STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001073	A. BUILDING 00 B. WING	03/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERPOINTE SURGERY CENTER	500 ARCADE AVE STE 100 ELKHART, IN 46514

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000 Bldg. 00	The visit was for a Licensure survey. Facility Number: 009967 Survey Dates: 3/27-29/17 QA: 5/25/17 jlh	S 0000		
S 0164 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H) 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 interview, the facility failed to provide documentation of a post offer physical on 2 out of 5 PRN (as needed) registered nurses (N1 and N2). Findings include; 1. Review of personnel files indicated staff members #N1 and N2 lacked documentation of a post offer physical.	S 0164	S 164 The two PRN are being contacted for the physical exam and will be completed immediately but will not be allowed to work in the facility until physical is complete. Complete Date: 6/30/2017 Policy II-01 is being amended to include a requirement of a post-offer physical. The policy will be approved by the Board within the	07/22/2017

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

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	2. Requested written policy regarding post offer physicals from P1 Executive Assistant/Human Resource on 03/27/17 at 3:40 pm and again on 03/29/17 at 11:00 am. 3. Interview with P1 Executive Assistant\Human Resources on 03/29/17 at 11:30 am confirmed that 2 out of 5 PRN nurses (N1 and N2) did not have a post offer physical in their personnel file. No other documentation was offered.		next 30 days. The Executive Assistant/ Human Resources and Pre-Op Supervisor will monitor that all new hires will be offered the physical. The Employee Checklist will be completed to indicate the physical was offered. Complete Date 7/22/2017	
S 0226 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3) The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following: (3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided. Based on document review and interview, the center failed to maintain a list of all contracted services, including the scope and nature of services	S 0226	S 226 The vendor list has been updated to	06/30/2017

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	provided, for 1 contracted service. Findings include: 1. Review of the Contracted Vendor Listing 2017 provided by the Executive Assistant, staff A2 lacked documentation indicating a medical record (MR) reviewer was utilized at the center. 2. Review of the Medical Quality Improvement Committee (MQIC) minutes dated 4-19-16 included documentation indicating a review of MR was performed by the MR reviewer, CS15 and a review of MQIC minutes dated 1-19-17 indicated a review of MR was performed by the MR reviewer, CS16. 3. On 3-29-17 at 1545 hours, the Executive Assistant, staff A2 confirmed the Contracted Vendor Listing failed to indicate the name of the current MR reviewer and had not been maintained.		include the medical record reviewer (MR). The Business Manager and Materials Manager are responsible for monitoring the list and will check it monthly for compliance but will be modified promptly upon any changes. Complete Date 6/30/17	
S 0310 Bldg. 00	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:			

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	(1) All services, including services furnished by a contractor. Based on document review and interview, the governing body failed to ensure that all contracted services were evaluated through its Quality Improvement (QI) program for 6 contracted services (medical records (MR), general facility maintenance, patient transfers, pharmacy, radiology, and sterilization services). Findings include: 1. Review of the policy/procedure Outside Service Agreements (approved 7-16) indicated the following: "Riverpointe Surgery Center will review the performance of each outside vendor to evaluate the agreed upon performance ..." 2. Review of the document titled Outside Service Contract Evaluation Summary 2016 observed in the 1-19-17 Medical Quality Improvement Committee (MQIC) meeting minutes lacked documentation indicating a review of the MR reviewer, CS16 was performed. The Outside Service Contract Evaluation Summary identified the individual services of General Facility Maintenance, Patient Transfer Services, Pharmacy	S 0310	S 310 All categories of vendors have been added to an updated list along with a checklist for quality measures being used. The vendor review will be completed by July 10. OR Supervisor and QI and Regulatory Manager are responsible for monitoring that appropriate performance of the vendors is reviewed in accordance with the policy. Complete Date 7/10/17	07/10/2017

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	Services, Radiology Services and Sterilization Services provided by the host hospital and no documentation of the quality indicators for evaluating each service or the quarterly assessments performed for each service were identified. 3. On 3-29-17 at 0945 hours, the Executive Assistant, staff A2 confirmed the Outside Service Contract Evaluation Summary failed to indicate the name of the current MR reviewer, the quality indicators used to evaluate each hospital-based service, or the quarterly results of performance assessments for each hospital-based service and confirmed no other documentation was available.			
S 0432 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii) 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: (iii) Cleaning, disinfection, and sterilization.			

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	Based on document review, observation, and interview, the infection control (IC) program failed to maintain its policy/procedures for operating room (OR) cleaning and ensure that surgery cleaning and disinfecting was consistently performed in a manner to assure a safe and healthful surgical environment for patients and center personnel. Findings include: 1. The Association of PeriOperative Nurses (AORN) Recommended Practices for Environmental Cleaning (2015) indicated the following: "Alcohol should not be used to disinfect large environmental surfaces... A multidisciplinary team should designate personnel responsible for cleaning perioperative areas and equipment... Disinfectants should be applied and reapplied as needed, per manufacturers' instructions, for the dwell time indicated... Sterile processing areas should be terminally cleaned... sterile processing areas where decontamination occurs have some of the highest risks for environmental contamination of all perioperative areas... All work surfaces and high-touch objects should be cleaned with an EPA-registered disinfectant and a clean-low-linting cloth... Cleaning should	S 0432	S 432 Policies IE-002, IT-001 and IH-02 were adopted or amended on April 24, 2017 based on AORN Standard 2015 Edition. All areas have been cleaned in accordance with the policies as of March 29, 2017. The Housekeeping Supervisor was trained on the standards on March 31, 2017 by OR Supervisor. The OR Supervisor rounds once a month to confirm compliance with the standards. Any deficiencies are identified and logged and the Manager is notified by the OR Supervisor. Complete Date 4/24/2017	04/24/2017

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	progress from clean to dirty areas. Cleaning should progress from top to bottom areas... All high touch objects, in addition to objects cleaned as part of routine cleaning, should be cleaned and disinfected as part of enhanced [terminal] environmental cleaning... Policies and procedures... should include identification of responsible personnel [and] cleaning chemicals, materials, and equipment approved for use... Process monitoring must be a part of every perioperative setting... Process monitoring should include... cleaning procedures [and] monitoring cleaning and disinfection practices... Cleaning practices should be measured with qualitative measures (eg., visual observation of cleaning process, visual inspection of cleanliness, fluorescent marking) ... Completion of terminal and scheduled cleaning should be documented on a checklist or log ... Checklists that outline the health care organization's cleaning procedures guide cleaning personnel in performing terminal and scheduled cleaning procedures..." 2. The Infection Control policy/procedure titled Housekeeping / Sanitation (approved 7-16) indicated the following: "For terminal cleaning, mechanical friction and a disinfectant			

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	approved for use at RPSC (Riverpointe Surgery Center) will be used to clean equipment and areas... All areas and equipment will be cleaned according to an established routine and as contracted with [the host hospital] Housekeeping Department. Areas that are cleaned daily... include: Pre-Op Unit, PACU, Phase II Recovery, Decontamination Room, Clean/Pack/Prep Work Room..." 3. On 3-28-17 at 1545 hours, the OR Supervisor, staff A3 confirmed the Housekeeping / Sanitation policy procedure lacked documentation indicating the IC-approved cleaning and disinfecting products to be used including the surfaces, equipment, areas, and occasions for use and lacked documentation clearly indicating the center staff responsibilities and the contracted service staff responsibilities for cleaning perioperative areas. 4. On 3-28-17 at 1415 hours, the OR Supervisor, staff A3 confirmed the Housekeeping / Sanitation policy procedure listing of the areas to be cleaned daily indicated the Decontamination Room prior to the Clean/Pack/Prep Work Room and failed to assure that daily cleaning will occur from least contaminated to most contaminated areas in accordance with			

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	the AORN guidelines. The OR Supervisor, staff A3 confirmed no checklist for center and/or contracted housekeeping personnel was currently in use for staff to confirm the equipment, areas and order for cleaning was performed per IC program and AORN recommendations. 5. During a tour on 3-28-17 at 1241 hours of the restricted surgery area, in the company of the OR Supervisor, staff A3, the presence of dust was identified on the horizontal surface of the door opener above the doorway between the Pre-Op Unit and the surgery areas. 6. During a tour on 3-28-17 at 1244 hours and 1252 hours of the restricted surgery area, in the company of the OR Supervisor, staff A3, the presence of dust was identified on the lower horizontal surfaces of the anesthesia equipment in OR Room #1 and OR Room #2. 7. During a tour on 3-28-17 at 1256 hours of the restricted surgery area, in the company of the OR Supervisor, staff A3, the presence of dust was identified on the horizontal surface of the door opener above the doorway between the Post-Op Unit and the surgery areas. 8. The above was confirmed by staff			

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	member #A3 at time of observation.			
S 0442 Bldg. 00	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 interview, the facility failed to follow policy II-001 Immunization Program, last revised 10/16, regarding the completion of immunizations on 1 out of 5 PRN (as needed) registered nurses (N5). Findings include: 1. Review of policy II-001 Immunization Program, last revised 10/16, page 1, #4. "Any new hired employee will need to bring in proper documentation that proves immunity to Rubella, Rubeola, and Varicella prior to the start date. All	S 0442	S 442 N5 personnel was identified and sent for immunization March 30, 2017. Executive Assistant/Human Resources and Pre-Op Supervisor are responsible for monitoring compliance with the policy and the Employee Checklist has been amended to include immunizations. No personnel will be allowed to work in the Facility unless completed.	03/30/2017

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	documentation must be in place prior to start date." 2. Review of personnel files lacked documentation of Rubeola immunity on 1 out of 5 PRN (as needed) registered nurses (N5) who was hired on 12/19/16. 3. Interview with P1 Executive Assistant/Human Resources on 03/27/17 at 11:50 am confirmed the immunization was not documented in personnel file for N5. No other documentation was offered.		Complete Date 3/30/2017	
S 0664 Bldg. 00	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 interview, the facility failed to ensure that an operative note was written or dictated immediately following surgery per policy in 2 of 12 (PT#11 and PT#12) medical	S 0664	S 664 The Facility has issued a memo to all physicians reminding them of the	06/30/2017

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	records. Findings include; 1. Review of policy AM-03 last revised 7/16, page 2. G. states "Operative reports shall be written (or dictated) immediately following surgery, the report promptly signed by the surgeon, and made a part of the current medical record." 2. Review of medical record PT#11 and PT#12 revealed a post-operative note dictated on 12/16/16 with a procedure date of 12/14/16 in both medical records. 3. Interview with P3 PACU Charge RN on 03/28/17 at 4:50 pm confirmed dictation completed 48 hours post procedure for PT#11 and PT#12. No other documentation was offered.		deadlines and possible sanctions if they fail to comply. The Facility has also adopted a new tracking spreadsheet to monitor compliance with the medical record deadlines. Business Manager is responsible for monitoring compliance. The tracking report will be presented to the MQIC quarterly and to the Board. Any physician who fails to meet the deadlines will be contacted by the Facility and be subject to sanctions under the Medical Staff Bylaws. Complete Date 06/30/17	
S 0672 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13) All patient records must document and contain, at a minimum, the following: (13) A copy of the transfer form, if the patient is referred to a hospital or other facility.			

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	Based on document review and interview, the facility failed to follow policy regarding the completion of a transfer form on 1 of 2 (PT1) transferred from the facility. Findings include; 1. Review of policy CT-01, last revised 4/14, page 1. Procedure #5. "A Hospital Transfer Form will be completed by the RN (registered nurse) documenting the patient's status and will serve as a communication tool for the receiving hospital." 2. Review of medical record PT#1 lacked documentation of a transfer form. 3. Interview with P1 Executive Assistant/Human Resources, P3 PACU Charge RN and P4 Pre-op Charge RN on 03/28/17 at 12:30 pm, confirmed lack of transfer form on medical record. No other documentation was offered.	S 0672	S 672 PACU Supervisor conducted an inservice/meeting on 4/30/17 with staff regarding the transfer form requirement. The PACU Supervisor is responsible for monitoring compliance with this policy. Complete date 4/30/2017	04/30/2017
S 0772 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M) These bylaws			

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	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 document review and interview, the facility failed to ensure a History and Physical was on the medical record for 1 of 12 patients (PT#9). Findings include; 1. Review of policy AM-03, last revised 7/16, page 1. B. states "Reports, histories, and physicals, progress notes, lab reports, x-rays, operative reports, and other patient information shall be incorporated	S 0772	S 772 A memo to physician staff was issued addressing the requirement under Policy AM-03. The Pre-Op staff was educated on the Policy on 6/3017, patients will not be allowed back for surgery unless the record shows a history and physical dated within 30 days. In order to ensure ongoing compliance with the Policy (specifically the	06/30/2017

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	into the record in a timely manner." 2. Review of medical record PT#9 lacked documentation of a history and physical. 3. Interview with P1 Executive Assistant/Human Resources, P3 PACU Charge RN and P4 Pre-op Charge RN on 03/28/17 at 12:30 pm confirmed lack of history and physical documented on medical record for PT#9. No other documentation was offered.		history and physical) medial record quarterly audits by external auditor will be completed and the audit results will be discussed at the quarterly MQIC meeting. Pre-Op Supervisor is responsible for ensuring compliance with this Policy at facility. A copy of the Memo to physicians, monitoring report and medical record audit tool are attached. Complete date 6/30/2017	
S 0784 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(P) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (P) A requirement that the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge. Based on document review and interview, the facility failed to ensure completion of medical records within 30 days per policy in 2 of 12 (PT#11 and	S 0784	S 784 A memo to the physician staff was sent addressing	06/30/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	PT#12). Findings include; 1. Review of policy AM-03 last revised 7/16, page 5. B. states " ...the authentication shall not exceed 30 days from the date of procedure." 2. Review of medical record PT#11 and PT#12 revealed post-operative notes dictated on 12/16/16 with a procedure date of 12/14/16 authenticated on 01/18/17 in both medical records. 3. Interview with P3 PACU Charge RN on 03/28/17 at 4:50 pm confirmed dictation authenticated greater than 30 days after procedure for PT#11 and PT#12. No other documentation was offered.		Policy AM-03, specifically the requirement that the medical records be completed within 30 days. To ensure that the medical records are complete within 30 days the Business Manager will require every record be reviewed to ensure compliance and an Incomplete Chart Report will be printed and reviewed. Also, the facility will have medical records audited quarterly for compliance. Complete date 6/30/2017	
S 1162 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(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:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001073	A. BUILDING 00 B. WING	03/29/2017

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	(4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: Based on document review, observation and interview, the facility failed to ensure all patient care equipment was maintained in accordance with the manufacturer's recommendations for one cardiac defibrillator in use at the center. Findings include: 1. Review of the Zoll Medical Model M Series Operator's Guide (revised 10-2010) indicated the following: "Zoll recommends battery replacement every eighteen months or sooner." 2. During a tour on 3-28-17 at 1258 hours, in the company of the OR (operating room) supervisor, staff A3 the Zoll Model M Defibrillator battery was observed with an in-service date of 9-10-10 date and the spare battery in the Zoll battery charger was observed with an in-service date of 12-20-10. 3. On 3-29-17 at 1015 hours, the OR supervisor, staff A3 reviewed the Zoll Model M Operator's Guide recommendations for battery replacement and confirmed the defibrillator batteries	S 1162	S 1162 Batteries replaced on March 30, 2017. OR Supervisor is responsible for compliance and the dates were added to the crash-cart checklist. Complete Date 6/30/17	06/30/2017

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	observed on tour had not been maintained in accordance with the manufacturer's recommendations.			
S 1196 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAc 15-2.5-7(c)(5) (c) A safety management program must include, but not be limited to, the following: (5) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with center policy and state and local regulations.			
	Based on document review and interview, the safety program failed to ensure that periodic fire inspections were conducted at the facility. Findings: 1. Review of center safety documentation indicated the most recent State and/or local fire inspection was performed on 7-22-15. 2. On 3-27-17 at 1305 hours, the Director of Engineering Services, staff A8 confirmed the most recent fire inspection was conducted in 2015 and confirmed that no documentation requesting an inspection from fire officials in 2016 or 2017 was available.	S 1196	S 1196 Facility has requested fire inspection by local fire inspector. The regulatory and QI Manager is responsible for enforcement and monitoring. Completion date July 22, 2017.	07/22/2017

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	15C0001073	A. BUILDING 00 B. WING	03/29/2017

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