

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
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S 0000 Bldg. 00	This visit was for a State licensure survey. Facility Number: 005973 Survey Date: 6-23/25-2015 QA: cjl 07/15/15	S 0000		
S 0010 Bldg. 00	410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a) Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules. Based on document review and interview, the facility failed to comply with an applicable state law for 3 (AH#1, AH#2, AH#3) of 3 unlicensed credentialed employee files reviewed. Findings: 1. IC 16-28-13-4: a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee, for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository	S 0010	A new process in place to correct this issue is for all employees and allied health members currently on staff who are not licensed by the state a one-time criminal background check as well as a query to the state nurse aid registry and kept in each file. All future potential employees and allied health members will be subject to this at initial appointment or application. This information will be kept in the individuals file to reference as needed. Responsible parties: executive director and credentialing coordinator	08/30/2015

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see 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.

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S 0153 Bldg. 00	<p>for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of the files of credentialed employee AH#1, a Certified Ophthalmology Assistant, AH#2, an Electroencephalography Technologist, and AH#3, a Certified Surgical Technician, indicated each was not a licensed health care provider by the State of Indiana.</p> <p>3. Further review of each of the above-stated files indicated that each was privileged by the facility to provide direct patient care activities.</p> <p>4. Further review of the above-stated files indicated none contained any documentation of a copy of the person's state nurse aide registry report from the state department nor a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>5. In interview, on 6-24-2015 at 2:00 pm, employee #A2, Credentialing Coordinator, confirmed all the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p>			

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	<p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review and interview, the facility failed to implement its policy to provide orientation of contracted employees to the facility and the employees's jobs for 2 (P1, P2) of 2 contracted employee personnel files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a facility policy entitled Employee Orientation - General, approved 5-13-2014, indicated various topics on which new employees are oriented. Review of the personnel files of contracted employees P1, radiology tech, and P2, radiology tech, indicated they did not contain any documentation of having been oriented on various topics per the Employee Orientation - General policy. In interview, on 6-26-2015 at 10:20 am, employee #A1, Executive Director, confirmed this and no other documentation was provided prior to 	S 0153	<p>For all contracted services employees an orientation packet is being assembled and implemented. The orientation will include both orientation to facility and to job/department specific within facility. This has given us the opportunity to review our employee orientation for each department ensuring that key components (orientation to facility, orientation to job, orientation to department) are encompassed in all in a consistent manner.</p> <p>Responsible parties: executive director and credentialing coordinator</p>	08/31/2015

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S 0156 Bldg. 00	<p>exit.</p> <p>4. Review of various facility documents for department specific orientation, indicated there was no department specific orientation for radiology techs.</p> <p>5. Review of the personnel files of contracted employees P1 and P2, indicated they did not contain any documentation of having had department specific orientation.</p> <p>6. In interview, on 6-26-2015 at 10:20 am, employee #A1 confirmed this and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including</p>			

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S 0326	<p>contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to implement its policy to maintain annual performance evaluations for 2 (P1, P2) of 2 contracted employees.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a facility policy EMPLOYMENT - PERFORMANCE EVALUATION AND MERIT INCREASE, Revised 05/14, indicated all employees' performance will be formally evaluated annually. 2. Review of 2 contracted employee personnel files, P1, radiology tech, and P2, radiology tech indicated there were no performance evaluations, per facility policy, by any authorized surgery center person. 3. In interview, on 6-24-2015 at 1:55 pm, employee #A1, Executive Director, confirmed all the above and no other documentation was provided prior to exit. <p>410 IAC 15-2.4-2</p>	S 0156	<p>For all contracted employees a copy of the Center a copy of the performance evaluation and merit increase will be kept in the file from their home department supervisor. This performance evaluation will be reviewed and signed/dated by the executive director and will be accepted as satisfactory to meet our guideline of an annual evaluation on contracted employees.</p> <p>Responsible parties: executive director and credentialing coordinator</p>	08/31/2015

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Bldg. 00	<p>QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(3)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(3) All services performed in the center with regard to appropriateness of diagnoses and treatments related to a standard of care and anticipated or expected outcomes.</p> <p>Based on document review and interview, the facility failed to include a review of appropriateness of diagnosis and treatments related to a standard of care for 2 (MD#1, AH#2) of 10 credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 10 credential files indicated files MD#1 had an incomplete review (not all criteria reviewed), and AH#2 did not have any documentation of review of appropriateness of diagnosis and treatments related to a standard of care.</p> <p>2. In interview, on 6-24-2015 at 2:00 pm, employee #A2, Credentialing Coordinator, confirmed all above and no other documentation was provided prior to exit.</p>			S 0326	<p>At reappointment appropriateness of diagnosis and treatments related to standard of care are reviewed. For the two files that were missing these have been reviewed and files updated accordingly. Moving forward allied health members will have peer review, supervising physician review, and Executive director review performance within the surgery center. The oversight on the medical staff member's review being incomplete was not noted to be a trend, but rather an isolated miss and has been corrected. Responsible parties: executive director, credentialing coordinator, medical director</p>		08/31/2015

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S 0400 Bldg. 00	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, the facility failed to provide a safe and healthful environment that minimized infection exposure and risk to patients, health care workers and visitors in 4 areas toured.</p> <p>Findings:</p> <p>1. On 6-23-2015 at 3:35 pm in the presence of employees #A3, Maintenance Technician, and #A4, Support Services Team Leader, it was observed in a basement housekeeping storage area there were 21 packages of paper handtowels on an open shelf rack. The ends of the packages were exposed, not wrapped, not in a storage container, and had no barrier between the packages and the room. The room also contained mop buckets, one with some type of chemical in it, and other various cleaning equipment.</p> <p>2. On 6-23-2015 at 12:15 pm in the presence of employees #A5, Surgery Manager and #A6, Infection Control Officer, it was observed in a janitor closet</p>	S 0400	<p>1.All paper products will be stored in packaging/container prior to use such that no paper products (toilet paper, towelingpaper) will have potential for exposure.</p> <p>2.All paper products will be stored in packaging/container prior to use such that no paper products (toilet paper, towelingpaper) will have potential for exposure.</p> <p>3.Clean supply closet in PACU all shelving hasbeen moved, cleaned under for any dust bunnies. This storage area has been highlighted on the assigned EVS worker's cleaning assignment sheet as needing more attention. The Team Leader for EVS will follow up weekly to ensure that the area is being completely cleaned and not accumulating dust.</p> <p>4.Surgical bonnet education to contain hair wasgiven to staff in the OR. In addition, if earrings are worn the earlobes must be covered by hat. This policy was already in place but wasreinforced to staff as a reminder. The window in between decontam and the clean</p>	08/31/2015	

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S 0826 Bldg. 00	<p>on the 16-bed Recovery Center that there were 10 packages of paper handtowels and 17 rolls of bathroom tissue on an open shelf rack. The ends of the packages of paper handtowels were exposed, not wrapped, not in a storage container, and had no barrier between the packages and the room. The room also contained mop buckets and other various cleaning equipment.</p> <p>3. On 6-23-2015 at 1:35 pm in the presence of employees #A5 and #A6, it was observed in a clean utility room on the Post-anesthesia care unit that there were supplies and dust clumps under the supply storage shelves.</p> <p>4. On 6-23-2015 at 1:55 pm in the presence of employee #A5, it was observed in the sterile area that surgical bonnets were being worn behind the ears, exposing some hair and earrings and in the central processing area, the pass-through window was open.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve</p>		<p>side of the instrument room that was left open inadvertently after the passing of clean instruments was finished has been addressed to staff that it needs to remain closed unless actively being utilized. Alternative options to a manual open/close window for this area are being explored. Responsible parties: OR team leader, PACU team leader, EVS team leader</p>	

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	<p>policies and procedures which include but are not limited to, the following:</p> <p>(E) Safety training required of personnel.</p> <p>Based on document review and interview, the facility failed to implement its policy to provide safety training in areas where anesthetics are used for 2 (MD#4, MD#5) of 10 medical staff credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a facility policy entitled EDUCATION: - MANDATORY INSERVICES, revised approved 05/2015, indicated MEDICAL STAFF ONE TIME ONLY TRAINING (1 of the following): Safety - Fire, Haz Chem, Spills, MRI Fire Management in the O.R. Surgery Center OR Safety Quiz Review of 10 credential files indicated files MD#4, pain management practitioner, and MD#5, a podiatrist, did not contain any documentation of safety training in according to facility policy. In interview, on 6-24-2015 at 11:35 am, employee #A1, Executive Director, confirmed all the above and no other documentation was provided prior to exit. 	S 0826	<p>One time safety training for all medical staff has been updated to include the listed: Safety - Fire, Haz Chem, Spills, MRI Fire Management in the O.R. Surgery Center OR Safety Quiz As well as a video that can be viewed with an accompanying attestation that the staff member did in fact view. This is being distributed to all medical staff at reappointment if safety training not already completed. Reappointment could be delayed as a result of non-compliance. Responsible parties: executive director, medical director, credentialing coordinator</p>	09/30/2015

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S 1164 Bldg. 00	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</p> <p>(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:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(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 document review and interview, the hospital failed to regularly maintain 2 pieces of patient care equipment.</p> <p>Findings:</p> <p>1. Review of the user manual for the Zoll R Series defibrillator, indicated to check</p>	S 1164	<p>1. Zoll letter received after exit of surveyors indicates that a back up battery need not accompany the unit but rather must be readily available. See attached. However, we have also purchased a battery charger for our upstairs unit so that we have spare, fully charged batteries for the defibrillator on both levels of our Surgery Center. 2. Zoll letter</p>	07/30/2015

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S 1168 Bldg. 00	<p>that a fully charged spare battery pack accompanies the unit.</p> <p>2. In interview, on 6-24-2015 at 3:45 pm, employee #A1, Executive Director, indicated none of the three (3) facility defibrillators had a charged spare battery pack which accompanied the unit and no documentation was provided by exit.</p> <p>3. On 6-23-2015, employee #A1 was requested to provide documentation of regular (preventive) maintenance on a patient stretcher.</p> <p>4. In interview, on 6-26-2015 at 9:50 am, employee #A1 indicated there was no documentation of regular (preventive) maintenance on a patient stretcher and no documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</p> <p>(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:</p>		<p>received after exit of surveyors indicates that a back up battery need not accompany the unit but rather must be readily available. See attached. However, we have also purchased a battery charger for our upstairs unit so that we have spare, fully charged batteries for the defibrillator on both levels of our Surgery Center. 3/4. PM for stretchers will be added to our facilities management technician or clinical engineering duties. If confirmation from clinical engineering that they can/will provide this we will utilize their services. If they are unable we will follow manufacturer's instructions on the PM of patient stretchers. Responsible parties: executive director and support servicesteam leader</p>	

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S 1188	<p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the facility failed to conduct triennial analysis of preventive maintenance (PM) for 1 of 12 pieces of patient care equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of PM for 12 pieces of patient care equipment indicated a triennial analysis of PM was not done for a patient stretcher. In interview, on 6-24-2015 at 4:50 pm, employee #A1, Executive Director, confirmed there was no documentation of triennial analysis for the above-stated piece of equipment and no other documentation was provided prior to exit. <p>410 IAC 15-2.5-7</p>	S 1168	<p>PM for stretchers will be added to our facilities management technician or clinical engineering duties. If confirmation from clinical engineering that they can/will provide this we will utilize their services. If they are unable we will follow manufacturer's instructions on the PM of patient stretchers. Triennial review will be completed also by clinical engineering or by facilities management technician to ensure that manufacturer's instructions for PM are being followed. Responsible parties: executive director and support services team leader</p>	08/31/2015	

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Bldg. 00	<p>PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in calendar 2014 in accordance with the facility's fire control plan in 6 of 12 instances, and failed to include in its written fire control plan a provision for cooperation with firefighters in 1 instance.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled FIRE DRILL PROCEDURE, approved 5-13-2014, indicated the time of a drill for a shift will not be duplicated within the four quarters of any calendar year and will vary by at least one hour.</p> <p>2. Review of fire drills for calendar year</p>	S 1188	<p>1, 2, 3. Procedure will be updated to include that the time will not be duplicated but we will omit the variation by at least one hour requirement. The update to this procedure will be taken to the operations committee for approval. 4. In fire disaster plan an additional paragraph will be added indicating that cooperation with firefighters will occur whenever they are on scene. This update to the disaster plan will also be reviewed and approved by the operations committee. Responsible party: executive director</p>	11/13/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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	<p>2014 indicated the following:</p> <table border="1"> <thead> <tr> <th>Quarter/Shift</th> <th>Time</th> </tr> </thead> <tbody> <tr> <td>1/Day</td> <td>8:30 am</td> </tr> <tr> <td>1/Eve</td> <td>7:00 pm</td> </tr> <tr> <td>2/Day</td> <td>8:00 am</td> </tr> <tr> <td>2/Eve</td> <td>8:00 pm</td> </tr> <tr> <td>3/Day</td> <td>9:00 am</td> </tr> <tr> <td>3/Eve</td> <td>9:00 pm</td> </tr> <tr> <td>4/Day</td> <td>7:45 am</td> </tr> <tr> <td>4/Eve</td> <td>8:30 pm</td> </tr> </tbody> </table> <p>3. The above table indicated for each shift, the time did not vary by at least one hour in 6 cases: 1/Day and 2/Day, 1/Day and 3/Day, 1/Day and 4/Day, 2/Day and 4/Day, 2/Eve and 4/Eve, and 3/Eve and 4/Eve.</p> <p>4. Review of a facility document entitled FIRE DISASTER PLAN, approved 5-13-2014, indicated it did not include a provision for cooperation with firefighters.</p> <p>5. In interview, on 6-24-2015 at 2:25 pm, employee #A1, Executive Director, confirmed all the above and no other documentation was provided prior to exit.</p>	Quarter/Shift	Time	1/Day	8:30 am	1/Eve	7:00 pm	2/Day	8:00 am	2/Eve	8:00 pm	3/Day	9:00 am	3/Eve	9:00 pm	4/Day	7:45 am	4/Eve	8:30 pm			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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