the OR nurse, staff member #5, indicated the blade soaked in the solution for 10 minutes, then he/she would take it out and rinse it in the scrub sink for about a minute. After that, it would air dry before being placed back on the anesthesia cart for the next case.</p> <p>6. At 11:15 AM on 03/24/15, some equipment was observed soaking in a container of Rapiocide OPA in the substerile room.</p> <p>7. At 11:15 AM on 03/24/15, the Certified Surgical Tech, staff member #6, indicated the equipment soaked in the solution for 10 minutes, then had a double bath rinse in sterile water, and was allowed to air dry.</p> <p>8. At 1:00 PM on 03/25/15, the Director of Nursing, staff member #1, confirmed the facility's policy and practices for high level disinfection were not according to the manufacturer's directions for Rapiocide OPA/28, the solution used in the facility.</p>			

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Q 261  Bldg. 00	<p>416.52(a)(1) ADMISSION ASSESSMENT</p> <p>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.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure a history and physical was completed according to policy and on the chart for 4 of 30 medical records reviewed (#17, #18, #21, and #27).</p> <p>Findings included:</p> <p>1. The facility policy "Medical Records", originated 04/93 and revised 03/13, indicated, "9. Timeliness of Completion: a. Physicians' or practitioners' history and physical examinations must be completed within seven (7) days prior to surgery. i. A photocopy of a patient evaluation done in a physician's office within 30 days prior to performance of a procedure will be accepted, provided a current pre-procedure note by the practioner is done the day of procedure. ... 2. General Guidelines: ...4. A completed history and physical will be</p>	O 261	<p>In reviewing the policy it will not be changed our method of insuring the policy is followed will be changed. The History and Physical date upon arrival of the document will be checked by the front desk employees and by the pre-op Nurse. If the H&amp;P is older than 30 a new H&amp;P will be requested on that day. If the H&amp;P is less than 30 days it will need to be updated, when not done on that day. The front desk employees and pre-op nurses have been notified one on one or by reading the information. This will be monitored by the Medical Records Coordinator and her designee with a daily QA beginning 4/20/2015.</p>	04/20/2015

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	<p>written or dictated no more than thirty days before admission. There must be an update and changes noted on the record on the day of surgery."</p> <p>2. The medical record for patient #17, who had a procedure performed on 11/10/14, indicated a History and Physical form, but without a date or practitioner signature to determine when it was performed and by whom.</p> <p>3. The medical record for patient #18, who had a procedure performed on 11/19/14, indicated a photocopy of a physician visit and History and Physical from Oct. 1, 2014 and a physician written note of "No changes", but the history and physical was over 30 days prior to the procedure.</p> <p>4. The medical record for patient #21, who had a procedure performed on 01/07/15, indicated a photocopy of a physician visit and History and Physical from Nov. 17, 2014 with no update, but the history and physical was over 30 days prior to the procedure.</p> <p>5. The medical record for patient #27, who had a procedure performed on 01/28/15, indicated a photocopy of a physician visit and History and Physical from Jan. 14, 2015, but there was no</p>			

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S 000 Bldg. 00	<p>physician update on the day of surgery.</p> <p>6. At 1:15 PM on 03/25/15, staff member #1, the Director of Nursing, confirmed the medical record findings and indicated the history and physicals were not according to facility policy.</p>	S 000					
S 414 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 006136</p> <p>Survey Date: 3/23/2015 through 3/25/2015</p> <p>QA: cl 04/09/15</p> <p>IDR Meeting 05-20-15: No changes made. JL</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p>						

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	<p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on facility document review and interview, the facility failed to ensure the infection control committee met quarterly, and included the appropriate membership, to ensure all aspects of the Infection Prevention Program were reviewed.</p> <p>Findings included:</p> <p>1. The facility's "Quality Assessment and Performance Improvement Plan", which originated 04/93 and was revised 03/13, indicated, "VI. Scope of Performance Improvement Activities: ...C. Provide</p>	S 414	The policy and procedure for the QAPI Team was reviewed and discussed with the Administrator and Board of Directors on 4/14/2015. The Medical Director and at least one representative from the medical staff will be attending the QAPI meeting and the Infection Control Meeting. A message will be sent to each member the date, time and place of the meetings. This will be coordinated by the QAPI and Infection Control Coordinators. This will be monitored by the Administrator/and Director of Nursing along with the minutes of the meeting. This will begin with	04/20/2015

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	<p>surveillance of the Center's infection potentials. review and analyze actual infections, and recommend corrective programs to minimize infection hazards. ...VII. QAPI Team: The QAPI Team shall consist of two or more representative practitioners from the Professional Staff, clinical nursing staff, the Administrator/Director of Nursing, and the Medical Director. ...VIII. Functions and Interrelationships of the Team: ...The Team coordinates and directs performance improvement activities of the Center, including but not limited to: credentials, infection control, tissue review, patient transfers to hospital, medical records review, contract services, pharmaceutical activity, inservice/training, safety, fire, and disaster activities."</p> <p>2. Minutes from the last two QAPI meetings were reviewed and indicated the following: A. Oct. 13, 2014- Five nurses were in attendance, but no representatives from the medical staff or the Medical Director were present. Infection Control information was presented by the Infection Control Nurse, staff member #15. B. Jan. 20, 2015- Four nurses were in attendance, but no representatives from the medical staff or the Medical Director</p>		the meetings of the second quarter of 2015.				

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S 432 Bldg. 00	<p>were present. The minutes indicated Infection Control information was presented by the Infection Control Nurse; however, staff member #15 was not listed as in attendance.</p> <p>3. At 1:10 PM on 03/24/15, the facility's Director of Nursing, staff member #1, indicated all issues, including infection control information, were discussed at the QAPI meetings which were held quarterly. He/she confirmed there were no physicians at the meetings, but the minutes did go to the board.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, policy and procedure review, manufacturer's directions, and interview, the infection control committee failed to ensure the</p>	S 432	The Rapiocide OPA/28 policy was reviewed and revised. Revisions: 10 minutes for soaking the device was added to the policy to clarify the "according to manufacture's	03/26/2015

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	<p>appropriate rinsing procedures for high level disinfection were followed in the operative area.</p> <p>Findings included:</p> <p>1. The facility policy "Cleaning and High Level Disinfection of Esophagoscope and Bronchoscope", last revised 02/14, indicated, "D. Immerse scope, components, and biopsy forceps in high level disinfectant. Soak per manufacturer's recommendations (12 minutes). E. After disinfection, rinse scope, flushing all channels/lumens with tap water."</p> <p>2. The facility policy "High Level Disinfectant (Rapicide OPA)", last revised 02/14, indicated, "B. Usage and Maintenance: ...5. Instruments must be soaked in the disinfecting solution according to the manufacturer's directions. 6. Following disinfection, rinse the instruments thoroughly, flushing all channels and lumens. Repeat the rinsing process using a different water rinse."</p> <p>3. The manufacturer's directions for the Rapicide OPA/28 High Level Disinfectant indicated, "C. High Level Disinfection Procedure: 1. Manual Reprocessing: Place pre-cleaned medical device into compatible tray. Immerse</p>		<p>directions." It now includes to rinse in three separate pans totally submerged for 1 minute each pan. The pans of water are to be changed after each device. The policy will be reviewed by each employee with an inservice to staff. There will be random monitoring and QA completed by the Infection Control Nurse this will be done in the 2nd quarter 2015. This report will go to the Infection Control Committee to act upon and then reported to the QAPI Committee. The Director of Nursing will be responsible for ensuring compliance</p>	

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	<p>device completely, filling all lumens, with Rapicide OPA/28 solution for a minimum of 10 minutes at room temperature. ...D. Rinsing Instructions and Procedure: Following removal from Rapicide OPA/28, thoroughly rinse the semi-critical device by immersing it in a large volume of water (e.g. 8 liters). ...Keep the device entirely submersed for a minimum of 1 minute in duration, unless a longer time is specified by the reusable device manufacturer. Manually flush all lumens with large volumes of rinse water unless otherwise noted by the device manufacturer. Remove the device from the water and discard the rinse water. Always use fresh volumes of water for each rinse. Do not reuse the water for rinsing for any other purpose. Repeat the procedure for rinsing manual devices TWO additional times for a total of THREE (3) RINSES with large volumes of fresh water to remove Rapicide OPA/28 HLD residues. Proper rinsing of devices is required, see warnings and precautions. Three (3) separate large volume water immersion rinses are required unless otherwise specified by device manufacturer's instructions."</p> <p>4. At 10:35 AM on 03/24/15, the nurse brought the laryngoscope blade, that was used for the surgical case, and placed it in</p>			

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	<p>a small pan of Rapiocide OPA solution located on the shelf of the scrub sink outside of the OR suite (Operating Room).</p> <p>5. At 10:35 AM on 03/24/15, the OR nurse, staff member #5, indicated the blade soaked in the solution for 10 minutes, then he/she would take it out and rinse it in the scrub sink for about a minute. After that, it would air dry before being placed back on the anesthesia cart for the next case.</p> <p>6. At 11:15 AM on 03/24/15, some equipment was observed soaking in a container of Rapiocide OPA in the substerile room.</p> <p>7. At 11:15 AM on 03/24/15, the Certified Surgical Tech, staff member #6, indicated the equipment soaked in the solution for 10 minutes, then had a double bath rinse in sterile water, and was allowed to air dry.</p> <p>8. At 1:00 PM on 03/25/15, the Director of Nursing, staff member #1, confirmed the facility's policy and practices for high level disinfection were not according to the manufacturer's directions for Rapiocide OPA/28, the solution used in the facility.</p>			

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S 442 Bldg. 00	<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> <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 file review, and interview, the employee health program failed to ensure all staff had documentation of immunization status in 5 of 7 files reviewed (#3, #12, #13, #14, and #15).</p> <p>Findings included:</p> <p>1. The facility policy, "Infection Control for Employee Health", originated 04/93 and last reviewed 02/14, indicated, "D. A communicable disease history will be taken to determine documentation of history or of immunity to Rubella,</p>	S 442	<p>The plan of correction is to have all current and future employees provide either a record of varicella vaccination or sign a letter of declination if they refuse the vaccination.</p> <p>The Director of Nursing will be responsible for making sure all current and future employee files are compliant with this plan of correction</p>	05/26/2015

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	<p>Rubeola, Hepatitis B and Chicken Pox.</p> <p>1. According to Indiana State Department of Health, Communicable Disease Division, a reliable history of chickenpox is a valid measure of varicella zoster immunity (VZI). A history of chickenpox will be utilized as a valid measure of VZI at this Center. 2. If documentation is not available regarding immunity of Rubella, Rubeola, and Hepatitis B, titers will be drawn to determine levels. 3. Employees found to be non-immune will be offered the vaccination. 4. Employees who refuse the vaccine must sign a waiver document which clearly identifies his/her declination of the vaccine and acceptance and understanding of the inherent risks."</p> <p>2. The file for staff member #3, an RN (Registered Nurse) with a hire date of 05/22/09, indicated a Health History form, but no actual documentation of proof of immunity to Rubella, Rubeola, Varicella, or Hepatitis B. The file also lacked documentation of an offer of, or declination of, the Hepatitis B vaccination series.</p> <p>3. The file for staff member #12, a Certified Surgical Tech with a hire date of 03/31/14, indicated a Health History form with the box checked for "Reliable history of Chicken Pox", but no actual</p>			

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	<p>documentation of proof of the disease or immunity.</p> <p>4. The file for staff member #13, an RN with a hire date of 01/10/06, indicated a Health History form, but no actual documentation of proof of immunity to Rubella, Rubeola, Varicella, or Hepatitis B. The file also lacked documentation of an offer of, or declination of, the Hepatitis B vaccination series.</p> <p>5. The file for staff member #14, an RN with a hire date of 06/22/01, indicated a Health History form, but no actual documentation of proof of immunity to Rubeola or Varicella.</p> <p>6. The file for staff member #15, an RN with a hire date of 04/25/05, indicated a Health History form, but no actual documentation of proof of immunity to Rubeola or Varicella.</p> <p>7. At 11:00 AM on 03/23/15, staff member #1, the Director of Nursing, indicated the facility followed the CDC (Centers for Disease Control) and OSHA guidelines regarding immunizations and was not aware of the policy indicating a history of chickenpox was acceptable. He/she indicated he/she had just assumed this position about a year ago and the Infection Control Nurse was on sick</p>			

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S 444 Bldg. 00	<p>leave and was unavailable for clarification.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks.</p> <p>Findings included:</p> <p>1. The facility policy "Surgical Attire", last reviewed 03/13, indicated, "E. All persons entering restricted areas of the surgical suite will wear a mask when there are open sterile items and equipment present. 1. Masks will be carefully removed and discarded after use</p>	S 444	<p>the policy was reviewed. the nursing staff is to read the policy, It was reviewed with the Board of Directors. This will be included in a letter to the physicians. The Infection Control Nurse will review the improper use of PPE and will do a QA report for the Infection Control Committee meeting in the second quarter of 2015 The Director of Nursing will be responsible for ensuring compliance</p>	04/20/2015

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	<p>by handling only the ties. 2. Used masks are not to be saved by hanging around the neck or tucking into a pocket for future use."</p> <p>2. While observing in the pre-op area at 9:50 AM on 03/24/15, the anesthesiologist, staff member #2, and the surgeon, staff member #4, were observed coming out of the surgical area, going to the nurses' station, and talking with patients with their surgical masks hanging around their necks, then returning to the surgical area. At 10:10 AM, the OR nurse, staff member #5, came out of an OR (Operating Room) suite with a surgical mask on, pulled the mask down around his/her neck, talked with the patient in pre-op, then returned to the OR and pulled the mask back up.</p> <p>3. While walking through the post-op area at 9:15 AM on 03/25/15, a male staff member was observed sitting at the nurses' station with a surgical mask hanging around his neck.</p> <p>4. At 9:45 AM on 03/25/15, staff member #1, the Director of Nursing, confirmed the facility followed AORN (Association of periOperative Registered Nurses) recommendations which indicated surgical masks were to be changed between cases and not worn</p>			

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S 676 Bldg. 00	<p>around the neck or stored in pockets.</p> <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 staff interview, the facility failed to ensure there was a waiver for storing patient medical records offsite.</p> <p>Findings included:</p> <p>1. At 11:30 AM on 3/25/2015, staff member #1 (Director of Nursing) indicated patient records are hard copies and that the older patient records are stored in a physician's office which is located offsite of the ambulatory surgery center. The staff member</p>	S 676	A waiver request was sent to Marylee Gruver at the ISDH on March 31, due to computer problems on SSS end it was resent on 04/09/2015. Spoke with Ms. Gruver on 4/09/2015, she was going to process and mail the waiver to Sagamore Surgical Services. Awaiting the waiver in the postal service.	04/09/2015

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S 772 Bldg. 00	<p>confirmed the surgery center does not have a written waiver for storing patient records offsite.</p> <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 policy review, medical record</p>	S 772	In reviewing the policy it will not be changed our method of	05/01/2015

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	<p>review, and interview, the facility failed to ensure a history and physical was completed according to policy and on the chart for 4 of 30 medical records reviewed (#17, #18, #21, and #27).</p> <p>Findings included:</p> <p>1. The facility policy "Medical Records", originated 04/93 and revised 03/13, indicated, "9. Timeliness of Completion: a. Physicians' or practitioners' history and physical examinations must be completed within seven (7) days prior to surgery. i. A photocopy of a patient evaluation done in a physician's office within 30 days prior to performance of a procedure will be accepted, provided a current pre-procedure note by the practioner is done the day of procedure. ... 2. General Guidelines: ...4. A completed history and physical will be written or dictated no more than thirty days before admission. There must be an update and changes noted on the record on the day of surgery."</p> <p>2. The medical record for patient #17, who had a procedure performed on 11/10/14, indicated a History and Physical form, but without a date or practitioner signature to determine when it was performed and by whom.</p>		<p>insuring the policy is followed will be changed. The History and Physical date upon arrival of the document will be checked by the front desk employees and by the pre-op Nurse. If the H&amp;P is older than 30 a new H&amp;P will be requested on that day. If the H&amp;P is less than 30 days it will need to be updated, when not done on that day. The front desk employees and pre-op nurses have been notified one on one or by reading the information. This will be monitored by the Medical Records Coordinator and her designee with a daily QA beginning 4/20/2015.</p>	

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	<p>3. The medical record for patient #18, who had a procedure performed on 11/19/14, indicated a photocopy of a physician visit and History and Physical from Oct. 1, 2014 and a physician written note of "No changes", but the history and physical was over 30 days prior to the procedure.</p> <p>4. The medical record for patient #21, who had a procedure performed on 01/07/15, indicated a photocopy of a physician visit and History and Physical from Nov. 17, 2014 with no update, but the history and physical was over 30 days prior to the procedure.</p> <p>5. The medical record for patient #27, who had a procedure performed on 01/28/15, indicated a photocopy of a physician visit and History and Physical from Jan. 14, 2015, but there was no physician update on the day of surgery.</p> <p>6. At 1:15 PM on 03/25/15, staff member #1, the Director of Nursing, confirmed the medical record findings and indicated the history and physicals were not according to facility policy.</p>			

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S 164  Bldg. 00	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on documentation review and staff interview, the facility failed to ensure preventive maintenance inspections on three blanket warmers and a Lifepak 9P Defibrillator.</p> <p>Findings included:</p> <p>1. Sagamore Surgical Services, Inc Preventive Maintenance policy (last approved 4/15/2013)</p>	S 164	Sagamore Surgical Services has one blanket warmer and two Life Air 1000 patient warming units. The Lifepak 9 defibrillator and all 3 warming units will have preventive maintenance on April 24, 2015. We currently have two bio medical companies reviewing the equipment list to submit a contract for all equipment. The policy has been reviewed and is being acted upon by the Administrator and Director of Nursing.	05/14/2015			

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	<p>indicated the preventive maintenance routine inspections shall be conducted accordingly to the facility's preventive maintenance checklist.</p> <p>2. The Lifepak 9P defibrillator/monitor/pacemaker operating manual recommends preventive maintenance in-depth tests and calibration to be conducted semi-annually by a qualified clinical engineer.</p> <p>3. Review of facility preventive maintenance documents on 3/24/2015, Sagamore Surgical Services, Inc. indicated lack of preventive maintenance on three blanket warmers and the Lifepak 9P Defibrillator.</p> <p>4. At 10:30 AM on 3/24/2015, staff member #1 (Director of Nursing) confirmed the three blanket warmers and the Lifepak 9P Defibrillator were not on the preventive maintenance checklists. The staff member indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001041	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  03/25/2015
NAME OF PROVIDER OR SUPPLIER  SAGAMORE SURGICAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2320 CONCORD ROAD, SUITE B LAFAYETTE, IN 47909		
(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	
	electrical checks are performed annually on all electrical components only. The blanket warmers and the defibrillator never received routine preventive maintenance inspections.				