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	15C0001024	A. BUILDING 00 B. WING	10/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON SURGERY CENTER	1011 W SECOND ST BLOOMINGTON, IN 47403

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Q 0000 Bldg. 00	This visit was for a Federal recertification survey of an ambulatory surgery center. Facility number: 005405 Dates: 10/1/18, 10/2/18 and 10/15/18 QA: 10/9/18 and 10/23/18	Q 0000		
Q 0082 Bldg. 00	416.43(b), 416.43(c)(2), 416.43(c)(3) PROGRAM DATA; PROGRAM ACTIVITIES (b)(1) The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC. (b)(2) The ASC must use the data collected to - (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care. (c)(2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time. (c)(3) The ASC must implement preventive strategies throughout the facility targeting			

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

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	adverse patient events and ensure that all staff are familiar with these strategies. Based on document review and interview, the Center failed to follow their Quality Improvement Plan (QIP) by failing to use objective measures to assess, analyze and track quality indicators for 8 of 17 monitors/indicators (biomedical engineering, biohazardous waste, housekeeping, laundry, maintenance, medical records, nursing and discharge) and failed to collect and aggregate data for analysis as per their plan for 1 facility. Findings include: 1. Review of the center's Quality Improvement Plan, approved 12/19/17, indicated the following: A. IV. PURPOSE: i. - A. The Quality Improvement Program (QIP) will use objective measures to assess, analyze and track quality indicators and/or other aspects of performance that the Center establishes or develops to reflect the various processes of patient care and Center operations. ii.- E. A second part of this annual review...Was necessary data available (internally to review the status and externally for comparison?) B. VI. METHODS OF REVIEW:	O 0082	A new system has been implemented to accumulate objective measureable data in order to assess, analyze, and track quality indicators for biomedical engineering, biohazardous waste, housekeeping, laundry, maintenance, medical records, nursing, and discharge as per policy. Please see attached spreadsheet. Director of Surgical Services will be responsible for this correction. The monitoring will be ongoing, quarterly.	10/30/2018

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	i. - B. To ensure appropriate evaluations are conducted, the Quality Improvement process will be designed to follow these steps... ii. - 4. Identify indicators; specific, measurable variable for each aspect of care/service to be monitored. iii. - 5. Pre-establish the thresholds (the beginning point or limit) for indicators that will trigger evaluations. a. Thresholds can be expressed as ratios, percentages, or numbers B. Thresholds should be set based upon research, past practice patterns, or national standards. iv. - 6. Collect and organize the data pertaining to the indicators. a. Data source. b. Sample size/selection. c. Persons responsible for data collection, aggregation and analysis of data. d. Frequency of data collection, aggregation and analysis 2. Review of the document titled Quality Monitoring Elements 2018 indicated the QIP ... lacked documentation of objective measures/"Standard"(s) by which to assess, analyze and track the monitors of biomedical engineering, biohazardous waste, housekeeping, laundry,			

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	maintenance, medical records, nursing and discharge; lacked documentation of what data was to be collected, aggregated and analyzed for the monitors/indicators; and lacked documentation of pre-established thresholds as per their policy. 3. Review of Quality Assurance Committee Meeting minutes dated 7/17/18, 4/24/18, 1/23/18 and 10/24/17 indicated assessments for biomedical engineering, biohazardous waste, housekeeping, laundry, medical records, nursing and discharge were reported with a percentage of compliance, however, the minutes lacked documentation of objective data used/collected to calculate the percentages. 4. On 10/2/18, between approximately 11:30 a.m. and 1:00 p.m., A1, Director of Surgical Services, verified QIP did not have objective measures set to assess, analyze and track quality indicators, nor had the QIP pre-established thresholds for their monitors. A1 further indicated that the percentages reported in minutes were based on subjective reports/observations and that the center did not have documentation of data having been collected and aggregated to support the reported findings.			

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Q 0100 Bldg. 00	416.44 ENVIRONMENT The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. A Recertification Survey was conducted by the Indiana State Department of Health. Bloomington Surgery Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). This facility, located on the first floor of a two story building, was determined to be of Type II (111) construction and was fully sprinklered. The facility was surveyed with NFPA 101, LSC Chapter 21, Existing Ambulatory Health Care Occupancies. The facility has a fire alarm system with duct detectors installed in HVAC ductwork. Based on record review, observation and interview; the facility failed to ensure 2 of 2 fire barriers that separate other	O 0100	1.) HFI (service company) was contacted. The company arrived on 10/25/2018 and in-serviced select staff (Building and Grounds Coordinator and Director of Surgical Services) on the functionality of the fire dampers, also conducted an inspection of the dampers. Moving forward, this inspection will occur every four years. Director of Surgical Services is responsible for this correction. It will be monitored every four years with QA performed on the contracted services. 2.) Admittedly, the second quarter fire drill was inadvertently missed. It has now been added to the Outlook Calendar as a repeat appointment every quarter as to, hopefully, avoid missing again. Director of Surgical Services is responsible for this correction. It will be monitored quarterly via Safety Inspection Form, which is attached. 3.) **Our Monthly Generator Test Report spreadsheet records**	10/25/2018

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	occupancies were protected to maintain the fire resistance rating of the fire barrier (see tag K131), the facility failed to ensure 100 % of fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A (see tag K521), the facility failed to provide documentation of a fire drill conducted on the first shift for 1 of 4 quarters (see tag K712), the facility failed to maintain a complete written record of monthly generator load testing for 12 months of the most recent 12 month period (see tag K918), the facility failed to ensure 1 of 1 piped gas system supply areas was enclosed with a separation of 1 hour fire resistive construction (see tag K923). The cumulative effect of this systemic problem resulted in the facility's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.		**the hour meter time prior to testing and after testing. This measurement shows the 0.5 hours the generator was running for the load test. This is also noted on the Buckeye Power Sales printed report. However, Buckeye has been contacted to add verbiage to the report to clearly state the load test was operated for "30 minutes." Buckeye was also contacted to add the load percentage to the printed monthly report along with the transfer time. Each of these have also been added to the Monthly Generator Test Report spreadsheet located in the Generator Logbook, so they will be documented on this sheet if Buckeye is unable to print on their generated report. The updated spreadsheet is attached. Director of Surgical Services is responsible for this correction. It will be monitored monthly via the spreadsheet.**	
Q 0101 Bldg. 00	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services.			

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	Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on record review, observation and interview; the facility failed to ensure 100 % of fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name	Q 0101	1.) HFI (service company) was contacted and scheduled to in-service select staff (Building and Grounds Coordinator and Director of Surgical Services) on the functionality of the fire dampers and along with an inspection of the dampers. This occurred on 10/25/2018. Moving forward, this inspection will occur every four years. Director of Surgical Services is responsible for this correction. It will be monitored every four years with QA performed on the contracted services. 2.) Our Monthly Generator Test Report spreadsheet records the hour meter time prior to testing and after testing. This measurement shows the 0.5 hours the generator was running for the load test. This is also noted on the Buckeye Power Sales printed report. However, Buckeye has been contacted to add verbiage to the report to clearly state the load test was operated for "30 minutes." Buckeye was also contacted to add the load percentage to the printed monthly report along with the transfer time. Each of these have also been added to the Monthly Generator Test Report	11/12/2018

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	of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all patients, staff and visitors, the facility failed to maintain a complete written record of monthly generator load testing for 12 months of the most recent 12 month period. NFPA 99, Health Care Facilities Code, 2012 Edition, Chapter 6.4.4.1.1.4(A) requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 2010 Edition, Section 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available Emergency Power Supply System (EPSS) load for 30 minutes or until the water temperature and the oil pressure have stabilized. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all patients, staff and visitors in the facility, the facility failed to document the transfer time to the alternate power source on monthly load tests for 12 of the most recent 12 months to ensure the alternate power supply was capable of supplying		spreadsheet located in the Generator Logbook, so they will be documented on this sheet if Buckeye is unable to print on their generated report. The updated spreadsheet is attached. Director of Surgical Services is responsible for this correction. It will be monitored monthly via the spreadsheet. 4.) **Vectren (gas service company) has been contacted, by phone and email 10/22/2018, requesting a Letter of Reliability. Follow- phone call made on 10/25/2018 and 10/29/2018; still awaiting letter. Allowing Vectren two weeks will to submit proper documentation for the gas supply, hopeful to receive such documentation by 11/12/2018.** **Director of Surgical Services is responsible for this correction.** **Monitoring will occur yearly with approval of contracts at end of year Governing Board meeting.**	

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	service within 10 seconds. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.4.1.1.1 states the generator set or other alternate power source and associated equipment, including all appurtenance parts shall be so maintained as to be capable of supplying service within the shortest time frame practicable an within the 10 second interval specified in 6.4.1.1.10 and 6.4.3.1. This deficient practice could affect all patients, staff and visitors, the facility failed to ensure the reliable source documentation for the off site fuel source for 1 of 1 emergency generators included a statement of reasonable reliability of the natural gas delivery, the history and probability of an interruption of service and was signed by a person with the technical expertise to make the reliable source claim. NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems, Chapter 5, Emergency Power Supply (EPS), 5.1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): (1) Liquid Petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of			

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	interruption of offsite fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all clients, staff and visitors. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all patients, staff and visitors. Findings include: 1. Based on record review with the Director of the Surgery Center, the Assistant Director of the Surgery Center			

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	and the Maintenance Assistant from 10:00 a.m. to 2:00 p.m. on 10/15/18, documentation of fire damper inspection and maintenance within the most recent four year period was not available for review. Based on observations with the Director of the Surgery Center, the Assistant Director of the Surgery Center and the Maintenance Assistant during a tour of the facility from 2:00 p.m. to 3:10 p.m. on 10/15/18, two fire dampers held in the fully open position with a fusible link were noted in the tenant separation fire wall on the west side of the facility above the suspended ceiling above the corridor door to the clean utility room. Manufacturer's documentation affixed to each damper did not state the year of manufacture and no testing date documentation was observed affixed to the dampers. Based on interview at the time of the observations, the Director of the Surgery Center the stated they were unaware of the fire damper locations and fire damper inspection and maintenance within the most recent four year period was not available for review. 2. Based on review of Buckeye Power Sales "Order No." documentation, "BuckEye Power Sales Monthly Checklist" documentation, "Monthly Preventive Maintenance Checklist" documentation and "Monthly Test			

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	Report" documentation with the Director of the Surgery Center, the Assistant Director of the Surgery Center and the Maintenance Assistant during record review from 10:00 a.m. to 2:00 p.m. on 10/15/18, monthly load testing documentation for September 2017 through September 2018 did not include if the generator was run for at least 30 minutes or until the water temperature and the oil pressure have stabilized. Based interview at the time of record review, the Maintenance Assistant stated Buckeye Power Sales performs monthly load testing for the facility and agreed the documentation did not include the generator was run for at least 30 minutes or until the water temperature and the oil pressure have stabilized. 3. Based on review of Buckeye Power Sales "Order No." documentation, "BuckEye Power Sales Monthly Checklist" documentation, "Monthly Preventive Maintenance Checklist" documentation and "Monthly Test Report" documentation with the Director of the Surgery Center, the Assistant Director of the Surgery Center and the Maintenance Assistant during record review from 10:00 a.m. to 2:00 p.m. on 10/15/18, monthly load testing documentation for September 2017 through September 2018 did not include			

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	transfer time from normal power to emergency power. Based on interview at the time of record review, the Maintenance Assistant stated Buckeye Power Sales performs monthly load testing for the facility and agreed documentation for monthly load testing for September 2017 through September 2018 did not include transfer time from normal power to emergency power. 4. Based on record review with the Director of the Surgery Center, the Assistant Director of the Surgery Center and the Maintenance Assistant from 10:00 a.m. to 2:00 p.m. on 10/15/18, a reliability letter from the natural gas provider was not available for review. Based on interview at the time of record review, the Director of the Surgery Center stated the fuel source for the emergency generator was natural gas supplied by Vectren via pipeline and agreed a reliability letter from the natural gas provider was not available for review.			
Q 0104 Bldg. 00	416.44(b)(1)-(3) SAFETY FROM FIRE (b) Standard: Safety from fire. (1) Except as			

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	otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served, and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4). (2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. Based on record review, observation and interview; the facility failed to ensure 2 of 2 fire barriers that separate other occupancies were protected to maintain the fire resistance rating of the fire barrier. NFPA 101, 2012 edition, Section 8.3.5.6.1 states membrane penetrations for cables cable trays conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall,	O 0104	**1.)** **a.) The door was left propped open following a wheelchair patient having gone through to exit. The nurse was attempting to maneuver the wheelchair and propped the door open in order to move the wheelchair through. The staff has now been re-educated to the hazards of propping open a fire door. As a group during a staff meeting on 10/22/2018, we have implemented a protocol to have 2 staff members assist all patients in wheelchairs; this will**	10/30/2018

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	floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. Section 8.3.5.6.2 states the firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Test of Through Penetration Fire stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops. In addition, doors are self-closing and are kept in the closed position, except when in use. This deficient practice could affect all patients, staff and visitors, the facility failed to provide documentation of a fire drill conducted on the first shift for 1 of 4 quarters. This deficient practice affects all patients, staff and visitors, the facility failed to document activation of the fire alarm system for first shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 21.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all patients, staff and visitors in the facility, the facility failed to ensure 1 of 1 piped gas system supply areas was		**allow one staff member to assist the patient and one staff member to hold the door open in place of using a door prop. Director of Surgical Services is responsible for this correction. It will be monitored at random and documented quarterly by the Safety Officer on the quarterly Safety Inspection Form which is attached.** **b.) The hole has been patched with fire barrier sealant rated for 4 hours, by Building and Grounds Coordinator. A photograph of the patched hole is attached. Director of Surgical Services is responsible for this correction.** c.) HFI (service company) has been notified regarding the two fire dampers located in the west fire wall. They were scheduled to inspect these dampers and educate select staff members (i.e. Building and Grounds Coordinator and Director of Surgical Services) on the functionality of the dampers as well as conducting an inspection on the dampers. This occurred on Thursday 10/25/2018. Inspection form is attached. Director of Surgical Services is responsible for this correction. This will be monitored as we are adding this to contracted service	

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	15C0001024	A. BUILDING 00 B. WING	10/02/2018

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	enclosed with a separation of 1 hour fire resistive construction. NFPA 99, Standard for Health Care Facilities, 2012 Edition, Section 5.1.3.3.2(4) states locations for central supply systems and the storage of positive-pressure gases, if indoors, shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating. This deficient practice could affect two patients. Findings include: 1. Based on observations with the Director of the Surgery Center, the Assistant Director of the Surgery Center and the Maintenance Assistant during a tour of the facility from 2:00 p.m. to 3:10 p.m. on 10/15/18, the following was noted: a. the corridor door serving as the entrance to the laser work up room from the sterile corridor in the tenant separation fire wall on the west side of the facility was propped in the fully open position with a wedge on the floor under the door. The door was equipped with a self closing device and self closed when the wedge was removed. b. a one inch by one inch hole was noted above the suspended ceiling in the tenant		agreement to be inspected every four years as per regulation. 2.) Admittedly, the second quarter fire drill was inadvertently missed. It has now been added to the Outlook Calendar as a repeat appointment every quarter as to avoid missing again. Director of Surgical Services is responsible for this correction. It will be monitored quarterly via Safety Inspection Form, which is attached. 3.) The surgeon requested to not sound alarm during procedure. This was discussed at the QA/Safety Committee Meeting and Governing Board Meeting on October 23, 2018. The Committee agreed, moving forward, if conducting fire drills during patient care hours, the alarm will be pulled as per regulation however, done in between procedures as to not disrupt the surgeon. The Governing Board approved. Director of Surgical Services is responsible for this correction. 4. **Building and Grounds Coordinator, contacted General Interiors regarding the door closure. It was installed, Friday, October 26, 2018.**	

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	separation fire wall on the east side of the facility in the parlor above where the refrigerator was located. The wall consisted of two layers of 5/8ths inch thick drywall. c. two fire dampers held in the fully open position with a fusible link were noted in the tenant separation fire wall on the west side of the facility above the suspended ceiling above the corridor door to the clean utility room. Based on interview at the time of the observations, the Director of the Surgery Center stated they were unaware of the fire dampers and agreed the aforementioned corridor door in the west tenant separation fire wall did not self close due to being propped open with the wedge and the aforementioned hole in the east tenant separation fire wall did not maintain the fire resistance rating of the tenant separation fire barrier. 2. Based on review of "Fire Drill Check List" documentation with the Director of the Surgery Center and the Assistant Director of the Surgery Center during record review from 10:00 a.m. to 2:00 p.m. on 10/15/18, documentation of a fire drill conducted on the first shift in the second quarter (April, May, June) of 2018 was not available for review. Based on interview at the time of record review, the Director of the Surgery Center stated		**Photograph is attached.** **Director of Surgical Services is responsible for the correction.**	

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	the facility operates one shift per day and agreed documentation of a fire drill conducted on the first shift in the second quarter of 2018 was not available for review. 3. Based on review of "Fire Drill Check List" documentation with the Director of the Surgery Center and the Assistant Director of the Surgery Center during record review from 10:00 a.m. to 2:00 p.m. on 10/15/18, documentation for the first shift fire drill conducted on 03/01/18 at 7:30 a.m. did not verify activation of the fire alarm system and transmission of the fire alarm signal. The aforementioned documentation stated "N/A" in response to "Did all personnel hear the fire alarm?" In addition, the fire drill documentation stated "alarm was tested prior 02/09/18, surgeon requested not to pull/sound alarm." Based on interview at the time of record review, the Director of the Surgery Center stated the facility operates one shift per day, additional fire drill documentation on the first shift in the first quarter 2018 was not available for review, the alarm sounded on 02/09/18 was due to the fire alarm system contractor testing the fire alarm system and agreed documentation for the first shift fire drill conducted on 03/01/18 at 7:30 a.m. did not verify activation of the fire alarm system and transmission of			

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	the fire alarm signal for this fire drill conducted after 6:00 a.m. but before 9:00 p.m. 4. Based on observations with the Director of the Surgery Center, the Assistant Director of the Surgery Center and the Maintenance Assistant during a tour of the facility from 2:00 p.m. to 3:10 p.m. on 10/15/18, the entry door to the piped gas system supply room in the sprinkler riser room was not equipped with a self closing device. Based on interview at the time of the observations, the Director of the Surgery Center agreed the aforementioned door was not self closing in order to provide one hour fire resistive construction for the piped gas system supply room.			
S 0000 Bldg. 00	This visit was for a State licensure survey of an ambulatory surgery center. Facility number: 005405 Dates: 10/1/18 and 10/2/18 QA: 10/9/18	S 0000		

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S 0300 Bldg. 00	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a) (a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the Center failed to follow their Quality Improvement Plan (QIP) by failing to use objective measures to assess, analyze and track quality indicators for 8 of 17 monitors/indicators (biomedical engineering, biohazardous waste, housekeeping, laundry, maintenance, medical records, nursing and discharge) and failed to collect and aggregate data for analysis as per their plan for 1 facility. Findings include:	S 0300	A new system has been implemented to accumulate objective measureable data in order to assess, analyze, and track quality indicators for biomedical engineering, biohazardous waste, housekeeping, laundry, maintenance, medical records, nursing, and discharge as per policy. Please see attached spreadsheet. Director of Surgical Services will be responsible for this correction. The monitoring will be ongoing, quarterly.	10/30/2018

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	1. Review of the center's Quality Improvement Plan, approved 12/19/17, indicated the following: A. IV. PURPOSE: i. - A. The Quality Improvement Program (QIP) will use objective measures to assess, analyze and track quality indicators and/or other aspects of performance that the Center establishes or develops to reflect the various processes of patient care and Center operations. ii.- E. A second part of this annual review...Was necessary data available (internally to review the status and externally for comparison?) B. VI. METHODS OF REVIEW: i. - B. To ensure appropriate evaluations are conducted, the Quality Improvement process will be designed to follow these steps... ii. - 4. Identify indicators; specific, measurable variable for each aspect of care/service to be monitored. iii. - 5. Pre-establish the thresholds (the beginning point or limit) for indicators that will trigger evaluations. a. Thresholds can be expressed as ratios, percentages, or numbers B. Thresholds should be set based upon research, past practice			

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	patterns, or national standards. iv. - 6. Collect and organize the data pertaining to the indicators. a. Data source. b. Sample size/selection. c. Persons responsible for data collection, aggregation and analysis of data. d. Frequency of data collection, aggregation and analysis 2. Review of the document titled Quality Monitoring Elements 2018 indicated the QIP ... lacked documentation of objective measures/"Standard"(s) by which to assess, analyze and track the monitors of biomedical engineering, biohazardous waste, housekeeping, laundry, maintenance, medical records, nursing and discharge; lacked documentation of what data was to be collected, aggregated and analyzed for the monitors/indicators; and lacked documentation of pre-established thresholds as per their policy. 3. Review of Quality Assurance Committee Meeting minutes dated 7/17/18, 4/24/18, 1/23/18 and 10/24/17 indicated assessments for biomedical engineering, biohazardous waste, housekeeping, laundry, medical records, nursing and discharge were reported with a percentage of compliance, however, the			

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	minutes lacked documentation of objective data used/collected to calculate the percentages. 4. On 10/2/18, between approximately 11:30 a.m. and 1:00 p.m., A1, Director of Surgical Services, verified QIP did not have objective measures set to assess, analyze and track quality indicators, nor had the QIP pre-established thresholds for their monitors. A1 further indicated that the percentages reported in minutes were based on subjective reports/observations and that the center did not have documentation of data having been collected and aggregated to support the reported findings.			