STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 230110941	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWEST SPECIALTY SURGICAL CENTER LLC	315 W 89TH AVE , MERRILLVILLE, Indiana, 46410

(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
S0000	INITIAL COMMENTS This visit was for a State licensure survey of an Ambulatory Surgery Center. Facility Number: 011094 Dates of Survey: 7-5-2023 to 7-6-2023 QA: 7/19/2023	S0000		
S0400	INFECTION CONTROL PROGRAM CFR(s): 410 IAC 15-2.5-1 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview, the facility failed to ensure a sanitary environment in three (3) areas. (Pre/Post Operative Area and Operative Area). Findings include: 1. The policy titled, Surgical and Related Services, policy number QMI#157, indicated surgical procedures would be performed in a functional and sanitary environment. This policy was last revised on 07/01/2016. 2. During tour on 07/05/2023 at approximately 1:30 pm with administrative staff member A # 2 (Registered	S0400		

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

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S0400	Continued from page 1 Nurse-RN/Operating Room Manager), the following was observed: a. Tape on the walls in Operating Room (OR) number two (2) and number three (3). b. Rust on the bottom of the Bovie Cart in OR number two (2). c. Torn seat cushion (Podiatry Stool) in OR number four (4). d. Visible/wipeable dust on three (3) of five (5) patient transport carts (base) in the pre-operative area. e. Visible/wipeable dust on top of eighteen (18) lockers in the female locker room. f. Visible/wipeable dust on the Respiratory Cart and three (3) other supply carts in the pre/post operative storage room. g. Visible/wipeable dust on the floor in the pre/post operative storage room. h. Visible/wipeable dust on the top of the patient lockers in the pre/post operative area. 3. In interview on 07/06/2023 at approximately 4:20 pm with administrative staff member A # 1 (Registered Nurse-RN/Chief Operating Officer), confirmed there should not be tape in the operating rooms, there should not be rust on any equipment, and there should not be visible/wipeable dust anywherey.	S0400		
S0444	INFECTION CONTROL PROGRAM CFR(s): 410 IAC 15-2.5-1 410 IAC 15-2.5-1(f)(2)(E)(ix) The infection control committee responsibilities must include, but are not limited to: (E) Reviewing and recommending changes in procedures, policies, and	S0444		

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S0444	Continued from page 2 programs which are pertinent to infection control. These include, but are not limited to, the following: (ix) Requirements for personal hygiene and attire that meet acceptable standards of practice. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview, the facility failed to ensure personnel who entered the semi-restricted and restricted areas of the surgical suite were in operating room attire in two (2) instances. (S # 2 and & S # 3). Findings include: 1. Review of the facility policy titled, Attire in the Operating Room, policy number SURG#384, indicated all personnel entering the semi-restricted and restricted areas of the surgical suite shall be in operting room attire. Personal jewelry worn in the surgical suites can only be worn if it is able to be contained or confined with the scrub attire. This policy was last revised on 09/01/2015. 2. During tour on 07/06/2023 at approximately 10:30 am the following was observed: a. S # 2 (Operating Room Registered Nurse/OR RN) - dangling bracelet on wirst/large necklace around neck/ring on finger (not a wedding ring) - not confined within scrub attire. b. S # 3 (OR RN) - 2 rings on fingers (not a wedding ring)/watch on wrist/dangling earrings in ears - not confined within scrub attire. 3. In interview on 07/06/2023 at approximately 10:45 am with administrative staff member A # 1 (RN/Chief Operating Officer), confirmed the operating room personnel should not be wearing all that jewelry. When he/she observed them in the OR the jewelry was not confined.	S0444		
S0472	INFECTION CONTROL PROGRAM CFR(s): 410 IAC 15-2.5-1	S0472		

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S0472	Continued from page 3 410 IAC 15-2.4-1(2)(h) (h) Environmental surfaces and equipment not requiring sterilization which have been contaminated by blood or other potentially infectious materials shall be cleaned then decontaminated in accordance with acceptable standards of practice and applicable state laws and rules, 410 IAC 1-4. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview, the facility failed to ensure the glucometer was cleaned/disinfected according to the manufacturer's recommendations in one (1) instance. (One-Touch Blood Glucose Meter). Findings include: 1. The policy titled, Glucometer Use, policy number InfPrev&Safety#206A, indicated meter care - clean the device thoroughly after each use and disinfect the meter according to the manufacturers recommendations with an EPA (Environmental Protection Agency) approved disinfectant. This policy was last revised - no date. 2. Review of the User Guide - Cleaning your meter - clean your meter, wipe the outside with a soft cloth dampened with water and mild detergent. Do not use alcohol or another solvent to clean your meter. 3. During tour on 07/05/2023 at approximately 1:48 pm with administrative staff member A # 1 (Registered Nurse-RN/Chief Operating Officer), indicated that he/she would use the water and hand soap at the sink to clean the glucometer. The hand soap (Gold & Klean Antimicrobial Lotion Soap) - active ingredient - Cholorxylenol (Antimicrobial). 4. In interview on 07/06/2023 at approximately 3:45 pm with administrative staff member A # 1, confirmed that	S0472		

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S0472	Continued from page 4 the hand soap was probably not a mild detergent.	S0472		
S0488	INFECTION CONTROL PROGRAM CFR(s): 410 IAC 15-2.5-1 410 IAC 15-2.5-1(2)(i)(2) (2) Central clean linen storage space must be provided as follows: This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview, the facility failed to ensure the linen cart was clean in one (1) instance. (Pre/Post Operative Area). Findings include: 1. The facility policy titled, Laundry Handling and Transport, policy number InfPrev&Safety#233, indicated clean linen would be transported in carts which were kept clean and well maintained. This policy was last revised 08/01/2018. 2. Review of the Monthly Cleaning Log, dated 2023, indicated the Linen Cart had been cleaned every month (January - July). 3. During tour of the facility on 07/05/2023 at approximately 1:30 pm with administrative staff member A # 2 (Registered Nurse-RN/Operating Room Manager), observed the linen cart to have dust/hair on the rolling wheels and visible/wipeable dust on the back of three (3) shelves. 4. In interview on 07/05/2023 at approximately 1:30 pm with administrative staff member A # 2, confirmed the linen cart should not have dust/hair on the wheels and/or dust on the shelves.	S0488		
S0850	MEDICAL STAFF; ANESTHESIA AND SURGICAL CFR(s): 410 IAC 15-2.5-4 410 IAC 15-2.5-4 (d) (d) Surgical services must be organized according to scope of the	S0850		

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S0850	Continued from page 5 services offered, to meet the needs of the patient, in accordance with acceptable standards of practice and safety. Requirements for surgical services include: This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview, the facility failed to ensure sterilized materials were stored in a dust free environment in two (2) rooms. (Sterile Core Room & Sterile Storage Room). Findings include: 1. The facility policy titled, Event Related Shelf Life Sterile Storage, policy number InfPrev&Safety#213, indicated all items should be stored in an environment free of contamination. Outpatient Surgery staff are responsible for checking integrity of packaging and storage methodology on a monthly basis. This policy was last revised on 04/01/2011. 2. Review of the Monthly Cleaning and Outdate Assignments Log, dated 04/2023, 05/2023 & 06/2023, indicated the Sterile Core and Sterile Storage rooms had been cleaned. 3. During tour on 07/05/2023 at approximately 2:15 pm with administrative staff member A # 2 (Registered Nurse-RN/Operating Room Manager), the following was observed: a. Sterile Storage Room - Floor under Sterile Supply Cart with sterile storage packages had no wheels and no bottom shelf splash guard, with visible/wipeable dust and package integrity compromised. Cart shelves X's (times) four (4) had visible/wipeable dust. Sterile Peel Pack Cart shelves/bins X's four (4) had visible/wipeable dust. b. Sterile Core Room - Eight (8) carts X's thirty-two (32) shelves/bins had visible/wipeable dust. Sterile instrument cart X's two (2) with five (5) shelves/bins on each one had visible/wipeable dust. 4. In interview on 07/05/2023 at approximately 2:15 pm with administrative staff member A # 2 (Registered Nurse-RN/Operating Room Manager), confirmed both rooms needed to be cleaned and the sterile packages had been	S0850		

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S0850	Continued from page 6 compromised.	S0850		
S1010	PHARMACEUTICAL SERVICES CFR(s): 410 IAC 15-2.5-6 410 IAC 15-2.5-6(3)(A) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (A) Drug handling, storing, labeling, and dispensing. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview, the registered nurse failed to ensure a multi-dose medication vial was dated when opened in two (2) instances. (S # 1 Registered Nurse-RN), Findings include: 1. The facility policy titled, Safe Use of Injectables and single use syringes, policy number InfPrev&Safety#202, indicated multi-use vials are dated when opened. This policy was last revised on 05/01/2021. 2. During observation of the pre-operative assessment on 07/06/2023, two (2) vials of Lidocaine were dated with an expiration date. The vials were in a caddy on the nurses station counter. 3. In interview on 07/06/2023 at approximately 1:00 pm with administrative staff member A # 1 (RN/Chief Operating Officer), confimed the staff always put the expiration date on the multi-dose vials, not the open date.	S1010		

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S1010 S1024	PHARMACEUTICAL SERVICES CFR(s): 410 IAC 15-2.5-6 410 IAC 15-2.5-6(3)(E) Pharmaceutical service must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following: This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview, the registered nurse failed to ensure pre-drawn medication syringes were accurately labeled and stored appropriately in three (3) instances. (S # 1 Registerd Nurse-RN). Findings include: 1. The facility policy titled, Labeling Medications, policy number PHARM#472, indicated all medications must be labeled with the drug name, strength, amount, expiration date (when not used within 24 hours), expiration time, date prepared, and name or initials of the person transferring the drug. This policy was last revised on 04/17/2019. 2. Review of S # 1's Education Registered Nurse, date completed 01/26/2023 - Medication Management - Test - Information needed on syringe labels (drug name, drug	S1010 S1024		

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S1024	Continued from page 8 strength, date, time, and initials) - Medication should be stored according to requirements set by the FDA (Food & Drug Administration). 3. During observation of the pre-operative assessment on 07/06/2023 at approximately 10:00 am the following was observed: a. Three (3) syringes dated 07/05/2023 of Robinul 0.2 mg/ml (milligrams/milliliter) - no further information was on the syringe. b. The three (3) syringes were on the nursing station counter in a clear plastic cup. 4. In interview on 07/06/2023 at approximately 10:10 am with S # 1 (Registered Nurse-RN), confirmed he/she had drawn the medication the day before and it was good for 24 hours. He/she was not sure what time the medication had been transferred to the syringe because the syringe lacked the time. The syringe should be dated, timed with initials. 5. In interview on 07/06/2023 at approximately 10:45 am with administrative staff member A # 1 (RN/Chief Operating Officer), confirmed the syringes should have been labeled accurately and stored appropriately.	S1024		
S1172	PHYSICAL PLANT, EQUIPMENT MAINTENANCE, CFR(s): 410 IAC 15-2.5-7 410 IAC 15-2.5-7(b)(5) (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: (5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept	S1172		

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S1172	Continued from page 9 clean and orderly in accordance with current standards of practice, including the following: This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview the facility failed to ensure a scrub sink was in good working order in two (2) instances, failed to ensure baseboard was replaced in one (1) instance, and failed to ensure the wall was free of holes in one (1) instance. (Pre-Operative Area, Operating Room # 2, Clean Processing Room). Findings include: 1. The facility policy titled, Surgical Hand Scrub, policy number InfPrev&Safety#200, indicated all members of the sterile surgical team must properly complete the surgical hand scrub. Wet hands and forearms, scrub hands and forearms, and rinse thoroughly. Then repeat the procedure. This policy was last revised in 10/01/2015. 2. The facility policy titled, Physical Environment, policy number FAC&ENV#322, indicated to provide a functionally safe and sanitary environment, properly constructed, equipped and maintained to protect the health and safety of the patients, personnel, and visitors for the provision of surgical services. This policy was last revised in 12/01/2016. 3. The facility policy titled, Safe Environment for Patients, Personnel and Visitors, policy number FAC&ENV#301, indicated facilities should be clean and properly maintained. This policy was last revised in 04/01/2011. 4. Review of the Infection Control Committee meeting minutes dated 6/5/23, 3/6/23, 12/5/22 and 9/12/22, indicated two (2) operating room sinks were not working and maintenance had been notified. The corner baseboard in Operating Room (OR) two (2) needed to be replaced in meeting minutes dated 6/5/23 and 3/6/23. 5. During tour on 07/05/2023 at approximately 1:30 pm with administrative staff member A # 2 (Registered Nurse-RN/Operating Room Manager), two (2) scrub sinks (outside OR 3 & OR 4) were observed to have basins inside them. Operating Room two (2) had missing baseboard on the lower left entry wall. The clean processing room wall left of the Steris had a hole in the bottom wall base.	S1172		

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S1172	Continued from page 10 6. In interview on 07/05/2023 at approximately 1:30 pm with administrative staff member A # 2, confirmed the two (2) of the five (5) scrub sinks have been out of order for almost one (1) year. OR number two (2) could not be properly terminally cleaned with the missing baseboard and the clean processing room wall could not be properly cleaned with the hole in the wall base. 7. In interview on 07/06/2023 at approximately 3:15 pm with administrative staff member A # 1 (RN/Chief Operating Officer), confirmed the four (4) Operating Rooms were active and usually staff four (4) personnel per case. The month of August the facility performed 150 to 200 surgical cases. Maintenance should have replaced/repaired the above.	S1172		