## Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING 15C0001103

**Date Survey Completed:** 10/22/2013

### Name of Provider or Supplier

**Saint Charles Surgical Pavilion**

**Address:** 1900 Saint Charles ST, Jasper, IN 47546

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<th>Summary Statement of Deficiencies</th>
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<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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<td>This visit was for a re-certification survey.</td>
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**Facility Number:** 002523

**Survey Date:** 10/21/2013 through 10/22/2013

**Surveyors:**
- Jennifer Hembree, RN
- Public Health Nurse Surveyor
- Albert Daeger
- Medical Surveyor

**QA:** claughlin 10/28/13

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**Laboratory Director's or Provider/Supplier Representative's Signature**

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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.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 15C0001103

MULTIPLE CONSTRUCTION

DATE SURVEY COMPLETED: 10/22/2013

NAME OF PROVIDER OR SUPPLIER

SAINT CHARLES SURGICAL PAVILLION

STREET ADDRESS, CITY, STATE, ZIP CODE

1900 SAINT CHARLES ST
JASPER, IN 47546

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<tr>
<td>Q000002</td>
<td>416.2 DEFINITIONS</td>
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DEFINITIONS

As used in this part:

Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of this part. The ambulatory surgical center must comply with state licensure requirements.

Based on observation and staff interview, the facility failed to ensure the waiting room and staff were utilized distinctly for the ASC and not combined with the office practice.

Findings:

1. During observations throughout the day on 10/21/13, all patients entering were observed registering at the same front desk and directed to a large waiting area.

2. Staff member #A2 indicated in interview at 3:10 p.m. on 10/21/13 that the facility currently has a Physician and a Nurse Practitioner seeing patients on the practice side as well as the ASC is open.

Correction: Signage was added to the front desk admitting area for delineation of patient check-in for office and for surgery center. Patients being admitted to the surgery center will be directed by staff to the designated seating area for the surgery center, which is located and identified for the surgery center in the front corner of the lobby. The deficiency will not reoccur because admitting staff has been instructed on the procedure for admitting and seating direction for surgery center patients. Cynthia D. Gress is responsible for ongoing evaluation of the process. The deficiency was corrected on 10/30/2013.
## Statement of Deficiencies and Plan of Correction

### Identification Number:
15C0001103

### Name of Provider or Supplier
SAINT CHARLES SURGICAL PAVILLION

#### Street Address, City, State, Zip Code
1900 SAINT CHARLES ST JASPER, IN 47546

### Summary Statement of Deficiencies
Prefix: TAG: ID: Q000043
416.41(c) DISASTER PREPAREDNESS PLAN

1. The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC.

   2. The ASC coordinates the plan with State and local authorities, as appropriate.

   3. The ASC conducts drills, at least annually, to test the plan’s effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.

Based on documentation review and interview, the facility failed to ensure the emergency and disaster preparedness plan was coordinated with appropriate community, state, and federal agencies.

Findings included:

1. Saint Charles Surgical Pavillion Community Disaster Plan, last approved 9/1/2012, was reviewed with staff member A3. The plan does not identify how the facility will coordinate their efforts with local, state, and federal agencies.

Correction: Cindy Gress had become an assistant disaster preparedness coordinator for district 10 in southern Indiana. On 11/1/2013, she also contacted Memorial & Health Care Center’s disaster preparedness coordinator, Pat Todd, and will attend regional meetings in conjunction with Mr. Todd. Cindy Gress contacted Anne Haddox, Evansville, Indiana, the regional director for disaster preparedness for southern Indiana and also contacted Memorial Hospital and Health Care Center disaster preparedness representative, Pat Todd, and will coordinate with the nearby hospital for the community disaster preparedness plan. Saint Charles Surgical Pavilion has a preexisting agreement with the Dubois County Health Department to coordinate servies.

#### Corrective Action
Prefix: TAG: ID: Q000043
Correction: 11/04/2013
SAINT CHARLES SURGICAL PAVILLION
1900 SAINT CHARLES ST
JASPER, IN 47546

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federal agencies on any community emergency and/or natural disaster.

2. The last disaster drill the surgery center conducted was 3/2/2012. The drill was a tornado drill. The drill coincided with an actual tornado drill. The drill did not identify any procedure that was taken to communicate with local or state agencies.

3. At 12:20 PM on 10/22/2013, staff member A3 indicated the facility's Community Disaster Plan does not identify how the facility will coordinate with local, state, or Federal agencies.

Q000061 416.42(a)(1) ANESTHETIC RISK AND EVALUATION
A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.

during a local disaster. This coordination with the local hospital will be ongoing.
Based on observation and document review, the facility failed to ensure an assessment was performed prior to surgery for 1 patient observation (patient #22).

Findings include:

1. Facility policy titled "MEDICAL RECORD CONTENT" last reviewed/revised 9/12 states on page 2: "When the medical history and physical examination are completed within 30 days before admission, the facility must ensure than an updated medical record entry documenting an examination for any changes in the patient's condition is completed. This updated examination must be completed and documented in the patient's medical record prior to surgery....."

2. Patient #22 indicated in interview at 3:10 p.m. on 10/21/13 that he/she saw the surgeon and had a physical exam on 10/17/13.

3. During observation of patient #22 beginning at 3:10 p.m. on 10/21/13, the following was observed:
   (A) The patient was taken to the operating room at 5:55 p.m. on 10/21/13 and no examination was performed to determine if any changes had occurred
   
Correction: According to the RN who admitted this patient pre-operatively, the physician did indeed do a brief physical examination of this patient, however, it was not witnessed by the surveyor because she was in conversation with another staff member at that time. It is indeed the habit of both surgeons to see each patient preoperatively on the day of surgery. They do each evaluate the patient preoperatively for any changes since scheduling. This is a nonissue for this facility because both surgeons do see each patient preoperatively, mark the operative sites, and examine the patient and verify the status of the patient prior to the procedure. Jennifer did not witness this for this patient because she was having a discussion with another staff member when Dr. Love examined his patient.
since the history and physical was performed.

Q000162 416.47(b)
FORM AND CONTENT OF RECORD
The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:

(1) Patient identification.
(2) Significant medical history and results of physical examination.
(3) Pre-operative diagnostic studies (entered before surgery), if performed.
(4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body.
(5) Any allergies and abnormal drug reactions.
(6) Entries related to anesthesia administration.
(7) Documentation of properly executed informed patient consent.
(8) Discharge diagnosis.

Based on document review and staff interview, the facility failed to ensure evidence that operative notes were dictated per facility policy for 29 of 30 medical records reviewed. (patients #1-21 and 23-30) and failed to ensure history and physical (H&P) exams were accurate for 20 of 21 patients (patients #3-22).

Correction: The process was changed so that H&P's are now dictated on the day of the last office visit, so long as it is within thirty (30) days prior to surgery. An addendum is then signed on the day of surgery by the physician stating that surgery is to continue as planned. If the patient has not been seen within thirty (30) days of scheduled surgery.
Findings include:

1. Review of patients #1-21 and 23-30 medical records indicated the following:
   (A) The operative reports were not dated as to the day that they were dictated.
   (B) It could not be determined that the operative reports were dictated according to policy.

2. Facility policy titled "MEDICAL RECORD CONTENT" last reviewed/revised 9/12 states 3:
   "Operative reports are dictated for the medical record immediately following surgery....."

3. Staff member #N3 verified the above information in interview at 2:30 p.m. on 10/22/13.

4. Review of patient #3 medical record indicated the following:
   (A) He/she had a procedure on 10/18/13.
   (B) His/her H&P was dictated on 10/17/13 and states: "Vitals taken 10/17/13......"

5. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #3 had their pre surgery appointment on 10/3/13.

procedure, an H&P is dictated upon patients arrival.Prevention:
All staff was informed of the process change prior to implementation. Now that the process is set in place, it will continue without issue.Responsible: The surgeon is directly resposible to dictate the H&P for each patient.Date: This process change was implanted on 10/23/2013 This Process will be audited by Cynthia Gress monthly. It will also be audited quarterly by Kim Clodfelter with Med-Rec Services during chart audits.
6. Review of patient #4 medical record indicated the following:
   (A) He/she had a procedure on 10/09/13.
   (B) His/her H&P was dictated on 10/08/13 and states: "Vitals taken 10/08/13....".

7. Per staff member #A2 at 4:00 p.m. on 1/22/13, patient #4 had their pre surgery appointment on 9/19/13.

8. Review of patient #5 medical record indicated the following:
   (A) He/she had a procedure on 10/09/13.
   (B) His/her H&P was dictated on 10/08/13 and states: "Vitals taken 10/08/13....".

9. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #5 had their pre surgery appointment on 09/26/13.

10. Review of patient #6 medical record indicated the following:
    (A) He/she had a procedure on 08/28/13.
    (B) His/her H&P was dictated on 8/27/13 and states: "Vitals taken 08/27/13....".

11. Per staff member #A2 at 4:00 p.m.
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<td>10/22/13, patient #6 had their pre surgery appointment on 8/26/13.</td>
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<td>12. Review of patient #7 medical record indicated the following: (A) He/she had a procedure on 10/09/13. (B) His/her H&amp;P was dictated on 10/08/13 and states: &quot;Vitals taken 10/08/13....&quot;</td>
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<td>13. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #7 had their pre surgery appointment on 10/3/13.</td>
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<td>14. Review of patient #8 medical record indicated the following: (A) He/she had a procedure on 10/02/13. (B) His/her H&amp;P was dictated on 10/01/13 and states: &quot;Vitals taken 10/01/13....&quot;</td>
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<td>15. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #8 had their pre surgery appointment on 09/26/13.</td>
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<td>16. Review of patient #9 medical record indicated the following: (A) He/she had a procedure on 08/09/13. (B) His/her H&amp;P was dictated on 8/8/13 and states: &quot;Vitals taken 08/08/13....&quot;</td>
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<td>17.</td>
<td>Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #9 had their pre-surgery appointment on 08/07/13.</td>
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<td>18.</td>
<td>Review of patient #10 medical record indicated the following: (A) He/she had a procedure on 9/06/13. (B) His/her H&amp;P was dictated on 9/05/13 and states: &quot;Vitals taken 9/05/13......&quot;</td>
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<td>19.</td>
<td>Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #10 had their pre-surgery appointment on 08/12/13.</td>
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<td>20.</td>
<td>Review of patient #11 medical record indicated the following: (A) He/she had a procedure on 9/06/13. (B) His/her H&amp;P was dictated on 9/05/13 and states: &quot;Vitals taken 09/05/13......&quot;</td>
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<td>Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #11 had their pre-surgery appointment on 08/28/13.</td>
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<td>Review of patient #12 medical record indicated the following: (A) He/she had a procedure on 09/06/13. (B) His/her H&amp;P was dictated on 9/5/13 and states: &quot;Vitals taken 09/05/13......&quot;</td>
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<td>23.</td>
<td>Per staff member #A2 at 4:00 p.m.</td>
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<td>on 10/22/13, patient #12 had their pre-surgery appointment on 08/22/13.</td>
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<td>24. Review of patient #13 medical record indicated the following:</td>
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<td>(A) He/she had a procedure on 08/31/13.</td>
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<td>(B) His/her H&amp;P was dictated on 8/29/13 and states: &quot;Vitals taken 8/29/13....&quot;</td>
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<td>25. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #13 had their pre-surgery appointment on 08/08/13.</td>
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<td>26. Review of patient #14 medical record indicated the following:</td>
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<td>(A) He/she had a procedure on 08/30/13.</td>
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<td>(B) His/her H&amp;P was dictated on 8/29/13 and states: &quot;Vitals taken 8/29/13....&quot;</td>
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<td>27. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #14 had their pre-surgery appointment on 08/08/13.</td>
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<td>28. Review of patient #15 medical record indicated the following:</td>
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<td>Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #15 had their pre surgery appointment on 09/12/13.</td>
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<td>Review of patient #16 medical record indicated the following: (A) He/she had a procedure on 07/26/13. (B) His/her H&amp;P was dictated on 7/25/13 and states &quot;Vitals taken 07/25/13.......&quot;</td>
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<td>Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #16 had their pre surgery appointment on 05/30/13.</td>
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<td>Review of patient #17 medical record indicated the following: (A) He/she had a procedure on 07/26/13. (B) His/her H&amp;P was dictated on 7/25/13 and states &quot;Vitals taken 07/25/13.......&quot;</td>
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<td>Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #16 had their pre surgery appointment on 07/8/13.</td>
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<td>Review of patient #18 medical record indicated the following: (A) He/she had a procedure on 07/26/13. (B) His/her H&amp;P was dictated on 7/25/13 and states &quot;Vitals taken 07/25/13.......&quot;</td>
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<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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</table>
| 7/25/13 and states "Vitals taken 07/25/13.......

35. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #16 had their pre surgery appointment on 07/15/13.

36. Review of patient #19 medical record indicated the following:
   (A) He/she had a procedure on 06/14/13.
   (B) His/her H&P was dictated on 6/13/13 and states "Vitals taken 06/13/13.......

37. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #19 had their pre surgery appointment on 05/29/13.

38. Review of patient #20 medical record indicated the following:
   (A) He/she had a procedure on 06/14/13.
   (B) His/her H&P was dictated on 7/13/13 and states "Vitals taken 07/13/13.......

39. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #20 had their pre surgery appointment on 05/29/13.

40. Review of patient #21 medical record indicated the following:
   (A) He/she had a procedure on
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION 15C0001103

**Date Survey Completed:** 10/22/2013

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
</table>

#### Summary Statement of Deficiencies

- **05/31/13.**
  - (B) His/her H&P was dictated on 5/30/13 and states "Vitals taken 05/30/13...."

- **41.** Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #21 had their pre-surgery appointment on 04/25/13.

- **42.** Review of patient #22 medical record indicated the following:
  - (A) He/she had a procedure on 10/21/13.
  - (B) His/her H&P was dictated on 10/18/13 and states "Vitals taken 10/18/13...."

- **43.** Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #22 had their pre-surgery appointment on 10/17/13.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **IDENTIFICATION NUMBER:** 15C0001103
- **DATE SURVEY COMPLETED:** 10/22/2013

**NAME OF PROVIDER OR SUPPLIER:** SAINT CHARLES SURGICAL PAVILLION

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
1900 SAINT CHARLES ST
JASPER, IN 47546

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**PREFIX**

**TAG**

**ID**

**SUMMARY STATEMENT OF DEFICIENCIES**

416.48(a) **ADMINISTRATION OF DRUGS**

Drugs must be prepared and administered according to established policies and acceptable standards of practice.

Based on observation, the facility failed to ensure staff cleansed the I.V. ports prior to medication administration for 1 patient observation.

Findings include:

1. Staff member #A1 was observed administering I.V. medication x 2 beginning at 5:55 p.m. on 10/22/13.
   He/she did not cleanse the I.V. port with alcohol prior to medication administration.

**Correction:**

All staff members were informed that AORN standards will be followed related to the administration of intravenous medications. IV ports are to be wiped with an alcohol pad prior to the administration of medication. Prevention: All registered nurse staff are held accountable for following AORN protocol daily. Observance of protocol will be carried out daily. Failure to follow protocol will result in verbal counseling.

*Responsible party: All registered nurse staff. Caroline Roth, RN (Infection Control)*

**COMPLETION DATE:** 10/23/2013
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 15C0001103

A. BUILDING
B. WING

MULTIPLE CONSTRUCTION MG 00

DATE SURVEY COMPLETED: 10/22/2013

NAME OF PROVIDER OR SUPPLIER

SAINT CHARLES SURGICAL PAVILLION

STREET ADDRESS, CITY, STATE, ZIP CODE

1900 SAINT CHARLES ST
JASPER, IN 47546

SUMMARY STATEMENT OF DEFICIENCIES

PREFIX TAG ID

1. 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 observation and document review, the facility failed to ensure staff members performed hand hygiene according to policy and standard of practice for 1 of 3 staff members observed (staff member #N6).

Findings include:

1. During observation in the pre-operative area beginning at 4:45 p.m. on 10/22/13, staff member #N6 was observed washing his/her hands four (4) times. Each time, the staff member did not use a paper towel to shut the water off and used their bare hand.

2. Facility policy titled "HAND HYGIENE-CDC GUIDELINES" last reviewed/revised 9/1/12 states on page 1: "Turn off faucets with used paper towel and discard......"

Correction: The Hand Hygiene Policy was reviewed with staff. Staff was reminded of proper hand hygiene techniques. Water should be turned off with paper towel protecting clean hand. Prevention: This policy will be reinforced during staff meetings monthly, and observation of hand washing techniques by staff will occur monthly for the next quarter. Responsible: The administrator will observe handwashing techniques by staff daily. Date: The policy was reviewed 10/23/2013 with staff.

Nurse) will audit this process for all staff. Date: AORN standard for IV medication was reviewed with staff 10/23/2013. This included anesthesia.
<table>
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<tr>
<th>Q000242</th>
<th>416.51(b)</th>
<th>INFECTIO CONTROL PROGRAM</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Staff members #N1 and N2 personnel files lacked evidence of a current PPD or current TB risk assessment questionnaire.</td>
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<tr>
<td>2.</td>
<td>Staff members #N6 and N8 personnel files lacked evidence of a current PPD or current TB risk assessment questionnaire or evidence of immunity to Varicella.</td>
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<tr>
<td>3.</td>
<td>Staff member #7 personnel file lacked evidence of immunity to</td>
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</tr>
<tr>
<td>Q000242</td>
<td>Correction: All missing staff information was immediately obtained and placed in files. The RN staff member with missing varicella immunization documentation had titers drawn and results were placed in her file. The CST staff person who was documented to be missing varicella vaccination did have that in her file, it was not filed correctly and was missed. 4 staff persons completed TB risk questionnaires and these also were placed into the staff folders. All staff files are now up to date with complete information. Prevention: All staff files will be reviewed monthly for complete documentation. Responsible: The administrator will be responsible for reviewing staff files and updating information. Date: 10/23/2013</td>
<td>10/23/2013</td>
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</tr>
<tr>
<td>Q000245</td>
<td>416.51(b)(3)</td>
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</table>

Findings include:

1. Review of facility infection/complication surveillance log indicated the facility had a surgical site infection (SSI) the first and third quarters of 2013.

2. Review of infection control meeting

Varicella.

4. Staff member #A1 verified the above at 1:15 p.m. on 10/22/13.
SAINT CHARLES SURGICAL PAVILLION
1900 SAINT CHARLES ST
JASPER, IN 47546

minutes titled "First Quarter 2013: Infection Committee Meeting" states:
"I. Infection Control: a. Review of data identifies no reported SSI for first quarter."

3. Review of infection control meeting minutes titled "Third Quarter 2013:
Infection Committee Meeting" states:
"I. Infection Control: a. Review of data identifies no reported SSI for quarter."

4. Staff member #N2 (physician personal scrub tech) was observed with chipped nail polish during surgical observation beginning at 5:55 p.m. on 10/22/13.

5. AORN Recommended Practices for Hand Hygiene in the Perioperative Setting which was part of the infection control program, indicates on page 74: "Chipped fingernail polish should be removed prior to entry into the restricted area of the preoperative environment."
### Statement of Deficiencies and Plan of Correction

#### Identification Number:
- MULTIPLE CONSTRUCTION
  - A. BUILDING 00
  - B. WING

#### Date Survey Completed:
- 10/22/2013

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<tr>
<td>Q000261</td>
<td><strong>416.52(a)(1)</strong> ADMISSION ASSESSMENT</td>
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<td>10/24/2013</td>
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|        | Not more than 30 days before the date of 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. Based on document review and staff interview, the facility failed to ensure history and physical (H&P) examinations were performed on pain management patients for 4 of 4 pain management patients (patients #1, 28, 29, and 30).

Findings include:

1. Facility policy titled "HISTORY AND PHYSICAL-OUTPATIENT SURGERY" last reviewed/revised 8/12 states: "All patients, regardless of type of anesthesia to be given, shall have a history and physical in the medical record at the time of surgery...."

2. Review of patient #1 medical record indicated the following:
   - (A) He/she had a pain management procedure performed on 6/27/13.
   - (B) The medical record lacked documentation of an H&P.

Correction: The process for Saint Charles Surgical Pavilion was updated to include the dictation of a history and physical examination by the pain specialist physician, for all pain patients on the day of the procedure. Prevention: Each patient entering the facility will have a H&P dictated that day by Dr. Marjorie Oropilla.

Responsible: Dr. Marjorie Oropilla is the pain specialist at our facility. Date: This process change was implemented 10/24/2013.
3. Review of patient #1 medical record indicated the following:
   (A) He/she had a pain management procedure performed on 8/8/13.
   (B) The medical record lacked documentation of an H&P.

4. Review of patient #1 medical record indicated the following:
   (A) He/she had a pain management procedure performed on 8/8/13.
   (B) The medical record lacked documentation of an H&P.

5. Review of patient #1 medical record indicated the following:
   (A) He/she had a pain management procedure performed on 6/6/13.
   (B) The medical record lacked documentation of an H&P.

6. Staff member #N3 indicated in interview at 2:00 p.m. on 10/22/13 that H&P's are not performed on pain patients and he/she verified the above medical record information.
This visit was for a State licensure survey.

Facility Number: 002523

Survey Date: 10/21/2013 through 10/22/2013

Surveyors:
Albert Daeger, CFM, SFPIO
Medical Surveyor

Jennifer Hembree, RN
Public Health Nurse Surveyor

QA: claughlin 10/28/13
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION 15C0001103

**Date Survey Completed:** 10/22/2013

#### Name of Provider or Supplier

**Saint Charles Surgical Pavilion**

**Street Address, City, State, Zip Code:** 1900 Saint Charles St, Jasper, IN 47546

**Event ID:** KTMN11

**Facility ID:** 002523

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<td>002523</td>
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<td>23</td>
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#### Summary Statement of Deficiencies

**Prefix Tag:** S000153

**Regulatory or LSC Identifying Information:**

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<tr>
<td>410 IAC 15-2.4-1</td>
<td>410 IAC 15-2.4-1(c) (5) (C)</td>
<td>Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review and staff interview, the facility failed to provide evidence of general and job specific orientation for 1 of 1 certified surgical tech (CST). Findings include: 1. Staff member #N7's personnel file lacked evidence of orientation to the facility and to job specific duties. 2. Staff member #A1 verified the above beginning at 1:15 p.m. on 10/22/13.</td>
<td>S000153</td>
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<td>ID</td>
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<td>STATEMENT OF DEFICIENCIES</td>
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<tr>
<td>S000156</td>
<td>410 IAC 15-2.4-1</td>
<td>GOVERNING BODY; POWERS AND DUTIES</td>
<td>410 IAC 15-2.4-1 (c)(5) (E) Require that the chief executive officer develop and implement policies and programs for the following:</td>
</tr>
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Findings included:

1. Saint Charles Surgical Pavillion Organizational Chart defined staff member #3 as the surgery center's Administrator/Director.
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>2</td>
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<td>2. Credentialing file for staff member #3 (CRNA) indicated the staff member was a contracted health care provider. The credentialing file lacked a job description and annual evaluation for the position of Administrator.</td>
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<td>C1</td>
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<td>3. The facility was unable to provide staff member #3's contract.</td>
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<td>C2</td>
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<td>4. At 1:30 PM on 10/22/2013, staff member #3 indicated his/her contact was at home. The staff member indicated the contract did not define the Administrator's job responsibilities. The staff member indicated the Administrator's job title was given to him/her several years ago as an interim position; however, the job turned into a permanent position. The staff member indicated the surgery center never had a written job description for the Administrator/Director and the surgery center has never evaluated his/her performance as the Administrator.</td>
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<td>C3</td>
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**Name of Provider or Supplier:** SAINT CHARLES SURGICAL PAVILLION

**Street Address, City, State, Zip Code:** 1900 SAINT CHARLES ST, JASPER, IN 47546
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<tr>
<td>S000164</td>
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<td>Administrator/Director of Saint Charles Surgical Pavilion.</td>
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<td>S000164</td>
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<td>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H)</td>
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<tr>
<td>S000164</td>
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<td>Require that the chief executive officer develop and implement policies and programs for the following: (H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program. Based on document review and staff interview, the facility failed to ensure staff members received a post offer physical examination for 8 of 8 staff members or failed to ensure the infection control program developed a policy addressing the post offer physical examinations. Findings include;</td>
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<tr>
<td>S000164</td>
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<td></td>
<td>1. Staff members #1-8 personnel files lacked documentation of a post offer physical examination. 2. The facility has no policy addressing the post offer physical exams. 3. Staff member #A1 verified the above</td>
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Correction: The New Hire Policy has now been changed to include language denoting that a post offer physical examination is not required by this facility. Prevention: The policy is ongoing. Responsible: The Board of Directors is responsible for setting policy for the facility. Date: The policy was updated on 10/24/2013 and will go before the zBoard of Directors for approval in the fourth quarter meeting.
SUMMARY STATEMENT OF DEFICIENCIES

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 observation and document review, the facility failed to ensure staff members performed hand hygiene according to policy and standard of practice for 1 staff member, failed to ensure staff followed hand hygiene recommendations within the infection control program for 1 staff member, and failed to ensure staff cleansed the I.V. ports prior to medication administration for 1 patient observation.

Findings include:

1. During observation in the pre-operative area beginning at 4:45 p.m. on 10/22/13, staff member #N6 was observed washing his/her hands four (4) times. Each time, the staff member did not use a paper towel to shut the water off and used their bare hand.
2. Staff member #N2 (physician personal scrub tech) was observed with chipped nail polish during surgical observation beginning at 5:55 p.m. on 10/22/13.

3. Staff member #A1 was observed administering I.V. medication x 2 beginning at 5:55 p.m. on 10/22/13. He/she did not cleanse the I.V. port with alcohol prior to medication administration.

3. Facility policy titled "HAND HYGIENE-CDC GUIDELINES" last reviewed/revised 9/1/12 states on page 1: "Turn off faucets with used paper towel and discard......"

4. AORN Recommended Practices for Hand Hygiene in the Perioperative Setting which was part of the infection control program, indicates on page 74: "Chipped fingernail polish should be removed prior to entry into the restricted area of the preoperative environment."
SAINT CHARLES SURGICAL PAVILLION
1900 SAINT CHARLES ST
JASPER, IN 47546

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<td>S000418</td>
<td>410</td>
<td>IAC 15-2.5-1</td>
<td>INFECTION CONTROL PROGRAM</td>
<td>410</td>
<td>IAC 15-2.5-1(f)(2)(A)</td>
<td>10/23/2013</td>
<td>Correction: Missing information regarding infections was updated. Infection control committee meetings were indeed held. Existing infections were reviewed by the infection control committee and by the medical staff and the Board of Directors. The error identified was documentation of those infections in the infection control report. The reports were edited to include correct information. Prevention: Close monitoring of proper documentation will occur in the future. Deligation of reporting will occur in times where the administrator requires assistance. Responsible Person: The administrator in conjunction with the infection control nurse. Date: 10/23/2013</td>
<td>10/23/2013</td>
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</table>

Findings include:

1. Review of facility infection/complication surveillance log indicated the facility had a surgical site infection (SSI) the first and third quarters of 2013.

2. Review of infection control meeting minutes titled "First Quarter 2013: Infection Committee Meeting" states: "I. Infection Control: a. Review of data identifies no reported SSI for first quarter."

3. Review of infection control meeting minutes titled "Third Quarter 2013: 
Infection Committee Meeting" states:
"I. Infection Control: a. Review of data identifies no reported SSI for quarter."

S000442
410 IAC 15-2.5-1
INFECTION CONTROL PROGRAM
410 IAC 15-2.5-1(f)(2)(E)(viii)

The infection control committee responsibilities must include, but are not limited to:

(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:

(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.

Based on document review and staff interview, the facility failed to ensure staff members had a current PPD or completed the TB risk questionnaire for 4 of 8 staff members and failed to ensure documentation of disease history or immunization to Varicella for 3 of 8 staff members.

Findings include:

1. Staff members #N1 and N2 personnel

Correction: All missing staff information was obtained and placed in staff files. Staff member with missing varicella immunization documentation had titers drawn and results were placed in her file. The TB Risk questionnaire was filled out by the 4 staff persons who were outdated and these were also placed into their files.

Prevention: Staff files will be reviewed monthly to make sure all data is within date and complete.

Person Responsible: 10/23/2013
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<td>S000630</td>
<td>410 IAC 15-2.5-3</td>
<td>MEDICAL RECORDS, STORAGE, AND ADMIN.</td>
<td>410 IAC 15-2.5-3(d)</td>
<td>The administrator: Date: 10/23/2013</td>
<td>10/23/2013</td>
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- files lacked evidence of a current PPD or current TB risk assessment questionnaire.
- Staff members #N6 and N8 personnel files lacked evidence of a current PPD or current TB risk assessment questionnaire or evidence of immunity to Varicella.
- Staff member #7 personnel file lacked evidence of immunity to Varicella.
- Staff member #A1 verified the above at 1:15 p.m. on 10/22/13.

Correction: The facility process was changed so that H&P’s are now dictated on the day of the last office visit, so long as it is within thirty (30) days prior to
Findings include:

1. Review of patient #3 medical record indicated the following:
   (A) He/she had a procedure on 10/18/13.
   (B) His/her H&P was dictated on 10/17/13 and states: "Vitals taken 10/17/13.......

2. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #3 had their pre surgery appointment on 10/3/13.

3. Review of patient #4 medical record indicated the following:
   (A) He/she had a procedure on 10/09/13.
   (B) His/her H&P was dictated on 10/08/13 and states: "Vitals taken 10/08/13.......

4. Per staff member #A2 at 4:00 p.m. on 1/22/13, patient #4 had their pre surgery appointment on 9/19/13.

5. Review of patient #5 medical record indicated the following:
   (A) He/she had a procedure on 10/09/13.
   (B) His/her H&P was dictated on 10/08/13 and states: "Vitals taken 10/08/13.......

surgery. An addendum is then signed on the day of surgery by the physician stating that surgery is to continue as planned. If the patient has not been seen within thirty (30) days of scheduled procedure, an H&P is dictated upon patients arrival. Prevention: Daily monitoring of the process will occur by the nursing staff to assure compliance with the process. Monitoring will be done by Cynthia Gress. Audit of this issue will occur quarterly by Kim Clodfelter (Med-Rec Services) during chart review. Responsible person: The surgeons are responsible for the dictation of the history and physical for each patient. Date: 10/23/2013
6. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #5 had their pre surgery appointment on 09/26/13.

7. Review of patient #6 medical record indicated the following:
   (A) He/she had a procedure on 08/28/13.
   (B) His/her H&P was dictated on 8/27/13 and states: "Vitals taken 08/27/13......"

8. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #6 had their pre surgery appointment on 8/26/13.

9. Review of patient #7 medical record indicated the following:
   (A) He/she had a procedure on 10/09/13.
   (B) His/her H&P was dictated on 10/08/13 and states: "Vitals taken 10/08/13......"

10. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #7 had their pre surgery appointment on 10/3/13.

11. Review of patient #8 medical record indicated the following:
    (A) He/she had a procedure on 10/02/13.
    (B) His/her H&P was dictated on
State Form  KTMN11  Facility ID: 002523

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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>10/01/13 and states:</td>
<td>&quot;Vitals taken 10/01/13......&quot;</td>
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<tr>
<td>12. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #8 had their pre surgery appointment on 09/26/13.</td>
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<td>13. Review of patient #9 medical record indicated the following:</td>
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<td>(A) He/she had a procedure on 08/09/13.</td>
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<td>(B) His/her H&amp;P was dictated on 8/8/13 and states: &quot;Vitals taken 08/08/13......&quot;</td>
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<tr>
<td>14. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #9 had their pre surgery appointment on 08/07/13.</td>
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<td>15. Review of patient #10 medical record indicated the following:</td>
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<td>(A) He/she had a procedure on 9/06/13.</td>
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<td>(B) His/her H&amp;P was dictated on 9/05/13 and states: &quot;Vitals taken 9/05/13......&quot;</td>
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<tr>
<td>16. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #10 had their pre surgery appointment on 08/12/13.</td>
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<td>17. Review of patient #11 medical record indicated the following:</td>
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<tr>
<td>(A) He/she had a procedure on 9/06/13.</td>
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<td>(B) His/her H&amp;P was dictated on 9/05/13 and states: &quot;Vitals taken</td>
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10/01/13......" | | | | | |
18. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #11 had their pre surgery appointment on 08/28/13.

19. Review of patient #12 medical record indicated the following:
(A) He/she had a procedure on 09/06/13.
(B) His/her H&P was dictated on 9/5/13 and states: "Vitals taken 09/05/13.......

20. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #12 had their pre surgery appointment on 08/22/13.

21. Review of patient #13 medical record indicated the following:
(A) He/she had a procedure on 08/31/13.
(B) His/her H&P was dictated on 8/29/13 and states: "Vitals taken 8/29/13.......

22. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #13 had their pre surgery appointment on 08/08/13.

23. Review of patient #14 medical record indicated the following:
(A) He/she had a procedure on 08/30/13.
(B) His/her H&P was dictated on
24. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #14 had their pre surgery appointment on 08/08/13.

25. Review of patient #15 medical record indicated the following:
   (A) He/she had a procedure on 09/27/13.
   (B) His/her H&P was dictated on 9/26/13 and states: "Vitals taken 09/26/13...."

26. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #15 had their pre surgery appointment on 09/12/13.

27. Review of patient #16 medical record indicated the following:
   (A) He/she had a procedure on 07/26/13.
   (B) His/her H&P was dictated on 7/25/13 and states "Vitals taken 07/25/13...."

28. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #16 had their pre surgery appointment on 05/30/13.

29. Review of patient #17 medical record indicated the following:
   (A) He/she had a procedure on
<table>
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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>DATE SURVEY COMPLETED</th>
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<td>07/26/13</td>
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30. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #16 had their pre surgery appointment on 07/8/13.

31. Review of patient #18 medical record indicated the following:
(A) He/she had a procedure on 07/26/13.
(B) His/her H&P was dictated on 7/25/13 and states "Vitals taken 07/25/13...."

32. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #16 had their pre surgery appointment on 07/15/13.

33. Review of patient #19 medical record indicated the following:
(A) He/she had a procedure on 06/14/13.
(B) His/her H&P was dictated on 6/13/13 and states "Vitals taken 06/13/13...."

34. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #19 had their pre surgery appointment on 05/29/13.

35. Review of patient #20 medical record indicated the following:
(A) He/she had a procedure on 07/26/13.
(B) His/her H&P was dictated on 7/25/13 and states "Vitals taken 07/25/13...."
record indicated the following:
(A) He/she had a procedure on 06/14/13.
(B) His/her H&P was dictated on 7/13/13 and states "Vitals taken 07/13/13...."

36. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #20 had their pre surgery appointment on 05/29/13.

37. Review of patient #21 medical record indicated the following:
(A) He/she had a procedure on 05/31/13.
(B) His/her H&P was dictated on 5/30/13 and states "Vitals taken 05/30/13...."

38. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #21 had their pre surgery appointment on 04/25/13.

39. Review of patient #22 medical record indicated the following:
(A) He/she had a procedure on 10/21/13.
(B) His/her H&P was dictated on 10/18/13 and states "Vitals taken 10/18/13...."

40. Per staff member #A2 at 4:00 p.m. on 10/22/13, patient #22 had their pre surgery appointment on 10/17/13.
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<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
SAINT CHARLES SURGICAL PAVILLION
1900 SAINT CHARLES ST
JASPER, IN 47546

SUMMARY STATEMENT OF DEFICIENCIES

MEDICAL RECORDS, STORAGE, AND ADMIN.
410 IAC 15-2.5-3(f)(2)

All patient records must document and contain, at a minimum, the following:

(2) Appropriate medical history and results of a physical examination completed within the time frames in section 4(b)(3)(M) of this rule.

Based on document review and staff interview, the facility failed to ensure history and physical (H&P) examinations were performed on pain management patients for 4 of 4 pain management patients.

Findings include:

1. Facility policy titled "HISTORY AND PHYSICAL-OUTPATIENT SURGERY" last reviewed/revised 8/12 states: "All patients, regardless of type of anesthesia to be given, shall have a history and physical in the medical record at the time of surgery......."

2. Review of patient #1 medical record indicated the following:
   (A) He/she had a pain management procedure performed on 6/27/13.
   (B) The medical record lacked documentation of an H&P.

Correction: The facility process was changed so that a history and physical is dictated for all patients coming to the facility for pain procedures on the day of the procedure.

Prevention: Each patient who is scheduled for a pain procedure will have a dictated history and physical by Dr. Marjorie Oropilla. Responsible person: Dr. Marjorie Oropilla.

Date: the process change was implemented 10/24/2013
3. Review of patient #1 medical record indicated the following:
   (A) He/she had a pain management procedure performed on 8/8/13.
   (B) The medical record lacked documentation of an H&P.

4. Review of patient #1 medical record indicated the following:
   (A) He/she had a pain management procedure performed on 8/8/13.
   (B) The medical record lacked documentation of an H&P.

5. Review of patient #1 medical record indicated the following:
   (A) He/she had a pain management procedure performed on 6/6/13.
   (B) The medical record lacked documentation of an H&P.

6. Staff member #N3 indicated in interview at 2:00 p.m. on 10/22/13 that H&P's are not performed on pain patients and he/she verified the above medical record information.
## SUMMARY STATEMENT OF DEFICIENCIES

### 410 IAC 15-2.5-3
**MEDICAL RECORDS, STORAGE, AND ADMIN.**

410 IAC 15-2.5-3(f)(9)

All patient records must document and contain, at a minimum, the following:

9. A written or dictated report describing techniques, findings, and tissue removed or altered.

Based on document review and staff interview, the facility failed to ensure evidence that operative notes were dictated per facility policy for 29 of 30 medical records reviewed.

**Findings include:**

1. Review of patients #1-21 and 23-30 medical records indicated the following:
   
   A. The operative reports were not dated as to the day that they were dictated.
   
   B. It could not be determined that the operative reports were dictated according to policy.

2. Facility policy titled "MEDICAL RECORD CONTENT" last reviewed/revised 9/12 states 3:

   "Operative reports are dictated for the medical record immediately following surgery...."

### Correction:

The facility process was changed so that operative reports are now stamped with date and time of dictation and transcription to ensure facility policy is being followed. Prior to this change, the operative report did not carry a time/date stamp for dictation.

**Prevention:** The EMR set up automatically time stamps all dictations following the process change. Responsible person: The registered nurses are responsible to review charts and make sure that the process is continuing.

**Date:** The correction occurred on 10/23/2013
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<tr>
<td>15C0000103</td>
<td>A. BUILDING 00</td>
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<td>CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</td>
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<td>B. WING</td>
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3. Staff member #N3 verified the above information in interview at 2:30 p.m. on 10/22/13.
## SUMMARY STATEMENT OF DEFICIENCIES

410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL

410 IAC 15-2.5-4(a)(4)

The medical staff shall do the following:

1. Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:
   - A completed, signed application.
   - The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.
   - A current copy of the individual's:
     - Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.
     - Indiana controlled substance registration showing number as applicable.
     - Drug Enforcement Agency registration showing number as applicable.
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING 00

**Date Survey Completed:** 10/22/2013

**Name of Provider or Supplier:** SAINT CHARLES SURGICAL PAVILLION

**Address:**
- **Name:** SAINT CHARLES SURGICAL PAVILLION
- **Street Address:** 1900 SAINT CHARLES ST
- **City:** JASPER
- **State:** IN
- **ZIP Code:** 47546

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
<th>Deficiency Description</th>
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<tbody>
<tr>
<td>S000710</td>
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<td>Based on documentation review and staff interview, the facility failed to ensure 3 of 3 physicians maintained current hospital privileges in a hospital within the county or an Indiana county adjacent to the county in which Saint Charles Surgical Pavilion was located.</td>
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</table>

**Correction:** All staff did have active and current hospital privileges within the county or an Indiana county adjacent to the county in which Saint Charles Surgical Pavilion resides. They were obtained the day of the survey and placed into staff files. **Prevention:** Staff files will be reviewed monthly to evaluate contents and maintain up-to-date information in all staff files.

**Responsible:** Administrator

**Date:** 10/23/2013
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1. Saint Charles Surgical Pavillion Medical Staff By-Laws (Last approved 9/1/2012) Article II states, "Active medical staff members must maintain current privileges at an inpatient hospital located in Dubois County Indiana or any county adjacent to Dubois County Indiana."

2. Credential files for staff member A4 identified hospital privileges expired 9/15/2013.

3. Credential files for staff member A5 identified hospital privileges expired 9/7/2013.

4. Credential files for staff member A6 identified hospital privileges expired 7/20/2013.

5. Staff member #3 confirmed the hospital privileges expirations for A4, A5 and A6.
SAINT CHARLES SURGICAL PAVILION
1900 SAINT CHARLES ST
JASPER, IN 47546

410 IAC 15-2.5-4
MEDICAL STAFF; ANESTHESIA AND SURGICAL
410 IAC 15-2.5-4(b)(3)(M)

These bylaws and rules must be as follows:

(3) Include, at a minimum, the following:

(M) A requirement that a medical history and physical examination be performed as follows:

(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.

(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.

(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.

Based on observation and document review, the facility failed to ensure an assessment was performed prior to surgery for 1 patient observation.

Correction: The physicians at Saint Charles Surgical Pavilion always perform a physical assessment of each patient prior to procedure as policy states. Dr.
Findings include:

1. Facility policy titled "MEDICAL RECORD CONTENT" last reviewed/revised 9/12 states on page 2: "When the medical history and physical examination are completed within 30 days before admission, the facility must ensure than an updated medical record entry documenting an examination for any changes in the patient's condition is completed. This updated examination must be completed and documented in the patient's medical record prior to surgery....."

2. Patient #22 indicated in interview at 3:10 p.m. on 10/21/13 that he/she saw the surgeon and had a physical exam on 10/17/13.

3. During observation of patient #22 beginning at 3:10 p.m. on 10/21/13, the following was observed:
   (A) The patient was taken to the operating room at 5:55 p.m. on 10/21/13 and no examination was performed to determine if any changes had occurred since the history and physical was performed.
Based on documentation review and staff interview, the facility failed to ensure a fire drill was conducted once per quarter.

Findings included:

1. Saint Charles Surgical Pavillion Safety Plan (Last approved 9/1/2012) stated, "Fire drill will be held once each quarter."

2. The facility only provided 3 fire drills for the last four complete quarters: 6/13/2013, Correction: A Fire drill report for the third quarter of 2012 was apparently missing from the file. The fire drill was completed and the minutes were typed but not printed and placed in the correct folder. The minutes from the fire drill are now in the correct folder. Prevention: A fire drill will be held each quarter with all staff members. A fire alarm pull will accompany the fire drill (in compliance with the Life Safety Code Inspector). The company who is responsible for our fire alarm system will be involved. A dated report with all attendees sign in will be placed in the Frie & Disaster Binder. Responsible: The administrator Date: 10/23/2013
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<th>PROVIDER/Supplier</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tr>
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<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>S001198</td>
<td>3/11/2013, and 10/10/2012. The fire drill that was conducted before 10/10/2012 was dated 6/14/2012. Therefore, the surgery center did not provide a fire drill for the third quarter of 2012.</td>
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<td>S001198</td>
<td>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6) (c) A safety management program must include, but not be limited to, the following: (6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies. Based on documentation review and interview, the facility failed to ensure the emergency and disaster preparedness plan was coordinated with appropriate community, state, and federal agencies. Findings included: 1. Saint Charles Surgical Pavillion Community Disaster Plan, last approved 9/1/2012, was</td>
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Correction: Cindy Gress has been appointed District 10 assistant IFASC Disaster Preparedness Representative. She is now also coordinating with Pat Todd, director of Disaster Preparedness at Memorial Hospital and Health Care Center to plan and participate in the local disaster drills. The last drill conducted on 3/2/2012 was in fact an actual event and patients and public were evacuated to a shelter per policy. The facility was not directly affected by the tornado at that time. Prevention: Cindy Gress will be coordinating the facility with the local hospital to...
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<td>reviewed with staff member A3.</td>
<td>assist in the provision of</td>
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<td>The plan does not identify how the</td>
<td>emergency care in the event of a</td>
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<td>facility will coordinate their</td>
<td>local disaster.</td>
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<td>efforts with local, state, and</td>
<td>Responsible Person: Cindy</td>
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<td>federal agencies on any</td>
<td>Gress Date: 10/23/2013</td>
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<td>community emergency and/or</td>
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<td>natural disaster.</td>
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<td>2. The last disaster drill the</td>
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<td>surgery center conducted was 3/2/2012. The drill was a tornado</td>
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<td>drill. The drill coincided with an</td>
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<td>actual tornado drill. The drill did</td>
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<td>local or state agencies.</td>
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<td>3. At 12:20 PM on 10/22/2013,</td>
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<td>staff member A3 indicated the</td>
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<td>facility's Community Disaster Plan</td>
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<td>does not identify how the facility</td>
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<td>will coordinate with local, state,</td>
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<td>or Federal agencies.</td>
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