

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001055	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2013
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NAME OF PROVIDER OR SUPPLIER CENTRAL INDIANA SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9002 N MERIDIAN LOWER LEVEL INDIANAPOLIS, IN 46260
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(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
S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 008655</p> <p>Survey Date: 8-26/29-13</p> <p>Surveyor: Jack I. Cohen, MHA Medical Surveyor</p> <p>QA: claughlin 09/05/13</p>	S000000	Plan of Correction is being submitted 10/8/2013	
S000102	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(1)(A)</p> <p>The governing body shall do the following:</p> <p>(1) Ensure that the center: (A) meets all rules and regulations for licensure and certification, if applicable Based on document review and interview, the facility failed to comply with an applicable state law for 2 of 2 allied health credential files reviewed.</p> <p>Findings:</p>	S000102	AH#1 and AH#2 are not employees. These individuals go through a credentialing and re-credentialing process annually and both have been credentialled since 1995. It was my understnading that the regulation	09/09/2013

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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	<p>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 for criminal history information under IC 5-2-5 or another source allowed by law.</p> <p>2. Review of the credential files of allied health staff AH#1 and AH#2 indicated both were credentialed and privileged by the governing board in July, 2013 as certified surgical techs, both provided direct patient care, both did not have any state health care provider license, and both were not certified as a nurse aide.</p> <p>3. Review of both the above-stated files indicated there was no documentation of the employees' state nurse aide registry report from the state department and there was no 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>4. In interview, on 8-26-13 at 3:00 pm, employee #A1 indicated there was no documentation of the employees' state nurse aide registry report from the state department and was no documentation of a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another</p>		<p>was for employeeyes not Allied Health Members. Since the survey, Central Indiana Surgery Center has included in th's policy to include all non-state licensed persons when obtaining criminal background checks and nurse aide registry checks. This policy was updated and approved by the Governing Body on 9/9/13. The Director of Nursing will ensure that the policy is followed on all non-state licensed individuals, mployeeyes or Allied Health Members. The Director of Nursing has completed the Nurse Aide Registry Search for AH1 and AH2 and the Criminal Background Check is in process for AH1 and AH2 will be completed on 10/9/13 when this Allied Health Member is at the facility next in order to obtain her consent. The Director of Nursing will complete these checks.</p>				

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S000106	<p>source allowed by law. 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 (a)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Review the bylaws at least triennially. Based on document review and interview, the governing board failed to review its bylaws triennially in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the governing board bylaws indicated the most recent review of the bylaws was 9-21-09. 2. In interview, on 8-26-13 at 3:30 pm, employee #A1 confirmed the above and no further documentation was provided by exit. 	S000106	The By-Laws were being revised during the timeframe of the triennial review. The Governing Body reviewed and approved the By-Laws on 9/9/13. The Director of Nursing will ensure that the Governing Body reviews and approves the By-Laws triennially even if being revised and again after the revision is complete.	09/09/2013	

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S000122	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body.</p> <p>Based on document review and interview, the governing board failed to triennially review and approve the medical staff bylaws and the medical staff rules, respectively, in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of documents indicated the most recent time the governing board reviewed and approved of the medical staff bylaws was 9-21-09. 2. Review of documents indicated the most recent time the governing board reviewed and approved of the medical staff rules, as part of the facility's overall policies and procedures, was 9-21-09. 3. In interview, on 8-26-13 at 3:30 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit. 	S000122	<p>The Governing Body will ensure the Medical Staff reviews and approves the By-Laws and Rules triennially even if being revised. The Director of Nursing will be responsible for presenting the By-Laws and Rules to the Medical Staff triennially. The Medical Staff reviewed and approved the By-Laws and Rules 9/9/13 to satisfy this regulation.</p>	09/09/2013			

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S000614	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(2)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(2) A unit record system of filing should be utilized. When this is not practicable, a system must be established by the center to retrieve, when necessary, all divergently located record components.</p> <p>Based on document review and interview, the facility failed to have a policy describing the unit record procedure used by the facility to file medical records.</p> <p>Findings:</p> <p>1. Review of documents indicated the facility did not have a policy describing the unit record procedure used by the facility to file medical records.</p> <p>2. In interview, on 8-28-13 at 3:00 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	S000614	<p>A policy was written describing the Unit Record System that is utilized at Central Indiana Surgery Center. The Director of Nursing was responsible for writing this policy. The Policy was reviewed and approved by the Governing Board on 9/9/13. This policy satisfies the regulation and will not happen in the future.</p>	09/09/2013			

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S000620	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(5)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(5) Plain paper facsimile orders, reports, and documents are acceptable for inclusion in the medical record if allowed by the center policies.</p> <p>Based on document review and interview, the facility failed to have a policy that if faxed documents are included in the record, they are required to be on plain paper in 1 instance.</p> <p>Findings:</p> <p>1. Review of a document entitled Policy & Procedure, Subject: Faxing Protected Health Information, approved 9-9-13, indicated it did not indicate if faxed documents are included in the record, they are required to be on plain paper.</p> <p>2. In interview, on 8-28-13 at 3:10 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	S000620	<p>Wording was added to the Policy Faxing PHI to encompass the words "plain paper". The updated policy was written by the Director of Nursing. The Governing Board viewed and approved the policy 9/9/13. The policy update satisfies the regulation and will not happen in the future.</p>	09/09/2013			

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S000732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based on document review and interview, the medical staff did not review the medical staff bylaws and medical staff rules, respectively, at least once every three (3) years in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of documents indicated the medical staff last approved of the medical staff bylaws was on 9-21-09. 2. Review of documents indicated the medical staff last approved of the medical staff rules, as part of the facility's overall policies and procedures, was 9-21-09. 3. In interview, on 8-26-13 at 3:30 pm, employee #A1 confirmed the above and no further documentation was provided by exit. 	S000732	The Medical Staff had not reviewed the By-Laws and Rules because of revisions being made. The Medical Staff Reviewed and approved the By-Laws and Rules on 9/9/13. The Director of Nursing will ensure that the Medical Staff will review and approve the By-Laws and Rules triennially even if being revised.	09/09/2013	

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S000766	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(L)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(L) A provision for physician coverage of emergency care which addresses at least the following:</p> <p>(i) A definition of emergency care. (ii) A timely response.</p> <p>Based on document review and interview, the facility failed to address what was a timely response in an emergency in 1 instance.</p> <p>Findings:</p> <p>1. Review of facility Policy No. 5.26, entitled Subject: Physician Notification of Patient Change or Emergency, approved 9-21-09, indicated if the attending physician and or anesthesiologist/CRNA are not available, the facility Medical Director will be contacted. Further review of the document did not indicate how long the facility needed to wait if there was no response from the Medical Director before taking the next action.</p> <p>2. In interview, on 8-28-13 at 2:30 pm,</p>	S000766	<p>Policy No. 5.26 was revised to include the description of a timely response and next actions and follow through to a call to 911. The Director of Nursing revised the policy. The policy was approved by the Governing Body on 9/9/13 and the Director of Nursing instructed the clinical staff on 9/10/13 of this revision. The updated policy satisfies the regulation and will not happen in the future.</p>	09/09/2013			

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S000772	<p>employee #A1 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review and interview, the medical staff failed to include in its policies a requirement that</p>	S000772	Policy No. 2.02 was revised to include a consistency in the scope and complexity of the procedure in the history and	09/09/2013			

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	<p>the history and physical be consistent with the scope and complexity of the procedure to be performed in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of medical staff Policy No. 2.02, page 2 of 7, entitled SUBJECT: RULES & REGULATIONS OF THE MEDICAL STAFF, SECTION 5. Patient Admission Requirements, approved 9-21-09, indicated it did not include a requirement that the history and physical be consistent with the scope and complexity of the procedure to be performed. In interview, on 8-28-13 at 1:15 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit. 		<p>physical. The policy was revised by the Director of Nursing and presented to the Governing Board. The Governing Board approved the policy on 9/9/13. This was being followed on the History and Physicals, it just was not reflected in the policy.</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 and interview, the facility failed to have the appropriate amount and type of medication in its crash cart in 3 instances.</p> <p>Findings:</p> <p>1. On 8-29-13 at 12:30 pm, in the presence of employee #A1, an inventory of the items in the facility 's crash cart,</p>	S000862	All 3 medications on this deficiency were on back-order and were removed due to expiration of the medication. The Code Cart inventory log was updated on 8/30/13 to reflect these back-orders. The Director of Nursing instructed the Nurse responsible for medication ordering to include any back ordered medication with dates on the inventory sheet. These medication slots in the code cart	08/30/2013			

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	<p>compared to a document entitled CENTRAL INDIANA SURGERY CENTER CODE CART, indicated the following:</p> <table border="0"> <tr> <td colspan="2">Item</td> <td># Required in Cart</td> <td># Available in Cart</td> </tr> <tr> <td colspan="2">Amiodarone 150mg/3ml</td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td>1</td> <td></td> </tr> <tr> <td colspan="2">Lasix 20mg/2ml (2ml)</td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td>2</td> <td></td> </tr> <tr> <td colspan="2">Sodium Bicarbonate 8.4% Abboject (50 ml)</td> <td>5</td> <td>4</td> </tr> </table> <p>2. In interview on the above date and time, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>	Item		# Required in Cart	# Available in Cart	Amiodarone 150mg/3ml				2		1		Lasix 20mg/2ml (2ml)				4		2		Sodium Bicarbonate 8.4% Abboject (50 ml)		5	4		drawers were labeled as back-ordered. With documentation on the inventory sheet and in the drawer, it will be more clear why a medication slot is empty.	
Item		# Required in Cart	# Available in Cart																									
Amiodarone 150mg/3ml																												
2		1																										
Lasix 20mg/2ml (2ml)																												
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Sodium Bicarbonate 8.4% Abboject (50 ml)		5	4																									

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S000888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</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>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval. Based on document review and interview, the medical staff failed to have a policy that a written operative report required the inclusion of tissues removed or altered in 1 instance.</p> <p>Findings:</p> <p>1. Review of facility Policy No. 2.02 entitled SUBJECT: RULES & REGULATIONS OF THE MEDICAL STAFF, SECTION 11. Medical Records Requirements, indicated it did not have a requirement for the operative report to have an inclusion of tissues removed or</p>	S000888	Policy No. 2.02 was revised by the Director of Nursing to include the requirement for the Operative Report to have an inclusion of tissue removed or altered. The revised policy was reviewed and approved by the Governing Board on 9/9/13. This process is being completed, we just did not have a policy stating such.	09/09/2013	

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(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			
S001010	<p>altered.</p> <p>2. In interview, on 8-28-13 at 2:10 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation and interview, the facility failed to follow its policy to securely store a medication in 1 instance.</p> <p>Findings:</p> <p>1. On 8-29-13 at 12:30 pm, in the presence of employee #A1, it was observed there was 1 tube of Lidocaine 2% gel stored unsecured on the top of the crash cart located in the preop area.</p>	S001010	Lidocaine Jelly is now located in Drawer #4 of the locked Code Cart. The Director of Nursing placed the Lidocaine Jelly inside the Code Cart on 8/30/13. The Code Cart inventory record was changed to reflect the new location on 8/29/13. The new location will prevent it from being unsecure in the future.	08/30/2013			

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	<p>2. Review of a document entitled CENTRAL INDIANA SURGERY CENTER CODE CART indicated the tube was to be stored on the top of the cart.</p> <p>3. Review of Policy No. 5.25, entitled SUBJECT: MEDICATION SAFETY, approved 2-22-10, indicated all meds in the preop area are also locked up in cabinets or drawers at the end of the day to ensure medication safe-keeping.</p> <p>4. In interview, on the above date and time, employee #A1 confirmed the above. The employee also indicated the contracted cleaning staff came in after hours when no staff was present and the tube would normally be stored on the top of the cart unsecured, thus not locked up in a cabinet or drawer at the end of the day to ensure medication safe-keeping.</p>				