

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/05/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15C0001047</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/06/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHITEWATER SURGERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1900 CHESTER BLVD RICHMOND, IN 47374</b>	
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Q 000	INITIAL COMMENTS  This visit was for a recertification survey of an Ambulatory Surgery Center and Focused Infection Control survey.  Facility Number: 001222  Survey Date: 1/4-6/2021 and 1/25/2021	Q 000		
Q 083	QA: 1/11/21 and 2/1/21 PERFORMANCE IMPROVEMENT PROJECTS CFR(s): 416.43(d)  (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.  (2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results  This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to conduct and document a quality performance improvement project in 2020.  Findings include:  1. Review of facility quality documentation included a quality performance improvement project in 2020 that was only partially completed by staff.	Q 083		2/11/21

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

TITLE

(X6) DATE

03/04/2021

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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Q 083	Continued From page 1 2. In interview on 1-6-2021 at 1245 hours, employee #N1, Clinical Director, confirmed that the facility did not complete the COVID based quality performance improvement project in 2020. No other documentation was provided prior to exit.	Q 083			
Q 100	ENVIRONMENT CFR(s): 416.44  The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.  This CONDITION is not met as evidenced by: Based on record review, observation, and interview; the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier (see tag K372), and failed to ensure 4 of 4 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the past 4 quarters (see tag K712).  The cumulative effect of these systemic problems resulted in the facility's inability to ensure it had implemented a systemic plan of correction to prevent recurrence, therefore failing to ensure the provision of quality health care in a safe environment.	Q 100			
Q 104	SAFETY FROM FIRE CFR(s): 416.44(b)(1)-(3)  (b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must	Q 104			

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Q 104	<p>Continued From page 2</p> <p>meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served, and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).</p> <p>(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.</p> <p>(3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.</p> <p>This STANDARD is not met as evidenced by:</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 21.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations on 01/25/21 between 1:17 p.m. to 1:50 p.m. with the Clinical Director (CD) and Maintenance Supervisor, the following areas in the smoke barrier wall had unsealed penetrations above the drop ceiling.</p>	Q 104			

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Q 104	<p>Continued From page 3</p> <p>a. East smokewall had a metal conduit penetrating the smokewall into which two low voltage wires entered and the opening of the conduit was not sealed.</p> <p>b. South smokewall above fire door has a black cable with a 1/2 inch opening around cable and also a metal conduit penetrated the smokewall and had a 1/2 inch opening around it and both were not sealed.</p> <p>c. Small waiting room north smokewall had an outlet size hole and a double outlet hole in the drywall and a fist size hole with 3 low voltage wires penetrating the smokewall and were not sealed.</p> <p>Based on interview at the time of observations, the Maintenance Supervisor confirmed each penetration mentioned in a through c. This was discussed with the CD during the exit conference.</p> <p>2. Based on record review and interview, the facility failed to ensure 4 of 4 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the past 4 quarters. This deficient practice affects all patients in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review on 01/25/21 at 12:03 p.m. with the Clinical Director (CD), the fire drills performed between the hours of 6:00 a.m. and 9:00 p.m. for the past twelve months lacked verification of the transmission of the signal to the monitoring company. Based on interview at the time of record review, the CD stated the fire drill reports lacked verification of signal transmission to the monitoring company. This was discussed</p>	Q 104			

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Q 104	Continued From page 4 with the CD during the exit conference.	Q 104			
Q 181	<p><b>ADMINISTRATION OF DRUGS</b> CFR(s): 416.48(a)</p> <p>Drugs must be prepared and administered according to established policies and acceptable standards of practice.</p> <p>This STANDARD is not met as evidenced by: Based on document review and observation, Anesthesia failed to follow accepted standards of practice while accessing a multi-dose vial for medication administration and Nursing failed to reconcile the narcotic count.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of policy titled: Multiple-Dose Vials, indicated that "...multi-dose Vial Access Spike (clave) will be swabbed with 70% alcohol and allowed to air dry for 3 seconds before attaching sterile syringe each time medication is drawn from the vial".</li> <li>Tour of sub-sterile room between OR1 and OR2 on 01/06/21 with N1 (Clinical Manager) at 3:03 pm, this surveyor observed Anesthesia open a multi-dose vial and draw without wiping top of vial with 70% alcohol.</li> <li>Review of policy titled: Controlled Substances indicated that the administering licensed individual's signature will be documented on the Narcotic Control Sheet (NCS); at the beginning and end of each day of operation, a physical</li> </ol>	Q 181		2/12/21	

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Q 181	Continued From page 5 count shall be made of all controlled substances on the Perpetual Inventory Sheet (PIS).  4. Review of NCS dated 01/05/21 indicated that 43.5 (milligrams/micrograms not noted) given in OR2 and 40 given in OR1 for a total of 83.5 given; the PIS indicated that 31 2milligram/2milliliter vials and 2.8 1milligram/1milliliter of Versed were used for a total of 64.8 milligrams removed - unable to reconcile.  5. Interview with N1 on 01/06/21 at 12:10 pm confirmed unable to reconcile the NCS and PIS dated 01/05/21.	Q 181			
Q 242	INFECTION CONTROL PROGRAM CFR(s): 416.51(b)  The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.  This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to provide a COVID-19 screening process, per CDC (Centers for Disease Control) for personnel working in the facility.  Findings Include:  1. Review of the Infection Control Plan and policy titled: Screening of Employees and Medical Staff	Q 242		2/12/21	

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Q 242	Continued From page 6 indicated following recommendations of the CDC for screening of employees.  2. The CDC (Centers for Disease Control) indicated in a memo dated 12/14/20, to "Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19".  3. Review of process/form (Employee COVID-19 Questionnaire) for Employees to complete on a daily basis has not been used.  4. Interview with N3 (Infection Control Nurse) on 01/06/21 at 10:40 am confirmed lack of completion of Employee COVID-19 Questionnaire for symptoms.	Q 242			
Q 243	<b>INFECTION CONTROL PROGRAM - DIRECTION</b> CFR(s): 416.51(b)(1)  The program is - Under the direction of a designated and qualified professional who has training in infection control.  This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that the Infection Control Nurse had adequate education to lead an Infection Control Program (N3).  Findings Include:  1. Review of Infection Control Nurse's (N3) education file indicated last education 08/08/19 and 03/07/19; both were articles that were read.	Q 243		3/1/21	

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Q 243	Continued From page 7  2. Interview on 01/04/21 at 1:45 pm with N3 (Infection Control Nurse) confirms lack of education since 08/08/19.	Q 243		