PRINTED: 01/07/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001047	(X2) MU A. BUII B. WIN	DING	ONSTRUCTION  00	(X3) DATE COMPL 11/15/	ETED
	PROVIDER OR SUPPLIE			1900 C	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD		
WHITEW	ATER SURGERY			RICHIVI	OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
Q0000		, , , , , , , , , , , , , , , , , , , ,					
	This visit was for survey.	or a re-certification	O00	00			
	Facility Number	r: 001222					
	Survey Date: 1	1-13/15-12					
	Surveyors: Jack I. Cohen, N	ИНA					
	Medical Survey	or					
	John Lee, RN Public Health N	urse Surveyor					
	QA: claughlin	11/26/12					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001222

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  15C0001047	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/15/2012
	PROVIDER OR SUPPLIER  VATER SURGERY CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD OND, IN 47374	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Q0082	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 adverse patient events and ensure that all staff are familiar with these strategies.  Based on document review and interview, the facility failed to ensure 1 (transcription) directly provided service was included in the facility's quality assessment and performance improvement (QAPI) program.  Findings:  1. Review of the facility's QAPI indicated it did not include monitors and standards for the directly provided service of transcription.	O0082	The dashboard used to docunthe quality indicators did not include our in-house transcript service. This was added and standards set. The Surgery Center Manager is responsible implementing and monitoring QAPI projects on a quarterly basis	tion the e for

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		IDENTIFICATION NUMBER:  15C0001047	A. BUILDING  B. WING	00	COMPLETED  11/15/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD	
WHITEW	ATER SURGERY C	CENTER		OND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		on 11-15-12 at 2:15 pm,			
		onfirmed the above and			
	no further docum prior to exit.	nentation was provided			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		15C0001047	B. WIN			11/15/	2012
	PROVIDER OR SUPPLIER		•	1900 CI	ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD OND, IN 47374		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Q0083	PROJECTS (1) The number a improvement proj must reflect the sca ASC's services are (2) The ASC must that are being cordocumentation, a the reason(s) for and a description Based on documentation facility failed data of the correct an identified project entitled project entitled For Through Pridings:  1. Review of a project entitled For Through Pridings action taken will month, 6 month a determine if an immade in the compincrease in physical screported by or indicated as a corseptember 2012	t document the projects inducted. The taminimum, must include implementing the project, of the project's results ent review and interview, I to produce objective ective action and results to blem through a provement project.  Derformance improvement ROTATION OF STAFF MARY CARE, started in eated this [results of the I be monitored at 3 and 12 month intervals to improvement has been petence in the OR and an incian confidence in staff real recognition. It further inclusion to the project, - a re-evaluation of the vis. the primary nursing	000	083	The WSC policy now includes clear instruction for the surgery manager, or whoever is performing QA studies to obtain documented objective data to support findings in a QA study. The Surgery Center Manager is responsible for implementing correct procedure for performing QA studies and monitoring and reviewing the QAPI projects when they are completed or annually for compliance with the policy and procedure for corect collection of data.	in .s ng d	11/19/2012

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL		
		15C0001047	A. BUI. B. WIN			11/15/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WHITEW	ATER SURGERY (	CENTER			HESTER BLVD OND, IN 47374		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		w of the project indicated cumented objective data					
	to support the co	_					
	to support the eo	merusion.					
	3. In interview,	on 11-14-12 at 10:50 am,					
	employee #A1 ii	ndicated the project was					
	_	ise the module practice,					
		e previous primary					
	_	esulted in an increase in					
		ence in staff as reported on. The employee was					
		vide documentation of					
		support the conclusion					
	-	ata was provided prior to					
	exit.	• •					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15C0001047	B. WIN		<del></del>	11/15/	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				HESTER BLVD		
WHITEW	ATER SURGERY (	CENTER			OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Q0103	MAINTENANCE [The ASC must posanitary environments surgical services.] The ASC must estidentifying and promaintaining a same reporting the result authorities. Based on document and interview, the its policy/proced. Trash in one observing includes.  I. Review of policy and indicated to proper disposal of the patient and an area of the patient and an area of the patient and and an area of the patient and and the trash bags and the taking the trash to with a knot.  J. Bags are then into larger bags to transport to the total services.	stablish a program for eventing infections, nitary environment, and alts to appropriate  ent review, observation he facility failed to follow ture of the Disposal of ervation.  Example 1 is a control of the following: licy of the center is to and safe environment. For waste, excluding his important to the safety dinfection control is confined by the use of the cans are emptied by the cans are emptied by the control of the cans are emptied by the control of the cans are emptied by the cans are emptied by the control of the control of the control of the cans are emptied by the control of the control of the control of the cans are emptied by the control of the control of the cans are emptied by the control of t	O01	03	The WSC policy has been revised to state regular trash who confined to plastic trash bat that are secured at the top and may be put into larger bags for easier transport to the outside dumpster at the close of the da Regular trash accumulated duthe course of the day will be stored in secured bags on top or beside closed biohazard tracontainers. The regular trash not to be mixed in the same bat or same container as biohazar trash/waste and is to be dispos of in the sanitation department dumpster. Biohazard trash/wasis picked up by a contracted company specializing in biohazard disposal. The Surge Center Manager is responsible implementing and monitoring frompliance of trash disposal. Random inspections will be materially be surgery Manager of weekly basis to insure compliance.	gs d ay. ring of sh is ag d sed 's este ery e for ade	11/16/2012

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		15C0001047	B. WIN			11/15/	2012
	PROVIDER OR SUPPLIER			1900 CH	DDRESS, CITY, STATE, ZIP CODE HESTER BLVD DND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	area on 11-13-12 #40 the followin 6 large bags of the substerile hallwat touching open shaterile and clean 3. On 11-13-12 a confirmed that the rooms is usually substerile hallwaterile hal	rash on the floor in the cy. 2 bags of trash were nelves that contained					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DINC	00	COMPL	ETED
		15C0001047	A. BUII B. WIN			11/15/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HESTER BLVD		
WHITEW	ATER SURGERY (	CENTER			OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Q0162	The ASC must meach patient. Ever accurate, legible, Medical records of following:  (1) Patient ide (2) Significant of physical exami (3) Pre-operat (entered before see (4) Findings and operation, including all tissues remove those exempted before see (5) Any allerging reactions.  (6) Entries related administration.  (7) Documentation informed patient of (8) Discharge Based on document the facility failed record (MR) continuous information to just 16 cataract MRs 6, 9, 10, 11, 12, 27, and 30).  Findings included 1. Review of pat 12, 13, 17, 18, 22, MR indicated ear medication drops.	medical history and results nation. ive diagnostic studies urgery), if performed. Ind techniques of the ing a pathologist's report on ed during surgery, except by the governing body. It is an abnormal drug attention of properly executed consent. It diagnosis. It is ensure the medical intained sufficient in 16 of reviewed (Patient #1, 4, 13, 17, 18, 21, 22, 24, 26, 15).	O01	62	The process to update the physicians orders in a compute software program is being completed at this date. Until the revised orders are on the charwith explicit orders for Proparacaine drops prior to the instillation of other drops, the current orders will be corrected and signed by the physician. Surgery Manager is responsible for implementing the change be contact with the physicians to review and revise their orders accuracy and monitoring the completion of the the project be weekly contact with the physicito assess project completion.	ne t e d The le ly for	12/05/2012

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001047	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM 11/1	TE SURVEY TPLETED 15/2012
	PROVIDER OR SUPPLIER VATER SURGERY CENTER	1900 C	ADDRESS, CITY, STATE, ZIP CO HESTER BLVD OND, IN 47374	ODE	
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	administer the Proparacaie medication drops.				
	2. On 11-15-12 at 1105 hours, staff #40 confirmed there was no physician's order in patient #1, 4, 6, 9, 10, 11, 12, 13, 17, 18, 21, 22, 24, 26, 27 and 30's MRs to administer Proparacaine medication drops.				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		15C0001047	B. WIN			11/15/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				HESTER BLVD		
\ <b>\/UIT</b> E\ <b>\</b>	ATER SURGERY (	CENTED			OND, IN 47374		
VVIII I I I VV	AIER SURGERT	CENTER		KICHIVI	OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Q0221	patient's represer written notice of the advance of the de language and ma patient's represer Based on docum the patient rights their representation writing prior to serequired element.  Findings:  1. Review of a de Rights and Responsariation of the physical prior to surgery, patient right of in names of the physical prior to surgery. Eye Center, LLC interest or owner.  2. In interview, employee #A1 celement was not rights given to the representative very prior to surgery.	ovide the patient or the ntative with verbal and he patient's rights in ate of the procedure, in a more that the patient or the ntative understands. The patient or the ntative understands are treview and interview, a given to the patient or two verbally and in surgery lacked 1 of 13 is.  Idocument entitled Patient consibilities, Notice of an to the patient or their erbally and in writing did not contain the including the specific visician's of Whitewater C, who have a financial riship in the facility  on 11-15-12 at 3:15 pm, confirmed the above included in the patient are patient or their erbally and in writing	O02	221	Patient Rights given to the pat or representative prior to surge now clearly names the physici with a financial interest. The Surgery Center Manager is responsible for implementing to change by personally rewriting the document given to the patients and randomly monitor the accuracy of the Patient's rights being given to patients to requesting a copy of the document from the check in debiennially.	ery ans his J ring	12/04/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15C0001047			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/15/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD	
WHITEW	ATER SURGERY (	CENTER		OND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15C0001047	B. WIN			11/15/	2012
			B. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HESTER BLVD		
\A/LIITE\A/	ATER SURGERY (	SENTED			OND, IN 47374		
VVIIIEVV	ATER SURGERT	CENTER		KICHIVI	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Q0222	4166.50(a)(1)(i) NOTICE - POSTI In addition, the As Post the writter a place or places noticed by patient if applicable) wait ASC's notice of ri name, address, a representative in patients can repo the Web site for ti Beneficiary Ombo Based on docum the posted patient of 13 required el  Findings:  1. Review of a c Rights and Respo Ownership, poste reception area. in the specific name Center, LLC phy financial interest facility.  2. In interview, employee #A1 ce element was not	NG SC must - n notice of patient rights in within the ASC likely to be ts (or their representatives, ing for treatment. The ghts must include the not telephone number of a the State agency to whom rt complaints, as well as he Office of the Medicare adsman. ent review and interview, at rights did not contain 1 ements.  Idocument entitled Patient consibilities, Notice of ed in the facility's indicated it did not contain es of the Whitewater Eye resician's who have a ser or ownership in the confirmed the above included in the posted to further documentation	002		A revised document entitled Patient Rights and Responsibilities, Notice of Ownership posted in the waitir area now names the physician who have a financial interest ir the ASC. The Surgery Center manager is responsible for changing the text of the Patien Rights posted in the reception area and for obtaining a printe framed copy for posting in the waiting area. The monitoring oproject completion will be done via contact with the publishing company weekly until the finist copy is displayed.	is n d d	12/03/2012

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15C0001047	B. WING		11/15/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		HESTER BLVD	
WHITEW	ATER SURGERY	CENTER		IOND, IN 47374	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001047	(X2) MUI A. BUILI B. WING	DING	NSTRUCTION  00	(X3) DATE S COMPL 11/15/	ETED
	ROVIDER OR SUPPLIER		p. wind	STREET A	DDRESS, CITY, STATE, ZIP CODE HESTER BLVD DND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
Q0223	The ASC must all applicable, physic ownership in the with the intent of Disclosure of info and furnished to the date of the probable of the facility failed procedure indicating the specification ownership in the Findings:  1. Review of a factor procedure, entitle Responsibilities, approved 11-1-1 include the name Eye Center, LLC financial interest facility.  2. In interview, compolicy and procedure and procedure interest facility.	ent review and interview, I to have a policy and ecific names of all nave financial interests or facility  acility policy and ed Patient Rights and Notice of Ownership, 0, indicated it did not es of specific Whitewater C physicians who have s or ownership in the on 11-15-12 at 3:15 pm, onfirmed the above-stated dure did not include the c physicians who have s or ownership in the r documentation was	O022	23	The WSC policy regarding Patient's Rights has been revist to state the names of the physician owners are to be add to the information given to the patients. The paperwork has been adjusted to reflect this change. The Surgery Center Manager is responsible for implementing the change in poby personally rewriting to inclut the physician's names and monitoring for compliance by biennial review of the paperwobeing given to the patient's on check-in.	ded blicy de	12/04/2012

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15C0001047			LDING G	ONSTRUCTION 00	(X3) DATE COMPI 11/15	ETED			
	NAME OF PROVIDER OR SUPPLIER WHITEWATER SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1900 CHESTER BLVD RICHMOND, IN 47374					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	(X5) COMPLETION DATE		
S0000	This sick same f	on a Chata lia anguna anguna	S00	00					
	Facility Numbe	or a State licensure survey. r: 001222	500	00					
	Survey Date: 1	1-13/15-12							
	Surveyors: Jack I. Cohen, Medical Survey								
	John Lee, RN Public Health N	Turse Surveyor							
	QA: claughlin	11/26/12							

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15C0001047	A. BUII B. WIN			11/15/	2012
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HESTER BLVD		
WHITEW	ATER SURGERY (	CENTER			OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S0228	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)  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:						
	written transfer ag (1) or more hospi acceptance of pa complications or a postoperative cor all physicians, de podiatrists perfora center maintain a at one (1) or more same county or in adjacent to the co center is located.	nfinement, and that ntists, and ming surgery in the dmitting privileges hospitals in the an Indiana county bunty in which the	502	20			12/21/2012
	the governing bormedical staff me surgery in the factorial privileges at one the same county adjacent to the confacility is located credential files responsible.  1. Review of 10 files indicated files.	ent review and interview, bard failed to assure that imbers performing cility maintain admitting (1) or more hospitals in or in an Indiana county ounty in which the d for 4 of 10 medical staff eviewed.  medical staff credential les MD#6, MD#7, MD#9 not have documentation	S02:	28	Letters to the Committee Chair at Reid Hospital and Health Ca Services along with completed Applications for Modification of Staff Status or Privileges have been sent to the Medical Staff department at Reid Hospital for approval of admitting privileges. The surgery manager will be incontact with Medical Staff department routinely to obtain expected date of completion. the future, when surgery privileges are due for re-approadmitting privileges will be included in the request. The Surgery Center Manager is responsible for implementing to	are I f or s. n an In val,	12/31/2012

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001047	A. BUILDING 00 COMPLI		(X3) DATE SURVEY  COMPLETED  11/15/2012
	PROVIDER OR SUPPLIER		STREET A 1900 C	ADDRESS, CITY, STATE, ZIP C HESTER BLVD OND, IN 47374	CODE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
	hospitals in the s Indiana county a which the facilit 2. In interview, employee #A1 c documentation of	vileges at one (1) or more same county or in an adjacent to the county in y is located.  on 11-15-12 at 11:00 am, confirmed there was no of the above and no other was provided prior to exit.		change by contacting the privileging/credentialing committee at Reid Host completion of the necest paperwork and returning committee in time for the meeting scheduled for 2013. The surgery may monitor the completion process by obtaining a date from the hospital meeting and contact who hospital following that the results.	g spital, essary ng to the heir next January anager will n of this a specific for the vith the

State Form Event ID: RMU711 Facility ID: 001222 If continuation sheet Page 17 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15C0001047	B. WIN			11/15/	2012
NAME OF D	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			1900 CI	HESTER BLVD		
WHITEW	ATER SURGERY (	CENTER		RICHM	OND, IN 47374		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S0300	410 IAC 15-2.4-2 QUALITY ASSES						
	IMPROVEMENT	SSIVIENT AND					
	410 IAC 15-2.4-2	(a)					
		. ,					
	(a) The center must develop, implement, and maintain an effective,						
	•	-wide, comprehensive nt and improvement					
	program in which						
	. •						
center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is							
	not limited to, the	_					
		ent review and interview,	S03	00	As corrected in Q 082 the qua	lity	11/19/2012
	the facility failed	l to ensure 1			indicator for our in-house transcription has been added to		
	(transcription) di	rectly provided service			the QAPI dashboard used to		
	was included in	the facility's quality			monitor specific activities. The		
	assessment and p	performance			Surgery Center Manager is		
	improvement (Q	API) program.			responsible for implementing t		
	1	71 2			change by instituting a new Q		
	Findings:				dashboard that includes in-hou		
					transcription and for monitoring this service outlined quarterly.	J	
	1. Review of the	e facility's QAPI indicated			and control control quartorly.		
		e monitors and standards					
		rovided service of					
	transcription.	Tovided Scrvice of					
	transcription.						
	2 In interview	on 11-15-12 at 2:15 pm,					
		_					
		onfirmed the above and					
		nentation was provided					
	prior to exit.						
			1		l e e e e e e e e e e e e e e e e e e e		i l

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15C0001047	B. WIN			11/15/	2012
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	HESTER BLVD		
WHITEW	ATER SURGERY (	CENTER			OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S0428	410 IAC 15-2.5-1 The infection conresponsibilities m						
	programs which a infection control. are not limited to,	dures, policies, and are pertinent to These include, but					
	and interview, the its policy/proced Trash in one obsequence of the policy of policy. The policy of the policy of the patient and an analysis and the taking the trash by with a knot.  4. Bags are then into larger bags to the patient and the policy of the policy of the patient and the p	: icy/procedure Disposal of	S04	28	The WSC policy has been revised to state regular trash willbe confined to plastic trash bags that are secured at the to and may be putinto larger bags for easier transport to the outs dumpster at the close ofthe da Regular trash accumulated du the course of the day will bestored in secured bags on to of or beside closed biohazard trashcontainers. The regular trash is not to be mixed in the same bag or samecontainer as biohazard trash/waste and is to be disposed of in the sanitationdepartment's dumps: Biohazard trash/waste is picked up by a contracted company specializing in biohazard disposed. The Surgery Center Manager is responsible for implementing and monitoring for compliance trashdisposal. Random inspections will be made by the Infection Control nurseand/or to Surgery Manager on a weekly	op s s ide y ring pp s o ter d osal.  of e the	11/19/2012

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STATEMEN	IT OF DEFICIENCIES	FICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) M		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	ETED
		15C0001047	B. WIN			11/15/2	2012
			D. ((1)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			HESTER BLVD		
WHITEW	ATER SURGERY	CENTER			OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	parking lot."				basis to insure compliance.		
	This policy/proc	edure was last					
	reviewed/revised						
	2 During the for	cility tour of the surgery					
	2. During the facility tour of the surgery area on 11-13-12 at 1230 hours with staff						
	#40 the followin						
		rash on the floor in the					
	substerile hallwa	ay. 2 bags of trash were					
	touching open sl	nelves that contained					
	sterile and clean	items.					
	3 On 11-13-12	at 1230 hours, staff #40					
		rash from the operating					
	_	placed on the floor of the					
		ay floor prior to taking					
	outside to the du	impster at the end of the					
	day.						
	-						

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001047	(X2) MULTIPLE  A. BUILDING  B. WING	00	(X3) DATE COMPI 11/15	
	ROVIDER OR SUPPLIER		1900	ET ADDRESS, CITY, STATE, ZIP CODE O CHESTER BLVD HMOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE
S0622	ADMIN. 410 IAC 15-2.5-3  An adequate med be maintained with service rendered the center as follows:  (6) The center should be added to the center as follows:  (6) The center should be added to the center as follows:  (6) The center should be added to the center as follows:  (6) The center should be added to the center as follows:  (6) The center should be added to the center as follows:  (6) The center should be added to t	RDS, STORAGE, AND  (c)(6)  dical record must th documentation of for each patient of lows:  nall have a system of long medical records limely retrieval of losis and procedure, ndition on discharge, and to continuous quality limprovement activities. In the review and interview, and to have documentation that included diagnosis, cian and condition on andition on discharge.  I coument entitled DAILY POINTMENTS  CAL FOR: 9/24/2012 lot include diagnosis and	S0622	Our electronic medical rec system allows for retrieval records by diagnosis, proc and physician, but does not include condition on dischasis the responsibility of the Center Manager to implementh this system by creating a reto include the date of serviname of patient, birth date surgeon, anesthesiologist, condition on discharge, disposition, brief description problementhat resulted in a straight than good discharge. The manager is responsible for monitoring this by monthly retrieval of the log and repopuraterly to the BOD. The will be saved for review by accrediting agency or for Coprojects. It is our policy the patient's that are discharged other than good condition added to a secured file on	of edure, ot earge. It Surgery eent eew log ce s, on of eless surgery orting se logs any QAPI at ed in is	12/10/2012

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15C0001047		A. BUILDING  00		COMPLETED 11/15/2012	
		1300001047	B. WING	ADDRESS SYNV ST	11/15/2012
NAME OF PI	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE HESTER BLVD	
	ATER SURGERY (		RICHM	OND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				surgery manager's computer. the manager is unavailable to or review the file, an email is with patient name, DOB, date service and condition on discharge, to the surgery manager to add to the file whable. Retrieval of the file in the absence of the surgery manager.	If pladd sent of en ne ger

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPL	ETED
		15C0001047	B. WIN			11/15/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				HESTER BLVD		
WHITEW	ATER SURGERY (	CENTER			OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S0630	ADMIN. 410 IAC 15-2.5-3	RDS, STORAGE, AND					
	(d) The medical record must contain sufficient information to:						
	the patient's stay the results.	agnosis; tment; and urately the course of	S06	30	The Surgery Center Manager	is	12/05/2012
	the facility failed record (MR) consinformation to just 16 cataract MRs 6, 9, 10, 11, 12, 27 and 30).  Findings includes 1. Review of pat 12, 13, 17, 18, 2 MR indicated easu medication drops documentation of administer the Padrops.	to ensure the medical tained sufficient stiffy treatment in 16 of reviewed (Patient #1, 4, 13, 17, 18, 21, 22, 24, 26, 27, 24, 26, 27, 24, 26, 27, 24, 26, 27, 26, 27, 26, 27, 27, 27, 28, 29, 29, 29, 29, 29, 29, 29, 29, 29, 29			The Surgery Center Manager is responsible for the implementation of the correction in the patient's medical record to include all orders for treatment in the surgery center including any and all eye drops. The process to update the physician's orders in a computer software program is being completed at this date. Charts that do not contain the proper orders for eye drops will have orders handwritten and signed by the physician. monitoring of this correction will be the responsibility of the surgery manager by checking patient's charts at the close of the day for accurate orders and for maintaining weekly contact with the physicians on the status of completing the computer change for preprinted orders.		12/03/2012
	in patient #1, 4, 6 18, 21, 22, 24, 26	was no physician's order 5, 9, 10, 11, 12, 13, 17, 6, 27 and 30's MRs to tracaine medication					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15C0001047		A. BUILDING  B. WING	00	COMI	(X3) DATE SURVEY  COMPLETED  11/15/2012	
	PROVIDER OR SUPPLIER		1900 CI	ADDRESS, CITY, STATE, ZIP CO HESTER BLVD OND, IN 47374	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION JULD BE PROPRIATE	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)		X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DIVI DIDIC 00		COMPLETED	
		15C0001047	A. BUILDING		11/15/2012	
B. WING						
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE		
				HESTER BLVD		
WHITEW	ATER SURGERY (	CENTER	RICHM	IOND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(2	(5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPI	ETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DA	ГЕ
S0732	410 IAC 15-2.5-4					
		F; ANESTHESIA AND				
	SURGICAL					
	410 IAC 15-2.5-4	(b)(2)				
	These bylaws					
	and rules must be	e as follows:				
	and raiss must be	5 G5 15110116.				
	(2) Be reviewed	at least triennially.				
		ent review and interview,	S0732	The annual BOD meeting (alo	ng   01/14	/2013
	the medical staff	did not review the		with the MEC meeting) is		
	medical staff byl	laws and rules at least		scheduled for 1/14/13 at which		
	medical staff bylaws and rules at least once every three (3) years.  Findings:  The previous bylaws and rules at least time the Medical staff will review and vote on the Medical Staff Bylaws and Medical Staff Rules and Regulations. The previous bylaws and rules and regulations were approved by the only two surgeons employed when the				ew .	
				surgeons employed when the		
	and rules indicat	ed they were reviewed by		facility first opened in Nov. 200	9.	
	the Medical Dire	ector.		The Surgery Center Manager		
				responsible for implementing t		
	2. Review of the	e medical staff bylaws		correction by including the rev		
		ed the Medical Director		to the agenda of the annual B		
				meeting in Jan. and will monitor the expiration dates for review		
	nau no aumority	to solely review them.		the policies/and bylaws.	·	
	2 1	11 14 10 4 2 25				
	·	on 11-14-12 at 2:35 pm,				
		vas requested to provide				
	any documentati	on of a medical staff				
	bylaw, rule or m	eeting minute in which				
		ector had been given this				
		•				
	authority. The employee indicated there was no such documentation and none was					
	provided prior to exit.					
			1	1		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001047	(X2) MULTIF A. BUILDING B. WING	G 00	CON	TE SURVEY MPLETED 15/2012	
NAME OF PROVIDER OR SUPPLIER WHITEWATER SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1900 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	FIX PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE	
S0824	SURGICAL 410 IAC 15-2.5-4  The medical staff implement policies the governing bor policies and procedures are not limited.  (D) Safety rules Based on docume the facility failed rules for areas we procedures were surfacedures, appropriately appropriately and malignates.  1. Review of the procedures, appropriately appropriately and malignates.  2. In interview, employee #A1 current and indicated the face equipment in the surfacedures indicated for this equipment in the surfacedures in the surfacedures in the surfaced for the su	e; ANESTHESIA AND  (c)(1)(D)  shall write and so and procedures and dy shall approve edures which include do to, the following:  to be followed.  ent review and interview, do to have complete safety there anesthesian performed.  e facility's policies and coved 11-1-10, indicated or rules only for flammable mant hyperthermia.  on 11-15-12 at 12 noon, confirmed the above.  Interview, the employee dility used electrocautery is operating area.  e above policies and atted there were no safety	S0824	A policy is in the proce written to define safety specific to the operatin addressing safety of spatients. This will ider particular safety risks malignant hypertherm electrocautery, fire, no pollution, hand off of sprolonged standing. Twill provide rules for onequipment, response emergencies, noise lethe Surgery Center Maresponsible for implement correction by writing a addressing the rules for operation of equipment for monitoring the composervation monthly at to the QAPI dashboard	y issues ng room taff and ntify including; ia, bise sharps, The policy peration of to vel control. lanager is nenting policy or safe nt, etc and npliance of visual and adding	12/31/2012	

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		IDENTIFICATION NUMBER:  15C0001047	A. BUILDING  B. WING	00	COMPLETED  11/15/2012		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
WHITEWATER SURGERY CENTER			1900 CHESTER BLVD RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	confirmed there procedures for the	were no policies and ne electrocautery o further documentation					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
15C0001047		15C0001047	B. WING		11/15/2012		
			B. WIN		ADDRESS OVEN STATE JID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
			1900 CHESTER BLVD				
WHITEW	ATER SURGERY (	SENTER		RICHM	OND, IN 47374		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG			DATE
S0826	410 IAC 15-2.5-4						
	MEDICAL STAFF	F; ANESTHESIA AND					
	SURGICAL						
	410 IAC 15-2.5-4	(c)(1)(E)					
	The medical staff						
		es and procedures and					
	the governing boo						
	•	edures which include					
	but are not limited	d to, the following:					
	(E) Safety trainin	ag required of					
	personnel.	ig required of					
	•	ent review and interview,	S08	26	A policy is in the process of be	ina	12/31/2012
			300	20	written to define safety issues	eirig	12/31/2012
	•	l to have complete safety			specific to the operating room		
	training required	for areas where			addressing safety of staff and		
	anesthesia proce	dures were performed.			patients. This will identify		
					particular safety risks including	<b>a</b> ;	
	Findings:				malignant hyperthermia,		
					electrocautery, fire, noise		
	1 D	- C:114			pollution, hand off of sharps,		
		e facility's policies and			prolonged standing. The police	:y	
		roved 11-1-10, indicated			will also outline training		
	there was safety	training only for			requirements for safe practice	S	
	flammable usage	e and malignant			and use of equipment. The		
	hyperthermia.	-			Surgery Center Manager is		
	J1				responsible for writing, implementing and training		
	2 In intermiero	on 11-15-12 at 12 noon,			personnel and for monitoring t	he	
	· · · · · · · · · · · · · · · · · · ·				compliance of the policy throu		
	employee #A1 c	onfirmed the above.			annual competency training.	9	
	3. In the same in	nterview, the employee					
	indicated the fac	ility used electrocautery					
	equipment in the	,					
	-qarpinoni in the	operating area.					
	4. Review of the above policies and						
procedures indicated there were none for							
	safety training for	or this equipment.					

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		IDENTIFICATION NUMBER:  15C0001047	A. BUILDING  B. WING	00	COMPLETED 11/15/2012		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 CHESTER BLVD				
WHITEWATER SURGERY CENTER				OND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	confirmed there procedures for the	o further documentation					

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