

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2013
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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF INDIANAPOLIS LLC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2007 N CAPITOL AVE INDIANAPOLIS, IN 46202
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002463</p> <p>Survey Date: 9-4/5-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 09/06/13</p>	S000000		

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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S000110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(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.</p> <p>Based on document review and interview, the facility's governing board failed to review 2 contracted services during calendar year 2012 as part of the facility's QAPI program.</p> <p>Findings:</p> <p>1. Review of the governing board meeting minutes for calendar year 2012 indicated the governing board failed to review QAPI activities for the contracted services of security and lithotripsy.</p> <p>2. In interview, on 9-4-13 at 3:05 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p>	S000110	<p>1. Administrator, OR Manager, PACU Manager, and Medical Director met and reviewed the contract list. Lithotripsy contract has been terminated due to absence of procedures for the last 5 years. CSC security contract was reviewed and placed on the contract list. Each quarter the Safety committee will review all contracts and make sure that we are reviewing or terminating contracts that are necessary or no longer in use. 2. Safety committee will review the contract book and make sure that all contracts are listed on our outcome monitoring tool and reviewed by the QA, MAC, and QB.3. Ellen Farrell (safety manager). She will report to the QA, MAC and GB.4. 9/06/2013</p>	09/06/2013	

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S000310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</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>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include a monitor and standard for 2 services furnished by a contractor in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the contracted services of lithotripsy and security.</p> <p>2. Review of a document entitled AMENDMENT TO LITHOTRIPSY AGREEMENT, between Lithotripsy Institute of Indiana, LLC and Surgery Center of Indianapolis, LLC, dated March 1, 2008, indicated the term of this Agreement shall begin on the Effective Date of the <u>Amendment</u> and shall be in effect for one (1) year from the Effective Date (the "Term"). The contract shall</p>	S000310	<p>1. Administrator, OR Manager, PACU Manager, and Medical Director met and reviewed the contract list for Quality Assurance and for quarterly reports to the Board. The Committee terminated Lithotripsy contract by letter for no usage for past 5 years. The letter was signed by the President of the Governing Board. The CSC security contract was emailed to Administrator and reviewed. The Contract was added to the list for reporting. President of the Governing Board reviewed contract. 2. Each quarter the safety committee will review the contract book to update the contract listing for review to the QA, MAC, and GB. All contracts will be updated or terminated as needed. 3. Ellen Farrell(Safety Manager) will review with Safety committee and report to the QA, MAC, and GB. 4. 09-06-2013</p>	09/06/2013			

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S000400	<p>automatically renew on its anniversary date.</p> <p>3. In interview, on 9-4-13 at 3:05 pm, employee #A2 indicated they had an outside contractor for security services but when asked, did not provide any documentation of a contract or service activity.</p> <p>4. In interview, on the above date and time, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p> <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 and interview, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients.</p> <p>Findings include:</p> <p>1. During the facility tour, the following was observed under a sink in a common</p>	S000400	<p>1. OR Manager met GSF Housekeeping and their manager Randy McGlothlin to inform all members that the Microfiber mops and supplies for the OR must be kept in the OR Janitors Closet. No mops will be placed under a sink. Kara Dixon went over the CDC standard for terminal cleaning with both GSF staff and Manager. All parties were informed and stated their</p>	09/06/2013			

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S000630	<p>room between the Pre/Post recovery room and the Operating Rooms entrance: Microfiber mopheads & mopheads.</p> <p>2. On 09-04-13 at 1010 hours, staff #41 confirmed that housekeeping personnel use the microfiber mopheads & mopheads to clean the operating rooms and should be stored in the Housekeeping Closet located by the Operating Rooms.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on document review and interview, the facility failed to ensure that the medical record (MR) contain sufficient information to justify the treatment for 3 of 30 MRs reviewed (Patient #6, 22 & 23).</p> <p>Findings include:</p>	S000630	<p>understanding of the rules. 2. Kara Dixon(Infection RN) will monitor the Housekeeping quarterly or more often is needed. The Janitors closets will be checked monthly to make sure no mops are placed on the floor in the Pre Op hallway. OR Janitors closet will be checked for cleaning supplies and mops weekly. 3. Kara Dixon (Infection RN) and Annette Brackett(OR Manager). 4. 9-06-2013 Deficiencies will be reported quarterly to the Infection Committee, QA, MAC and Governing Board.</p> <p>1. After reviewing charts with John Lee, Administrator identified one MD not writing or signing orders 24 hours after verbal/written orders were given. RN staff in-service was given to all employees on the policy for having verbal or written orders signed with in 24 hours after order is given. MD was notified about the policy for signing orders</p>	09/09/2013			

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	<p>1. Review of patient #6's MR indicated the patient was administered Pepcid 20 mg PO on 06-14-13 at 0830 hours and patient #6's MR lacked documentation of a physician's order to administer Pepcid.</p> <p>2. Review of patient #22's MR indicated the patient was administered Kefzol 1 gm on 04-25-13 at 0950 hours and patient #22's MR lacked documentation of a physician's order to administer Kefzol.</p> <p>3. Review of patient #23's MR indicated the patient was administered Tylenol ii melts on 04-19-13 at 1000 hours and patient #23's MR lacked documentation of a physician's order to administer Tylenol ii melts.</p> <p>4. On 09-04-13 at 1420 hours, staff #40 confirmed there were no physician orders for patient #6's Pepcid, patient #22's Kefzol and patient #23's Tylenol ii melts.</p>		<p>after he gives them, to authenticate the order. MD understands rule and will make sure all orders are signed the day the order was initiated. RN will make Anesthesia sign the order before the patient goes back to the OR. 2. Nursing staff will perform random chart checks each day on the charts to make sure orders are signed by the appropriated MD giving the order. 3. PACU Manager and Medical Director will perform peer review on the Medical Charts and Physicians to make sure the policy is followed and orders are signed. Any deficiencies will be reported to the Medical Advisory committee for further disciplinary action. 3. PACU Manager and Medical Director. 4. 09/09/2013</p>		

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S000862	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(C)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(C) A provision for the following equipment and supplies to be available to the surgical and recovery areas:</p> <p>(i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff.</p> <p>Based on document review, observation and interview, the facility failed to ensure that the following equipment and supplies were available to the surgical and recovery areas as specified by the medical staff.</p> <p>Findings include:</p> <p>1. Review of policy/procedure 312, Code Cart Inventory, indicated the</p>	S000862	<p>1. 9/13/13 Policy 312 was pulled and reviewed with the Administrator , OR Manager, PACU Manager, and the Medical Director. The Committee has requested that the crash cart only carry those drugs required by ACLS and the supplies per 410 IAC 15-2.5-4(d)(2)(C). Due to the number of Drugs on back order the committee has made the recommendation to the MAC. The QA committee will report to</p>	10/03/2013			

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	<p>following to be in the Code Cart; "Small Stylet, Frova intubation introducer, Dopamine 200 mg 5 vials, 2 500 ml bags of Lidocaine Drip and a Laryngeal Mask Airway (LMA) size 5.</p> <p>2. During the facility tour on 09-04-13 at 1000 hours, the following was observed on the Code Cart: 1 small stylet with an expiration dated of 04-13. 1 Frova intubation introducer with an expiration dated of 04-12. 2 Dopamine 200 mg vials. 2 500 ml bags of Lidocaine Drip with an expiration date of 06-13. No LMA size 5.</p> <p>3. On 09-04-13 at 1000 hours, staff #41 confirmed the expired items should have been replaced and the Code Cart was missing 3 vials of Dopamine and 1 LMA size 5.</p>		<p>MAC and GB when any emergency drugs are on National Backorder and will give recommendations for replacements to the Medical Director. The MAC will meet on 10-02-13 to approved the new drug list for the crash cart and will make recommendations to the Governing Board. The Crash cart has been updated per the Medical Director and all expired equipment has been replaced. Outdated meds have been replaced or removed per our new policy 312. 2. The Center will perform monthly medication and equipment checks on the crash cart to review any outdated supplies or equipment. Any drugs that go on National Backorder will be reported to the Medical Director and safety committee for recommendation for replacements. Medical Director will report to the MAC and GB. 3. Ellen Farrell(PACU Manager) will be responsible for checking crash cart Monthly and report to the Medical Director. 4. 10/03/2013.</p>		