DEPARTMENT OF HEALTH AND HUMAN SERVICES

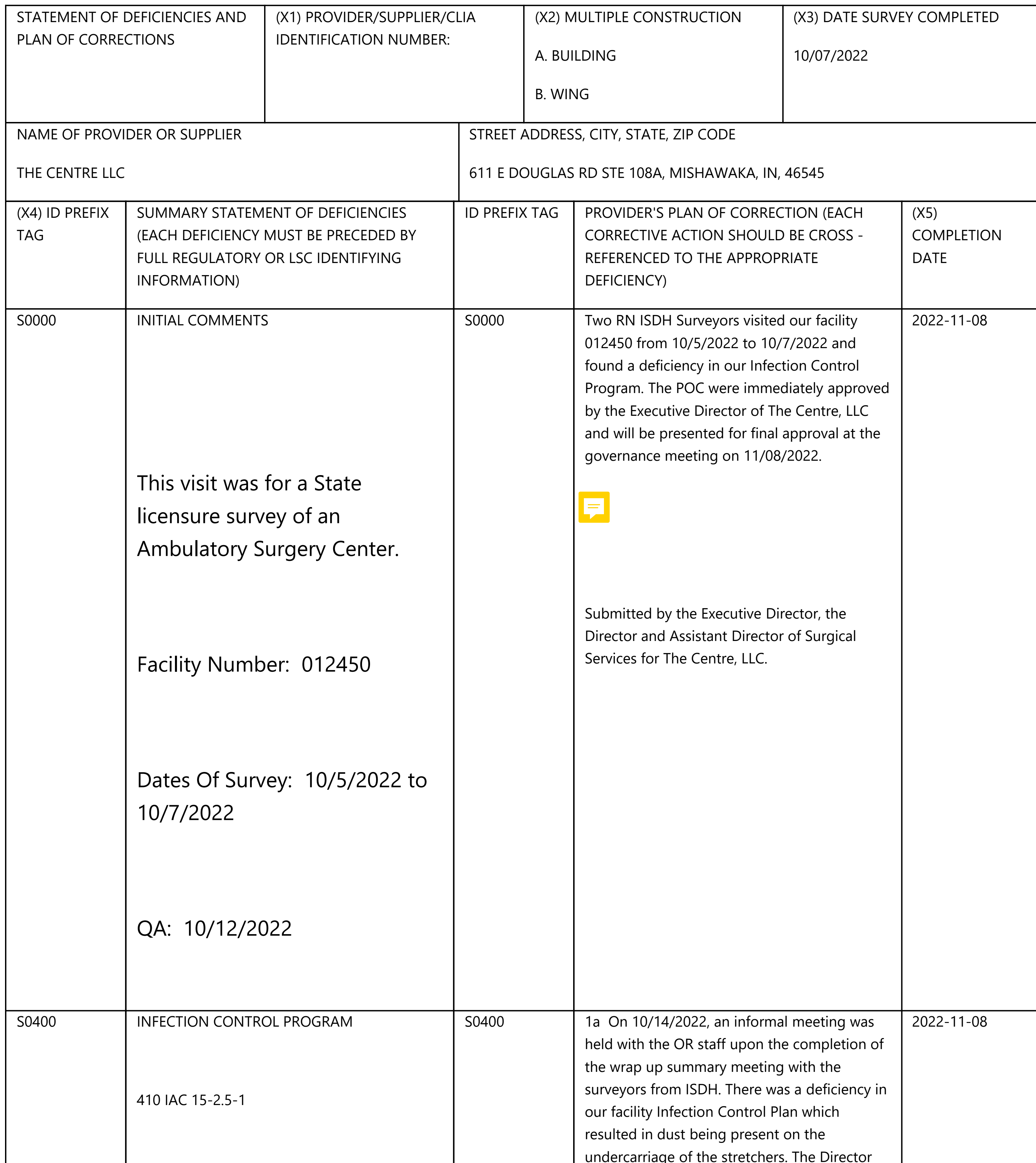
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CENTRE LLC	611 E DOUGLAS RD STE 108A, MISHAWAKA, IN, 46545



(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	INITIAL COMMENTS This visit was for a State licensure survey of an Ambulatory Surgery Center. Facility Number: 012450 Dates Of Survey: 10/5/2022 to 10/7/2022 QA: 10/12/2022	S0000	Two RN ISDH Surveyors visited our facility 012450 from 10/5/2022 to 10/7/2022 and found a deficiency in our Infection Control Program. The POC were immediately approved by the Executive Director of The Centre, LLC and will be presented for final approval at the governance meeting on 11/08/2022. Submitted by the Executive Director, the Director and Assistant Director of Surgical Services for The Centre, LLC.	2022-11-08
S0400	INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1	S0400	1a On 10/14/2022, an informal meeting was held with the OR staff upon the completion of the wrap up summary meeting with the surveyors from ISDH. There was a deficiency in our facility Infection Control Plan which resulted in dust being present on the undercarriage of the stretchers. The Director	2022-11-08

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, observation and interview, the facility failed to maintain a sanitary environment in one (1) of three (3) areas toured (Pre/Post Operative Area).

Findings include:

1. The facility policy titled, "ENVIRONMENTAL CLEANING", no policy number, indicated patient care equipment throughout the facility including pre/post operative areas will be maintained in a state of cleanliness. Pre/Post Operative areas to include all stretchers will be cleaned with a germicidal solution between patients. All horizontal surfaces

and Assistant Director of Surgical Services updated the Cleaning List to include the End Of Shift Stretcher Cleaning which entailed not only the bed but the rails, under storage, hydraulic sleeve, and wheels. The Cleaning Checklist was therefore updated on 10/14/2022 as well as the policy and procedure for this activity. This has all currently been approved by the Executive Director of The Centre, LLC and will be presented for final approval at the governance meeting on 11/08/2022.

1b The Cleaning of Non-Critical Equipment whether used or unused was therefore added on 10/14/2022 to to the Daily End of Shift duties to reduce/abate the transmission of infection. This has all currently been approved by the Executive Director of The Centre, LLC and will be presented for final approval at the governance meeting on 11/08/2022.

1c On 10/14/2022 the Policy for Environmental Cleaning (Cleaning Schedule's Form) was updated to state the stretchers (whether used or unused) were to be included in the daily cleaning by either the PACU RN or Late Shift RN staff. This has all currently been approved by the Executive Director of The Centre, LLC and will be presented for final approval at the governance meeting on 11/08/2022.

2 On 10/28/2022 the Executive Director of The Centre, LLC along with the Director of Facilities for The Centre, LLC met via telephone with the Manager of the Medical Office Building and the Owner of the cleaning service to discuss the deficiencies stated by the surveyors from the ISDH. The result of this conversation was a new position for the cleaning company which would be an audit person to weekly police the quality of the cleaning for the entire medical office building. This has all currently been approved by the Executive Director of The Centre, LLC and will be presented for final approval at the

	will be damp dusted. This policy was last revised on 08/17/2022. 2.The facility policy titled, "INFECTION CONTROL PROGRAM", no policy number, indicated the environment will be assessed and maintained for safety and sanitation. This policy was last revised on 08/17/2022. 3. During the facility tour on 10/06/2022 at approximately 10:30 am with administrative staff member A # 1 (Registered Nurse-RN/Assistant Director of Surgical Services/Infection Control Officer), the bottom of the patient transport carts (stretchers) in Bay one and Bay two were observed to have visible wipeable dust. 4. In interview on 10/06/2022 at approximately 11:45 am with administrative staff member A # 1, confirmed the above had visible wipeable dust and needed to be cleaned.		governance meeting on 11/08/2022. 3 In addition to this audit by the cleaning company, the Director and Assistant Director of The Centre, LLC will randomly check and document as of 11/02/2022 twice a week the quality of the internal and external cleaning of all of the stretchers. This has all currently been approved by the Executive Director of The Centre, LLC and will be presented for final approval at the governance meeting on 11/08/2022. 4 On 11/02/2022 the entire staff of the ASC were in-service on the proper procedure for cleaning the stretchers via a demonstration along with a review of the actual updated policies involved. This has all currently been approved by the Executive Director of The Centre, LLC and will be presented for final approval at the governance meeting on 11/08/2022. Submitted by the Executive Director, the Director and Assistant Director of Surgical Services for The Centre, LLC.	

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lain Ruch Downs	Executive Director	11/3/2022 1:48:29 PM