| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 15C0001060 | A. BUILDING<br>B. WING | 10/04/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EVANSVILLE SURGERY CENTER ASSOCIATES LLC | 520 MARY ST STE 130, EVANSVILLE, IN, 47710 |

| (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 |
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| S0000 | INITIAL COMMENTS<br><br>This visit was for a state licensure survey of an ambulatory surgery center.<br><br>Facility number: 009234<br><br>Dates: 10/3/22 and 10/4/22<br><br>QA: 10/21/2022 | S0000 | | 2022-11-30 |
| S0328 | QUALITY ASSESSMENT AND IMPROVEMENT<br><br>410 IAC 15-2.4-2<br><br>410 IAC 15-2.4-2(b) | S0328 | Plan of Corrections<br><br>Evansville Surgery Center Associations, LLC<br><br>520 Mary St STE 130 Box 2185 | 2022-11-30 |

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| | (b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:<br><br>(1) The action must be documented.<br>(2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.<br><br>Based on document review and interview, the Quality Assessment and Performance Improvement program/committee failed to take and/or document action(s) taken to address opportunities for improvement for 2 (two) issues (pediatric intravenous [IV] catheter placement and laboratory specimen labeling) discovered for 1 (one) facility and failed to document effectiveness and/or continued follow-up. | | Evansville, IN 47710<br><br>Facility number 009234<br><br>Event ID 4F2E8-H1<br><br>CLIA ID # 15C0001060<br><br>Survey date 10/4/22<br><br>S0328-<br><br>3. a. Evansville Surgery Center has reviewed and revisedPolicy and Procedure # 3223 “Care of Specimens”. Education to staff regardingchanges was provided. ESC hascommunicated expectations with Deaconess Hospital lab services to ensure anyspecimens received are correctly labeled. Quality will be measured by review ofincident reporting from ESC staff and Deaconess Lab Services for incorrect ormissing labeling. These policy changes, education and quality monitoringthrough incident report review will help prevent future incidents. Thisinformation will also be reviewed in QAPI meetings with minutes reflectingoutcome.<br><br>The Administrator, Clinical Director, Education Coordinatorand OR charge | |

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| | Findings include:<br>1. Review of the 2022 QAPI Plan, approved 2/16/22, indicated the following:<br>a. The Quality Assessment-Performance Improvement Council provides the driving force for overall facility wide Performance Improvement activities. The functions of the council include: Identifying opportunities for improvement.<br>b. The QAPI Council ranks process improvement priorities and determines monitoring. Developing strategies related to the planning and implementation of continuous performance improvement activities. Determine the education and training needs of the organization related to performance improvement. Evaluate the effectiveness of the Performance Improvement activities.<br>c. The primary focus when designing new processes or improving existing processes is on those processes, which have been identified through measurement and assessment require: Once actions are taken, the effect of the action must be | | nurses will be responsible for these tasks, along with thePerformance Improvement Coordinator reviewing incident reports, acting to resolve issues surrounding incidents, assessing for continued opportunities for improvement and quality monitoring. Monitoring will be ongoing, at least quarterly to assess for trends with increased surveillance and actions if continued or increasing incidents occur. .<br><br>This deficiency will be corrected by November 30, 2022.<br><br>See attached policy revision and meeting minutes cited inthe plan of corrections. Attachmentnames will reflect tag number.<br><br>3.c. Evansville Surgery Center reviewed and revised Policyand Procedure #3104 Nursing Care of Patients Receiving Intravenous Therapy.Staff will be provided education per the Education Coordinator regarding thispolicy, documentation of IV attempts in the OR and the need for incidentreporting on pediatric | |

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| | measured.<br>d. Ongoing measurement to ensure that the newly designed or revised process(es) achieve and maintain stability.<br>2. Review of incidents from 1/1/22 through 8/1/22 indicated the following: On 1/5/22, 2/22/22 and 8/16/22 laboratory specimens were improperly labeled. On 3/21/22, 5/2/22, and 8/30/22 the center recorded events related to excessive number of IV placement attempts on pediatric patients for non-emergent procedures.<br>3. Review of 4 quarters of QAPI Council meeting minutes dated 11/30/21-12/30/21, 1/22 (date not viewable), 5/10/22, and 9/13/22, and Quality Reports indicated the following:<br>a. January meeting minutes lacked evidence of QAPI review of the labeling incidents 1/5/22.<br>b. Meeting minutes dated 5/10/22 indicated the Council discussed ways to reduce number of IV sticks in peds (pediatric) patients. Resolution indicated the ped IV topic was discussed and parameters/guidelines "in place" to reduce number. The minutes lacked evidence/documentation of | | 4 IV insertion attempts. ESC will form a subcommittee to reviewoptions for alternate angiocaths for ease of use. These policy changes,education and quality monitoring through incident report review will helpprevent future incidents. This information will also be reviewed in QAPImeetings with minutes reflecting outcome.<br><br>The Administrator, Clinical Director, Education Coordinatorand OR charge nurses will be responsible for these tasks, along with the PerformanceImprovement Coordinator reviewing incident reports, acting to resolve issues surrounding incidents, assessing for continued opportunities for improvement and quality monitoring. Monitoring will be ongoing, at least quarterly to assess for trending with increased surveillance and actions if continued or increasing incidents occur.<br><br>This deficiency will be corrected by November 30, 2022.<br><br>See attached policy revision, meeting with Lab supervisorssummary, email correspondence, and meeting | |

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| | what the parameters/guidelines were. The Quality Report for Laboratory Services indicated the Center had 2 laboratory (lab) incidents during the 1st quarter 2022. Comments indicated specimen without label taken by hospital/lab. The minutes lacked evidence of the Council's review/evaluation of labeling issues to date.<br>c. Meeting minutes dated 9/13/22 indicated Lab (Contracted services) was reviewed. The minutes lacked evidence of QAPI Council evaluation lab/labeling issues and/or strategies to improve performance. The minutes also lacked evidence of follow-up for actions taken to improve performance of pediatric IV placement with evaluation of effectiveness.<br>4. On 10/4/22, beginning at approximately 2:15 PM, A2, Performance Improvement/Infection Prevention, verified the center did not have evidence of QAPI ongoing measurement/evaluation of effectiveness of changes implemented for pediatric IV placements, nor did they have documentation of performance improvement evaluation of, or | | minutes cited in the plan ofcorrections. Attachment names willreflect tag number. | |

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| | actions taken for the identified issue with lab labeling. | | | |

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 reverse for further 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Suzanne Glover | Performance Improvement Coordinator/Infection Preventionist | 11/9/2022 5:21:38 PM |