

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032			
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 004746</p> <p>Survey Date: 1/28/2013 through 1/29/2013</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 02/04/13</p>			S0000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE			STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S0646	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(3)</p> <p>All entries in the medical record must be as follows:</p> <p>(3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure all entries were authenticated according to policy in 7 of 21 patient records reviewed (#P5, P10, P13, P14, P15, P16, and P18).</p> <p>Findings included:</p> <p>1. The facility policy "Orders", last reviewed 05/01/12, indicated, "All practitioner orders are to be in writing or acceptable computerized form and must be authenticated preferable prior to the patient's discharge from the Center. ...If an author or responsible individual fails to authenticate orders after thirty (30) days of the order being implemented, the Center Director will report the infraction to the Medical Staff for follow up disciplinary action."</p> <p>2. The medical record for patient #P5, who had a procedure performed on 11/20/12, lacked documentation in the</p>	S0646	<p>1. The Facility called a MAC meeting on 1/29/13. The Facility Director discussed with the Medical Director and Physicians(15) the importance of dating and timing the Physician order sheet/ anesthesia Order sheet. Safety Committee went over our policy for ORDERS and documentation. a.) 7 of the 20 charts were presented to the Medical Advisory Committee. b.) Dr Frank (Medical Director sent a letter and email text to Anesthesia on staff about documenting the date and time in the allotted slot when writing orders. c.) The Post op RN will review the orders with Anesthesia and confirm that the orders have been dated and timed. d.) Policy on ORDERS was copied and mailed to all credentialed staff for Review 2. Next 6 months the PACU staff will audit all records at the end of the day to monitor the deficiency. Look for chronic issues with Anesthesia and Surgeons.3. Medical Director and PACU Manager, MAC and</p>	02/01/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>space "Date/Time" on the "Anesthesia Orders" sheet, making it unable to determine when the physician wrote or signed the orders.</p> <p>3. The medical record for patient #P10, who had a procedure performed on 09/14/12, lacked documentation in the space "Date/Time" on the "Anesthesia Orders" sheet, making it unable to determine when the physician wrote or signed the orders.</p> <p>4. The medical record for patient #P13, who had a procedure performed on 10/31/12, lacked a date or time in the areas provided on the preprinted "Physician Orders" sheet and lacked a date or time by the physician's signature, making it unable to determine when the physician sent or signed the orders.</p> <p>5. The medical record for patient #14, who had a procedure performed on 11/05/12, lacked documentation in the space "Date/Time" on the "Anesthesia Orders" sheet, making it unable to determine when the physician wrote or signed the orders. The record also lacked a date or time with the physician's signature on preprinted pre and post orders.</p> <p>6. The medical record for patient #15,</p>		Governing Board4. 2-01-13				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>who had a procedure performed on 12/27/12, lacked documentation in the space "Date/Time" on the "Anesthesia Orders" sheet, making it unable to determine when the physician wrote or signed the orders. The record also lacked a date or time with the physician's signature on preprinted pre and post orders.</p> <p>7. The medical record for patient #P16, who had a procedure performed on 10/26/12, lacked documentation in the space "Date/Time" on the "Anesthesia Orders" sheet, making it unable to determine when the physician wrote or signed the orders.</p> <p>8. The medical record for patient #P18, who had a procedure performed on 12/18/12, lacked a date or time with the physician's signature on preprinted pre and post orders.</p> <p>9. At 2:40 PM on 01/29/13, staff member #N1 confirmed the medical record findings and indicated the orders should have had a date/time with the physicians' signatures.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032
--	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032
--	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0654	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(4)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(4) Any allergies and abnormal drug reactions.</p> <p>Based on medical record review and interview, the facility failed to ensure the safety of 1 of 20 patients (#P7) regarding allergy documentation in the medical record.</p> <p>Findings included:</p> <p>1. Review of the medical record for patient #P7, who had a procedure performed on 09/06/12, indicated the following:</p> <p>A. A faxed copy of the history and physical performed in the physician's office on 08/17/12 which indicated the patient had no known drug allergies. The form was signed by the physician as updated on 09/06/12.</p> <p>B. A medication information form completed by the patient which indicated he/she was allergic to Demerol and the reaction was hallucinations.</p> <p>C. An admission form completed by the nurse which indicated the patient was allergic to Demerol and the reaction was</p>	S0654	<p>1. The One chart was presented to the MAC(Medical Advisory Committee on 1-29-13). MAC discussed the discrepancy with the Surgeon at the meeting. The Chart was reviewed by several MD's to discuss how the issue will not happen again. Anesthesia for the case was contacted on 1-30-13 to discuss medication error. Incident report was written for the medication error and signed by the MD. a.) Allergies will be reviewed by the Pre op RN with patient and with H&P.b.) MD sees patient in the morning Pre op RN, MD and Anesthesia will all confirm allergies with patient.c.) Time-Out in OR RN, CST, MD, ANESTHESIA will confirm allergies.d.) Post op RN will confirm allergies with report and review chart for consistency.2. Chart audit will be performed on all Anesthesia records at end of day by PACU staff to monitor Allergy documentation is consistent for 3 months with no deficiencies.3. Pre -Op RN, MD, ANesthesia responsible confirm with</p>	01/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>hallucinations.</p> <p>D. An anesthesia record form completed by the anesthesiologist which had "NKDA" (no known drug allergies) written in the area for allergies, then crossed out and Morphine written in. However, the form also indicated Morphine 10 milligrams was given during surgery by the anesthesiologist.</p> <p>E. An anesthesia order form, completed by the anesthesiologist on 09/06/12, which listed "Morphine- hives" in the area for allergies. The form also indicated Demerol 10 milligrams was ordered as needed for pain or shivering (this was the medication the patient reported an allergy to).</p> <p>G. The record lacked any documentation that the Demerol was given or that the patient had any allergic reaction to anything during the stay in the center.</p> <p>2. At 2:40 PM on 01/29/13, staff member #N1 confirmed the errors with the allergy documentation and the anesthesiologist documenting he/she gave Morphine after listing Morphine as an allergy. When copies of the forms were obtained, staff member #N1 acknowledged he/she had corrected the errors on the forms, not realizing the surveyor wanted copies of that record.</p>		<p>patient. OR Staff Time out in room PACU staff audit all charts for 3 months Medical Director MAC and Governing Board4. 1/30/2013</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032
--	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0710	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032
--	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the surgery center's physician credential files' privilege delineations were approved by the Medical Advisory Committee's (MAC) for 4 of 10 credential files that were reviewed (#2, 3, 4, and 7).</p> <p>Findings included:</p>	S0710	<p>1. 1/29/13 Discussed with Medical Director/MAC the importance of filling out the dilenation form correctly. The Medical Director will make sure he signs off on dileneation and initials and date for approval of privileges. 2/01/13: Director/Medical Director sat with New credentialing staff member and went through the paperwork on what need to be completed and signed. Discussed what the member needs to sign and what the MAC and Governing Boad needs to initial and sign after MD/DO/DPM</p>	02/13/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE	STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032
--	---

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>1. Bylaws and Rules and Regulations of the Medical Staff, last approved 5/1/2012, indicated the Medical Advisory Committee (MAC) shall forward to the Board of Governors, the physician's credential files with approval signatures of clinical privileges that were verified by the Medical Staff.</p> <p>2. Staff member #2 credential files were reviewed. The Anesthesiology Privilege Delineation form, dated 1/3/12, evidenced the practitioner requested clinical privileges for the The Surgery Center of Indianapolis; however, the practitioner did not request selected privileges for The Surgery Center of Carmel. The Medical Staff verified, but did not grant the privileges for Indianapolis and the Medical Staff did not verify nor grant privileges for The Surgery Center of Carmel.</p> <p>3. Staff member #3 credential files were reviewed. The</p>		<p>has been approved. 2/5/13 Discussed with Governing Board the credentialing process and reinforced what paperwork need to be signed and dated. MAC has asked that we review each record to make sure we are in compliance. Governing Board agrees and ask for follow up report. 2. New Credentialing Specialist has made a binder with all paperwork needed for Appointment or Re- Appointment. She has highlighted Areas that need to be signed and dated by MD/DO/DPM and what needs to be signed by MAC and Governing Board. Medical Director /Director/ Credentialing Specialist will sit for first review for the next 3 months to make sure all paperwork is being filled out appropriately. 3. Credentialing Specialist MAC Governing Board. 4. 2/13/13</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE				STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032			
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Anesthesiology Privilege Delineation form, dated 6/23/11, evidenced the practitioner did not request clinical privileges for the The Surgery Center of Carmel. Staff member #3 Anesthesiology Privilege Delineation form evidenced the Medical Staff did not grant privileges for The Surgery Center of Carmel.</p> <p>4. Staff member #4 credential files were reviewed. The Anesthesiology Privilege Delineation form, dated 5/3/11, evidenced the practitioner requested clinical privileges for the The Surgery Center of Carmel. Staff member #4 Anesthesiology Privilege Delineation form evidenced the Medical Staff did not verify nor grant privileges for The Surgery Center of Carmel.</p> <p>5. Staff member #7 credential files were reviewed. The IN Vitro Privilege Delineation form, dated 6/24/11, evidenced that the practitioner did not request any</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001146	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF CARMEL THE			STREET ADDRESS, CITY, STATE, ZIP CODE 12188 N MERIDIAN ST BLDG A STE 150 CARMEL, IN 46032		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	privileges for The Surgery Center of Carmel; however, staff member performs procedures at the center.				