STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001168	A. BUILDING 00 B. WING	05/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS MOORESVILLE SURGERY CENTER LLC	1215 HADLEY RD STE 100 MOORESVILLE, IN 46158

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S 000 Bldg. 00	This visit was for a State licensure survey. Facility Number: 012149 Survey Date: 5/26/2015 through 5/28/2015 QA: cjl 06/05/15	S 000		
S 400 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation and interview, the facility failed to minimize infection exposure and risk to patients and staff with the safe handling of IV (intravenous) supplies used for facility patients. Findings included:	S 400	Response: Staff has been educated on cross contamination in relationship to placing the IV caddy on the floor, then the bed and then the nurses' station desk, followed eventually by placing the caddy in the cabinet for storage. They have been instructed to wipe the caddy off with a wipe between uses.	06/02/2015

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

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	1. During the case observation on 05/27/15, beginning at 11:50 AM, the following observations were made while watching the patient being prepared for surgery: A. Staff member A8, an RN (Registered Nurse), brought a plastic caddy containing IV supplies: angiocaths, tourniquets, alcohol swabs, tape, into the patient's room and placed the caddy on the floor while he/she attempted to start an IV in the left hand. B. Staff member A8 placed the caddy on the cart touching the patient's leg. C. Staff member A8 placed the caddy on the other side of the cart touching the patient's other leg. D. Staff member A8 placed the caddy on the counter in the room. E. Staff member A8 placed the caddy on the counter of the nurses' station. F. Staff member A8 brought the caddy back into the patient's room for anesthesia to start the IV and placed the caddy on the table. G. Staff member A8 returned the caddy to the counter of the nurses' station. H. Another staff member refilled the supplies used from the caddy, then placed it into a cabinet, along side other caddies, at the nurses' station. I. The outside of the caddy was never cleaned or wiped with any disinfectant		Changes: The staff will be wiping off the IV Caddy after each use. Approval: No approval needed for this deficiency Prevention: Monitor for 1 year to ensure change in habit and report to the MAC & Board through the Quality Dashboard. Monitoring will be done on random observations. Responsibility: Director of the Center	

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	wipes. 2. At 11:55 AM on 05/28/15, the observations were discussed with staff member A1, the facility director, and staff member A6, the Patient Care coordinator and Infection Control Nurse, and both confirmed the process with the IV caddies could place patients and staff at risk for cross contamination and infection exposure.			
S 672 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. Based on policy and procedure review, medical record review, and interview, the facility failed to accurately and completely document in the medical record for two of two patients who were transferred to a higher level of care (#P15 and P16). Findings included: 1. The facility policy "Transfer of Patient	S 672	Response: Transfer forms have been changed to be more specific to the ASC setting. Additionally, the edits to the Transfer Form will make it easier to complete. Staff will be educated in the use of these forms. The Transfer Policy will also be changed to better reflect the procedure of transferring a patient to the hospital. Additionally, staff education has already happened through a staff meeting. The	06/12/2015

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	to Another Facility", last reviewed 03/03/2014, indicated, "V. Procedure: A. A physician's order and completion of the 'Authorization for Transfer' form (#11-11313) is required to transfer a patient to [hospital], another St. Francis campus or another facility. B. The transferring physician will: a) Write the discharge order (may be RVVO) [read and verified verbal order]. b) Complete and sign the 'Authorization for Transfer' form (#11-111313) (may be RVVO). c) Identify and communicate with the physician accepting the patient at the new location. d) Dictate a STAT discharge summary. ...D. The nurse will: a) Call the receiving unit to verify bed availability and readiness. Inform the unit of equipment and/or special needs (i.e. ventilator, isolation, etc.). b) Inform the patient and family or significant other of the transfer. ...d) If necessary, arrange method of ambulance transportation to best meet patient condition, monitoring, and equipment needs. ...f) Complete all discharge paper work. g) Call the receiving unit to give nurse-to-nurse report. At a minimum, the report should contain the following information to aid in smooth and safe continuation of the patient's care. Summary of the patient's current medical status including: admission date, medical/surgical history, physical and mental condition, venous		physicians will be educated on the findings regarding documentation through a letter. Changes: The Transfer Form and the Transfer Policy will be changed to be more specific to the Center and better reflect the process. Approval: MAC & Board approval are required for the Transfer Form and the Transfer Policy. Prevention: This deficiency will be prevented through the simplification of the Transfer form, education to staff and physicians and revision of the Transfer Policy. Additionally, a transfer audit form has been created and the audits will be reported on the Quality Dashboard for 1 year to ensure proper completion of records. Responsibility: Director of the Center	

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	access, equipment and monitoring needs, etc. Reason for transfer. Allergies." 2. The facility policy "Medical Records", last reviewed 03/03/2014, indicated, "Contents of the Medical Record: ...14. Justify the treatment. 15. Provide accurate documentation in order to follow the course of the patient's stay in the Center with documented results. ...18. Copy of Transfer Form if patient is transferred to a hospital or other facility." 3. The medical record for patient P15, who had a procedure on 04/30/15, indicated an incomplete Post Operative Physician Orders form. The Post-Operative Assessment form was marked as "released to home via wheelchair", but those areas were scribbled over and "nursing unit via cart" was written in. The form indicated report was called to nurse unit at 1604 hours and the patient left at 1606 hours, but the form lacked any documentation of what precipitated the change from home to transfer. The Authorization for Transfer form lacked any documentation indicating the receiving facility and the risks of transfer. The record also lacked any discharge summary or physician progress note documenting the course of treatment or reason for transfer.			

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	4. The medical record for patient P16, who had a procedure on 04/30/15, indicated a Post-Operative Assessment form which was marked as "released to home via wheelchair at 1430 hours", but nursing documentation at 1400 hours indicated report was called to the nursing unit for the patient to be transferred. The Authorization for Transfer form lacked any documentation indicating the transferring facility and the benefits of transfer. The record contained a Short Stay Discharge Summary form, signed by the physician at 9:30 AM, indicating the patient was stable on discharge and would be seen in one month, but the record lacked any physician progress note indicating the patient was subsequently transferred or the reason for the transfer. Nursing documentation also lacked any notation regarding the course of treatment or reason for transfer. 5. At 11:30 AM on 05/28/15, the medical records were reviewed with staff member A1, the facility director, who confirmed the incomplete documentation to determine the course of treatment and reason for transfer for patients P15 and P16.			
S 164 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE,			

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	410 IAC 15-2.5-7(b)(4)(B)(i) (b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.			
	Based on documentation review, observation, and staff interview, the facility failed to ensure the defibrillator had the required charged spare battery available for the one defibrillator that was onsite. Findings included: 1. St. Franciscan Mooresville Surgery Center has one defibrillator. The defibrillator operator's manual indicated the	S 164	Response: A battery, charger, adapter kit was ordered on May 27, 2015. The kit was received on June5, 2015 and installed/charged on June 8, 2015. Revisions to the Defibrillator Policy & Procedure were made to reflect the additional battery. Changes: The Defibrillator Log will show the manufacturer's date/# on the strip to reflect which battery was used during the check made on the days the Center is open. The policy will be changed to show how the additional battery will be checked in the daily routine. Approval: The MAC & Board will need to approve the policy change. Prevention: Ordering the additional	06/09/2015

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	defibrillator should have another battery that was fully charged available to the staff if needed. 2. At 10:30 AM on 5/28/2015, the facility was walked through with staff member #8 (Register Nurse Pre/Post) and could not locate another battery for the defibrillator the facility has. 3. At 11:00 AM on 5/28/2015, staff member #1 (Director) indicated the surgery center does not have a spare battery for the defibrillator that facility has.		battery and implementing the checks on 2 batteries rather than 1 will prevent this deficiency from happening again. Responsibility: Director of the Center	