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	15C0001158	A. BUILDING 00 B. WING	02/10/2021

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TERRE HAUTE SURGICAL CENTER LLC	227 MCCALLISTER DR TERRE HAUTE, IN 47802

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Q 0000 Bldg. 00	This visit was for a federal recertification survey and a focused infection control survey of an ambulatory surgery center. Facility number: 005650 Dates: 2/8-10/21 and 2/15/21 Facility was found in compliance with the CMS Focused Infection Control Survey for Acute & Continuing Care. QA: 2/12/21 and 2/22/21	Q 0000		
Q 0084 Bldg. 00	416.43(e) GOVERNING BODY RESPONSIBILITIES The governing body must ensure that the QAPI program- (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. Based on document review and interview, the governing body (GB) failed to ensure that the Quality Assurance Performance Improvement (QAPI) program specified data collection methods, frequency and details for performance	O 0084	Tag#Q084 The quarterly quality standards and monitors will be updated to further define the following services: Lab, Medical Records,	03/08/2021

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

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	measures of care and services for 4 services/functions (laboratory, medical records, pharmacy and transcription) in 1 facility. Findings include: 1. Review of documents titled "QA Plan", approved 1/16/20, lacked documentation of specified data collection methods, frequency and details for performance measures for monitoring laboratory, medical records, pharmacy and transcription services or functions. 2. Review of QAPI meeting minutes dated 5/5/20, 8/5/20, 10/6/20 and 2/2/21 lacked documentation of specified data collection methods, frequency and details for performance measures for evaluation of laboratory, medical records, pharmacy and transcription services/functions monitors. 3. On 2/10/21, between approximately 1:00 PM and 2:00 PM, A1, Clinical Director, verified the QA Plan did not provide for specific of data collection methods and that no methods with frequency and detail had been established for monitoring of laboratory, medical records, pharmacy and transcription.		Pharmacy, and Transcription. Lab criteria will be updated to state "the pathology reports will be returned within 7 business days". Medical Records criteria will be updated to state " The contracted Medical Records Consultant will review 30 medical records on a quarterly basis. A quarterly summary of results will also be provided." Pharmacy criteria will be updated to state "The contracted pharmacy consultant will review 10 patient charts for controlled medication documentation on a monthly basis." Transcription criteria will be updated to state "Post operative dictated reports will be received within 48 hours." This new criteria will begin March 8, 2021. The Clinical Director will be responsible for monitoring this criteria. This will be reported at quarterly quality meetings, which then flow up to MAC and Governing Board.	
Q 0100 Bldg. 00	416.44 ENVIRONMENT The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. Based on observation and interview, the facility failed to ensure 1 of 1 Janitors closet located in the PACU unit was protected in accordance with 21.3.2.1. LSC 21.3.2.1 requires doors to hazardous	O 0100	Tag#Q100 The Janitor's closet- automatic door closer was installed on March 2, 2021. The administrator secured an outside vendor to	03/12/2021

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	areas shall be self-closing (see tag K321) and failed to ensure that a complete automatic sprinkler system or documentation of fire-retardant material was provided for 1 of 1 canvas canopies (see tag K351). 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.		complete the installation. The Canvas canopy- The canopy will be removed from the building by March 12, 2021. The old covering will be removed and the frame re-covered with flame retardant material. The re-installation of the new canopy system will be installed when ready. I am told from the Landlord's contracted awning company that may be as late as May 1, 2021 depending on special order fabric availability. The Administrator will be responsible to ensure the work is completed. A copy of flame retardant material will be kept on file in the facility's safety binder. Actions taken as a result of the survey will be reported to the MAC and Governing Board at their next scheduled meetings.	
Q 0104 Bldg. 00	416.44(b)(1)-(3) SAFETY FROM FIRE (b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must 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). (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			

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	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. (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. Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system or documentation of fire-retardant material was provided for 1 of 1 canvas canopies. NFPA 13-2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible or limited combustible, or fire retardant. Textiles such as canvas used as an awning shall meet NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect at least 30 residents evacuating through main entrance. Findings include: Based on observations made during a tour of the facility on 02/15/21 at 11:56 a.m., there was a canvas canopy at the south end of the building that was not sprinkled and attached to the building. This canopy was approximately 50 feet in length and extended approximately 48 inches from the building to cover the existing sidewalk area. Based on record review with the Materials	Q 0104	Tag#Q104 The Canvas canopy- The canopy will be removed from the building by March 12, 2021. The old covering will be removed and the frame re-covered with flame retardant material. The re-installation of the new canopy system will be installed when ready. I am told from the Landlord's contracted awning company that may be as late as May 1, 2021 depending on special order fabric availability. The Administrator will be responsible to ensure the work is completed. A copy of flame retardant material will be kept on file in the facility's safety binder. Actions taken as a result of the survey will be reported to the MAC and Governing Board at their next scheduled meetings.	03/12/2021

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	Manager on 02/15/21 between 9:20 a.m. and 12:20 p.m., no documentation could be provided to show the canvas was inherently flame retardant. Based on interview at the time of records review the Materials Manager acknowledged there was no sprinkler coverage for the canopy and confirmed there was no documentation to show the canvas canopy was inherently fire retardant. During the exit conference with the building Administrator and the Materials Manager on 02/15/21 at 1:10 p.m., no additional information or evidence could be provided contrary to this deficient finding.			
Q 0107 Bldg. 00	416.44(b)(6) DOORS TO HAZARDOUS AREAS (6) Beginning July 5, 2017, an ASC must be in compliance with Chapter 21.3.2.1, Doors to hazardous areas. Based on observation and interview, the facility failed to ensure 1 of 1 Janitors closet located in the PACU unit was protected in accordance with 21.3.2.1. LSC 21.3.2.1 requires doors to hazardous areas shall be self-closing. This deficient practice could affect staff only. Findings include: Based on observation with the building Administrator and the Materials Manager on 02/15/21 at 12:35 p.m. there were approximately 80 rolls of toilet paper, 15 stacks of paper towels, and 10 mop heads on shelving within the Janitors closet located within the PACU unit. The door to this Janitors closet did not contain a self-closing device and was considered a hazardous area due to the number of combustible items stored within. Based on interview at the time of observation, the building Administrator, and the Materials	O 0107	Tag#Q107 The Janitor's closet- automatic door closer was installed on March 2, 2021. The administrator secured an outside vendor to complete the installation. Report of actions taken to be provided to MAC/GB at their next scheduled meetings.	03/02/2021

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	Manager both agreed that the room was a hazardous area due to the number of combustible items stored inside. The Materials Manager then stated that he would add a self-closing device to the door as soon as he could. During the exit conference with the building Administrator and the Materials Manager on 02/15/21 at 1:10 p.m., no additional information or evidence could be provided contrary to this deficient finding.			
Q 0241 Bldg. 00	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 document review and observation, the center failed to provide a functional and sanitary environment for the provision of surgical services by failing to ensure one (1) Certified Registered Nurse Anesthetist (CRNA), AH 9, adhered to acceptable standards of practice for medication administration via connector hubs/ports for intravenous (IV) medication administration in one (1) facility. Findings include: 1. Review of policy 2.2.35 titled Medication Administration, last approved 1/16/20, indicated that all IV ports shall be wiped with an alcohol wipe prior to accessing. 2. On 2/9/21 during observation of surgery for patient PA, beginning at approximately 8:15 AM, AH 9 was observed to have administered IV medication via connector hub(s) 4 different times without cleansing/swabbing the injection ports with alcohol prior to accessing.	O 0241	Tag#Q241 An in-service for staff, including CRNA, will be performed to include review of policy 2.2.35, titled Medication Administration, and infection control injection practices. In-service will be held March 4, 2021. Infection Control Nurse will present the in-service and beginning March 8, 2021, will monitor 10 instances of IV medication administration practices monthly for a period of 3 months to ensure compliance. This will be reported at the following quarterly quality meeting, which then reports up to the MAC and Governing Board.	03/04/2021

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S 0000 Bldg. 00	This visit was for a state licensure survey of an ambulatory surgery center. Facility number: 005650 Dates: 2/8/21 to 2/10/21 QA: 2/12/21	S 0000		
S 0400 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 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. Based on document review and observation, the center failed to provide a functional and sanitary environment for the provision of surgical services by failing to ensure one (1) Certified Registered Nurse Anesthetist (CRNA), AH 9, adhered to acceptable standards of practice for medication administration via connector hubs/ports for intravenous (IV) medication administration in one (1) facility. Findings include: 1. Review of policy 2.2.35 titled Medication Administration, last approved 1/16/20, indicated that all IV ports shall be wiped with an alcohol wipe prior to accessing.	S 0400	Tag#S400 An in-service for staff, including CRNA, will be performed to include review of policy 2.2.35, titled Medication Administration, and infection control injection practices. In-service will be held March 4, 2021. Infection Control Nurse will present the in-service and beginning March 8, 2021, will monitor 10 instances of IV medication administration practices monthly for a period of 3 months to ensure compliance. Report of actions taken to be provided to MAC/GB at their next scheduled meetings.	03/04/2021

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	2. On 2/9/21 during observation of surgery for patient PA, beginning at approximately 8:15 AM, AH 9 was observed to have administered IV medication via connector hub(s) 4 different times without cleansing/swabbing the injection ports with alcohol prior to accessing.			
S 0668 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(11) All patient records must document and contain, at a minimum, the following: (11) Condition on discharge, disposition of the patient, and time of dismissal. Based on document review and interview, the center failed to ensure that 6 of 30 patient's (#3, #11, #12, #13, #14, and #26) records contained documentation of condition on discharge. Findings include: 1. Review of medical records (MRs) lacked documentation of the patient condition on discharge for patients #3, #11, #12, #13, #14, and #26. 2. On 2/8/21 beginning at approximately 2:15 PM, A1, Clinical Director, verified that the MRs of patient #3 lacked documentation of condition on discharge. On 2/9/21 beginning at approximately 3:00 PM, A1 verified that the MRs of patients #11, #12, #13, and #14 lacked documentation of condition on discharge. On 2/10/21 beginning at approximately 10:45 AM, A1 verified that the MR of patient #26 lacked documentation of condition	S 0668	Tag#S668 All physicians will be educated that their post operative notations shall include documentation of the patient's condition on discharge. This will be communicated to all credentialed physicians by March 5, 2021. The administrator will be responsible to perform this education. Further, the documentation will be monitored by the medical record consultant per the next 4 quarters' reviews. This will begin on the next scheduled review on April 6, 2021. The administrator will be responsible to ensure this is completed in the records review. Report of actions taken to be provided to MAC/GB at their next scheduled meetings.	03/05/2021

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	on discharge.			
S 0670 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAc 15-2.5-3(f)(12) All patient records must document and contain, at a minimum, the following: (12) Final progress note, including instructions to the patient and family, with dismissal diagnosis. Based on document review and interview, the center failed to ensure that discharge instructions were provided to patients and/or escorts for 2 of 30 patients (#1 and #10) of 1 facility. Findings include: 1. Review of policy 2.2.133 titled Discharge Criteria, revised on 6/9/20, indicated that patients and/or escorts were to receive written discharge instructions. 2. Review of the medical records (MRs) for patients #1 and #10 lacked documentation of the patient and/or escort having received written discharge instructions. 3. On 2/8/21 beginning at approximately 2:15 PM, A1, Clinical Director, verified that the MRs of patients #1 and #10 lacked documentation the patients and/or escorts having received discharged instructions.	S 0670	Tag#S670 Written discharge instructions will be given to all patients post-operatively and copies maintained in the patient record. Education of preop/pacu RNs regarding the need for and documentation of discharge instructions and a copy for the patient record will be performed on March 4, 2021. The Clinical Director will be responsible for performing this education. Further, this will be monitored for compliance by the quarterly medical record audits, beginning at the next quarterly visit on April 6, 2021. The Administrator will ensure this is completed in the records review. Report of actions taken to be provided to MAC/GB at their next scheduled meetings.	03/04/2021
S 1152	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT			

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Bldg. 00	MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(B) (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: (3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plan and equipment by qualified personnel as follows: (B) All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule. Based on document review and interview, the center failed to ensure 1 piece of multi-functional mechanical equipment, the heating/ventilation/air conditioning system (HVAC), was maintained in accordance with the documented maintenance schedule for 1 facility over the past 4 quarters. Findings include: 1. Review of policy # 3.8.2 titled Utilities and Equipment - Scheduled maintenance and Inspections, last reviewed/approved 1/16/20, indicated the following: In order to maintain proper operation and efficiency of systems and mechanical devices, it is necessary that a system of maintenance be	S 1152	Tag#S1152 The final filters on the HVAC system were installed on February 24, 2021. The administrator secured contracted HVAC company to complete the installation. The Safety officer will put a reminder on their outlook calendar for annual HVAC external filter change annually to ensure this does not recur. Report of actions taken to be provided to MAC/GB at their next scheduled meetings.	02/24/2021

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	established. To accomplish this, routine inspection schedules have been established. These inspections will be conducted accurately and in a timely fashion in order to ensure the protection and comfort of patients, staff, and visitors. 2. Review of the document titled "Planned Maintenance Inspection List" (provided by A3, Materials Manager, as the scheduled maintenance of the HVAC system) indicated that "Final Filters" of the system were to be replaced annually. Review of 4 quarters of documents titled "Planned Maintenance Inspection List" and other maintenance documents lacked evidence of annual "Final Filters" replacement within the past 4 quarters. 3. On 2/10/21, beginning at approximately 9:15 AM, A3, Materials Manager, confirmed that the Center did not have documentation of the "Final Filters" of the HVAC system having been replaced within the past 4 quarters.			
S 1164 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i) (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: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must			

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	be in good working order and regularly serviced and maintained as follows: (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. Based on document review and interview, the Center failed to ensure patient care equipment was on a documented maintenance schedule for 12 of 12 pieces of equipment [anesthesia machine, electrocardiogram (EKG), defibrillator, electrocautery device, overhead operating room (OR) lights, patient stretcher, radiology equipment, sterilizer, suction, surgical table(s), wheelchair(s), arthroscopy pump] and failed to ensure preventive maintenance (PM) was completed in accordance with the manufacturer's recommended frequency and standards for 4 of the 12 pieces of equipment (anesthesia machine, EKG, patient stretcher and arthroscopy pump). Findings include: 1. Review of policy # 3.8.2 titled Utilities and Equipment - Scheduled maintenance and Inspections, last reviewed/approved 1/16/20, indicated the following: The Nurse Manager/Administrator or their designee will be responsible for ensuring scheduled maintenance and inspections are completed. Review of policy #2.2.209 titled Anesthesia Equipment - Cleaning and Checks, last approved 1/16/20, indicated manuracturer's recommendations shall be followed regarding anesthesia machine checks. Anesthesia providers shall be the personnel to perform these checks.	S 1164	Tag#S1164 A documented schedule will be maintained to ensure that all patient care equipment is in good working order and regularly serviced and maintained per the manufacturer's recommended schedule. For each item, the schedule will include details of the equipment, maintenance intervals, last maintenance dates and results. This schedule will be in place on March 3, 2021. The Administrator and Safety Officer together will be responsible to ensure this schedule is being followed. Further, specific logs will be created and/or updated for documentation purposes of adherence to manufacturer's maintenance recommendations for the following pieces of equipment: anesthesia machines, EKG, patient stretchers, and arthroscopy pumps. These logs will be in place and completed beginning March 8, 2021. The Administrator is responsible to oversee these logs are created and/or updated. Report of actions	03/08/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	2. Review of facility documents lacked evidence of a documented maintenance schedule that was of the recommended frequency in accordance with manufacturer's recommended maintenance schedule for 12 pieces of patient care equipment [anesthesia machine, electrocardiogram (EKG), defibrillator, electrocautery device, overhead operating room (OR) lights, patient stretcher, radiology equipment, sterilizer, suction, surgical table(s), wheelchair(s), arthroscopy pump]. 3. Review of individual manufacturer maintenance recommendations indicated the following (not all inclusive): A. Anesthesia machine: Daily: Perform 21% O2 calibration. Check the condenser reservoir. Drain if needed. Weekly: Zero the flow sensors. Monthly: Perform 100% O2 calibration. Lubricate all tee handle threads... B. EKG: Perform a visual inspection of all equipment and peripheral devices daily. *Check the case and display screen... *Regularly inspect all plugs, cords, cables and connectors... *Verify that all cords and connectors are securely seated. *Inspect keys and controls for proper operation. C. Patient stretcher: We recommend that you perform PM and testing...semi-annually. D. Arthroscopy pump: The manufacturer's manual indicated that the pump must be checked and maintained according the the schedule shown. The Periodic Inspection Guidelines in the chart indicated that weekly operational checks were to be performed, weekly, or after 10 procedures/uses specific cleaning was to be performed and monthly, or after 40 procedures, checks of the outflow control valve and pressure relief valve were to be performed.		taken to be provided to MAC/GB at their next scheduled meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001158	A. BUILDING 00 B. WING	02/10/2021

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	4. Review of patient care equipment maintenance/PM documents lacked evidence of: A. PM of the anesthesia machine(s) having been performed daily, weekly and monthly as indicated by the manufacturer; B. PM of the EKG machines having been performed daily in accordance with manufacturer recommendations; C. PM of the patient stretchers having been completed semi-annually; D. PM of the arthroscopy pump having been performed weekly, after every 10 and 40 procedures, or monthly in accordance with manufacturer recommendations. 5. Review of anesthesia records for patients #5, #6, #8, #16, #17, #19, #20, #24, #25, #27 and #30 lacked documentation of what was included in the "Pre-anesthesia Equipment Checks" and lacked documentation of the frequency of "Pre-anesthesia Equipment Checks" corresponding to the manufacturer recommended daily, weekly and monthly tasks as indicated by staff interview. Therefore it was unable to be determined when or if recommended tasks for the every 10 procedure tasks, the every 40 procedure tasks and/or the monthly tasks were performed. 6. On 2/10/21 the following was indicated in interview: Beginning at approximately 9:30 AM, A3, Materials Manager, indicated that the Center did not have a documented maintenance schedule in accordance with the frequency and recommendations of the manufacturers for patient care equipment. Beginning at approximately 9:30 AM, A2, Administrator, indicated that documentation of PM of the anesthesia machines was documented on the anesthesia records in patient medical			

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	records (MRs)and noted as "Pre-anesthesia Equipment Checks". A2 indicated the facility had a policy for what was included in the "Equipment Checks". A copy of the policy was requested at that time. Beginning at approximately 10:15 AM, A1, Clinical Director, confirmed that the Center did not maintain documentation of inspections and/or PM of the EKG machines, patient stretchers or arthroscopy pump as recommended by the manufacturer. A1 also indicated that evidence of PM for the anesthesia machines was included in patient MRs within the "Anesthesia Record". A1 verified that from the MR documentation it could not be determined what was included in the "Pre-anesthesia Equipment Checks".			