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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15C0001149 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/09/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>EAGLE HIGHLANDS SURGERY CENTER LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>6850 PARKDALE PLACE<br>INDIANAPOLIS, IN 46254 |
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| S 0000<br><br>Bldg. 00 | This visit was for a State licensure survey.<br><br>Facility Number: 004756<br><br>Survey Date: 9-8/9-2015<br><br>QA: cjl 09/17/15  | S 0000        | Agree   |                      |
| S 0110<br><br>Bldg. 00 | 410 IAC 15-2.4-1<br>GOVERNING BODY; POWERS AND DUTIES<br>410 IAC 15-2.4-1 (a)(5)<br><br>The governing body shall do the following:<br><br>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.<br>Based on document review and interview, the facility's governing board failed to review reports of the quality assessment performance improvement (QAPI) program of 2 directly-provided services and 1 other activity during calendar year 2014, as part | S 0110        | The Director is responsible for presenting to the governing body the uploaded contracted services document and report the outcomes. Highlighted in grey are the 2 directly provided services cited in S-0110; the Director is responsible for documenting the Board review and approval of this | 10/05/2015           |

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 0228<br><br>Bldg. 00   | <p>of the facility's QAPI program.</p> <p>Findings:</p> <p>1. Review of the governing board meeting minutes for calendar year 2014 indicated the governing board failed to review QAPI activities of the directly-provided services of nursing and radiology, and the activity of discharges.</p> <p>2. In interview, on 9-9-2015 at 10:30 am, employee #A4, Clinical Manager Operating Room, confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1<br/>GOVERNING BODY; POWERS AND DUTIES<br/>410 IAC 15-2.4-1(e)(4)</p> <p>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:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate</p> |   |  |  | <p>report at each quarterly meeting, The Director is responsible for reporting to the governing body the activity of discharges, This report has been added to follow the report on patient transfers in the quarterly summary of the QAPI committee activities; The POC is the Director to ensure documentation of review and decisions made by the governing board quarterly,</p> |   |                      |

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|                    | <p>acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that a podiatrist (MD#2) performing surgery in the facility maintained admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located, or, failed to have a properly written agreement in compliance with a Standing Waiver for 410 IAC 15-2-2.3-1 (e)(4), effective November 21, 2012, for 1 of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of facility documents indicated the facility had a Transfer Agreement with IU Methodist Hospital.</li> <li>2. Review of an Indiana State Department of Health Program Advisory Letter, entitled Standing Waiver for 410 IAC 15-2-2.3-1 (e)(4), effective November 21, 2012, indicated podiatrists must provide documentation to the</li> </ol> | S 0228        | <p>The clinical director is responsible for ensuring all regulatory documents meet the requirements set forth by the State and Federal regulatory bodies and such documents are approved by the governing body. Documents requiring signatures must be signed by the appropriate persons. A new document developed by the ASC Credentialing Specialist is uploaded with this POC. The Hospitalist at the facility in which the Center has a transfer agreement and the podiatrist has surgical privileges have agreed upon the stipulations in the uploaded document. Their relationship is that of Medical Staff at the same hospital and the hospitalists are involved with the podiatrists' patient if they require to be transferred to the hospital. The document will be signed by both parties no later than 10/8/2015.</p> | 10/05/2015           |

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|                    | <p>Ambulatory Surgery Center demonstrating that he/she has an agreement with one or more physicians, with admitting privileges in which the podiatrist has surgical privileges, agrees to admit podiatric patients in cases in which a transfer is necessary.</p> <p>3. Review of 7 medical staff credential files indicated file MD#2, a podiatrist, had surgical privileges at IU Methodist Hospital, but did not have documentation of admitting privileges at one (1) or more hospitals in the same county, Marion, or in an Indiana county adjacent to Marion county in which the facility is located.</p> <p>4. Further review of the file indicated there was a document entitled Documentation of Agreement, signed by MD#2, dated 9-27-13. Review of this document indicated the purpose of this letter is to validate there is a relationship between MD#2 and one or more physicians, with admitting privileges at IU Methodist Hospital in which the podiatrist has surgical privileges, who will admit podiatric patients in cases in which a transfer is necessary.</p> <p>5. Review of the Documentation of Agreement indicated it neither specified the nature of the relationship, nor specifically which physician(s) were</p> |               |   |                      |

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| S 1188<br>Bldg. 00 | <p>referenced in the letter. Further review of this document indicated physician(s) referenced in the letter had not signed (agreed) to this Agreement.</p> <p>6. In interview, on 9-9-2015 at 10:45 am, employee #A2 confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7<br/>PHYSICAL PLANT, EQUIPMENT MAINTENANCE,<br/>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.<br/>(B) Extinguishing of fires.<br/>(C) Protection of patients, personnel, and guests.<br/>(D) Evacuation.<br/>(E) Cooperation with firefighting authorities.<br/>(F) Fire drills.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility policy for 1 of 4 quarters in calendar year 2014.</p> | S 1188        | During the survey on 9/9/2015, the clinical manager providing documentation of the fire drills was unable to locate the 2nd quarter documentation. The documentation was located and is uploaded in this POC. The | 09/14/2015           |

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|  | <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of facility Policy Number: FP 8.00, approved June 2013, indicated Code Red [fire] drills will occur quarterly.</li> <li>2. Review of fire drills for calendar year 2014 indicated there were no fire drills conducted in the second quarter.</li> <li>3. In interview, on 9-9-2015 at 3:00 pm, employee #A3 confirmed the above and no further documentation was provided prior to exit.</li> </ol> |   | <p>clinical managers are ultimately responsible to ensure the disaster committee holds a fire drill each quarter, as per policy FP 8.00. The clinical manager is also responsible for ensuring the documentation is completed and is maintained in a log book for easy access. This was completed on 09/14/2014 and will prevent future reoccurrence of the situation noted in citation 1188 of this survey.</p> |                      |   |