

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/03/2012
NAME OF PROVIDER OR SUPPLIER SURGICAL CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY INDIANAPOLIS, IN 46256		
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005392</p> <p>Survey Date: 04-02/03-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Franco, Deborah, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 04/11/12</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.

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S0132	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(8)</p> <p>The governing body shall do the following:</p> <p>(8) Ensure surgical procedures are performed only by a physician, dentist, or podiatrist who is privileged to perform such procedures according to medical staff bylaws, regulations, and/or policies and procedures.</p> <p>Based on document review and interview, the governing body failed to specify privileges for 1 of 9 practitioners on the medical staff.</p> <p>Findings:</p> <p>1. Review of the Medical Staff Bylaws, Article VII, Section B entitled Delineation of Privileges in General, indicated each application for appointment and reappointment to the medical staff must contain a request for the specific privileges desired by the application.</p> <p>2. Review of 9 medical staff member credential files indicated there was a document with the request for privileges for practitioner AH#2, a surgery technician. Review of this document indicated the scope of practice requested was scrub and assist in all surgeries with</p>	S0132	<p>The allied health member that did not have specific privileges outlined reapplied for priviledges with a new application indicating what she is credentialed for and was supported by information that was previously obtained and still up to date. This was approved by the Medical Staff /BOD at an emergency meeting on 4/17/2012. We have developed a new application form for all allied health personnel to apply for priviledges. This will prevent this from happening in the future. It will be the resonsibility of the credentialing department and the Director to make sure this is done appropriately.</p>	04/17/2012			

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	<p>DC. There was no specification of the term "assist".</p> <p>3. On 4-3-12 at 10:00 am, upon interview, employee #A1 indicated there was no other documentation of current privileges requested or granted by the governing board for practitioner AH#2. No other documentation was provided by exit.</p>			

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S0404	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on personnel file review and interview, the facility failed to ensure the infection control plan was effective in relation to the documentation of time administered and time read for TB skin tests (P1, P2, P5, P6, and P7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of personnel files indicated the most recent TB skin tests documented in the personnel files of P1, P2, P5, P6, and P7 lacked documentation of time TB skin test was administered and time read. During interview with S1 on 4-2-2012 at 10:30 AM, S1 indicated: <ol style="list-style-type: none"> S1 is the Director of the facility and the Infection Control Officer. The facility follows CDC guidelines regarding TB skin testing and that CDC recommends TB skin tests be read no less 	S0404	<p>The Center has revised their infection control plan as well as the PPD documentation form. When an employee receives a PPD, the time and the date it was given as well as the time and date and it was read will be documented on every individual who receives a PPD through Surgical Care Center. The following policy was updated: 11.27. All changes were approved by the Medical Staff/BOD at an emergency meeting on 4/17/2012. It is the responsibility of the OSHA officer and the Director/Infection Control Officer to monitor this. The above steps will prevent this from happening in the future.</p>	04/12/2012			

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	<p>than 48 hours after and no longer than 72 hours after administration.</p> <p>c. verified the above findings in the personnel records.</p> <p>d. acknowledged that without documentation of time TB skin test was administered and read that it could not be reliably determined that the test was read within the 48 to 72 hours per the CDC guidelines.</p>			

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S0612	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure that the medical record was accurately documented in 1 of 30 closed medical records reviewed (N16).</p> <p>Findings included:</p> <ol style="list-style-type: none"> Facility policy "Charting Standards", last reviewed/revised May 2, 2010, provides in pertinent part on page1 that " Charting should be clear, concise, factual, objective, and accurate". Review of medical record of N16 indicated 4 pages of the record (the face sheet, the informed consent, the physician orders, and the post-op laser follow-up visit and instructions) were dated 8-31-2010 whereas the remainder of the medical record was dated 8-31-2011. 	S0612	<p>The documentation for the medical record was corrected by a single line through the date and the correct date written in and initialed by the employee making the correction. The staff was alerted to this error and they were advised of the importance of confirming all information on the patient's medical record. This was discussed in the employee staff meeting on 4/16/2012 and the importance of being very detail oriented and thorough was discussed. All medical records will be checked for accuracy prior to the charts being finalized. This should prevent this from happening in the future. The Director will monitor this.</p>	04/16/2012			

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	<p>3. During interview with S1 on 4-4-2012 at 2:30 PM, S1 indicated:</p> <p>a. S1 is the Director of the facility.</p> <p>b. N16 did not have a surgical procedure at the facility on 8-31-2010.</p> <p>b. confirmed the findings above in N16's medical record and established that the correct date of the procedure was 8-31-2011.</p> <p>c. explained that an error in record keeping had occurred regarding N16's chart that should have been detected by caregivers and medical records personnel.</p>			

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S0668	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(11)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(11) Condition on discharge, disposition of the patient, and time of dismissal.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure the accuracy of the medical record in 2 of 3 medical records of transferred patients (N1 and N29).</p> <p>Findings included:</p> <p>1. Facility policy "Patient Transfer to Another Healthcare Facility", last reviewed/revised May 2, 2010 provided in pertinent part, page 2, 6. "The attending physician will complete the Physician's Orders and Major Diagnosis portions of the Transfer form".</p> <p>2. Facility policy "Rules and Regulations of the the Medical Staff" provided in pertinent part, page 5, D "The patient's medical record must also contain ... any complications.... and discharge summary by the surgeon, and with the surgeon's signature".</p>	S0668	<p>The Center has updated their transfer policy as well as the transfer form. In addition, a new form has been established that will be completed by the attending physician indicating changes to their routine dictation template. This form will be attached to the operative record and will remain in the patient's medical record. The policies that were edited are: 7.05, 7.04, and 5.03. The staff and physicians were re-trained on transfer documentation procedures. In addition to the new dictation form the staff and physicians were reminded to make a notation on the anesthesia orders that the patient was transferred. All of these procedures will prevent this from happening in the future. This will be monitored by the person responsible for Quality Assurance of transfers and ultimately the Assistant Director.</p>	04/17/2012			

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	<p>3. Review of medical record of N1 indicated:</p> <p>a. N1 was admitted with a pre-operative diagnosis of right eye cataract and chronic open-angle glaucoma. N1 had elevated diastolic blood pressure in the pre-operative area which was treated but recurred in the recovery room.</p> <p>b. The anesthesiologist ordered N1 transferred to a hospital ER and N1 was transferred at 14:00. The transfer form had an area for major diagnosis which was blank. Another section of the transfer form indicated the patient's EKG monitoring had shown frequent PVCs (a cardiac arrhythmia).</p> <p>c. N1's operative report was dictated by the surgeon and included under discharge summary: "The patient was given a postoperative instructions sheet in the outpatient recovery area. An appointment has been made for a post-operative examination tomorrow, at which time we will again review all instructions with the patient. The patient was asked to continue all normal systemic medications, if any, and to resume their normal diet. The patient was discharged in good condition". The discharge summary lacked any reference to the post-operative episode of cardiac arrhythmia and abnormal vital signs which necessitated N1's transfer to an ER.</p>						

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	<p>4. Review of medical record of N29 indicated:</p> <p>a. N29 was admitted 4-13-2011 with left eye cataract. In the recovery room N29's blood pressure and pulse dropped to abnormal levels and did not respond well to treatment initiated.</p> <p>b. The surgeon and anesthesiologist ordered N29 to be transferred to a hospital ER, which was done at 14:50. The transfer form lacked documentation of a major diagnosis.</p> <p>c. The operative report/discharge summary indicated "The patient was given a postoperative instructions sheet in the outpatient recovery area. An appointment has been made for a post-operative examination tomorrow, at which time we will again review all instructions with the patient. The patient was asked to continue all normal systemic medications, if any. The patient was discharged in good condition".</p> <p>d. The physician's order sheet, which the surgeon signed, included an order "patient discharged at 14:50 per discharge criteria in stable condition".</p> <p>5. During interview with S1 on 4-3-2012 at 2:30 PM, S1 indicted:</p> <p>a. S1 is the Director of the facility.</p> <p>b. verified the above findings in the medical records.</p> <p>c. acknowledged that for N1 that the</p>						

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	<p>patient was not "discharged in good condition" but transferred to an ER for acute treatment of N1's symptoms.</p> <p>d. acknowledged that for N29 that the patient was not "discharged in good condition" as per the surgeon's discharge summary but transferred to an ER for acute treatment of N29's symptoms. The physician's order sheet which indicated N29 was released at 14:50 per discharge criteria in stable condition was incorrect.</p> <p>e. that the transfer forms for N1 and N29 were not complete as to major diagnosis which should have been filled out to indicate the post-operative diagnosis that necessitated the transfers.</p> <p>f. the documentation in the above medical records did not comply with the facility policies regarding patient transfers and medical record content.</p> <p>g. that surgeons use a template regarding the content of the discharge summary and that the discharge summaries for N1 and N29 did not accurately reflect the course of the patients' post operative care at the facility; the surgeons should have reviewed the documents and made appropriate revisions to include pertinent information regarding the patients' post-operative course and transfers to an ER prior to authenticating the documents.</p>			

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S1188	<p>410 IAC 15-2.5-7 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 accordance with hospital policy in 1 instance.</p> <p>Findings:</p> <p>1. Review of a document entitled EMERGENCY/DISASTER PREPAREDNESS PLAN, Section FIRE, indicated a fire drill shall be completed on a quarterly basis.</p> <p>2. Review of documentation of fire drill for calendar year 2011 indicated there were drills conducted on March 10, September 8 and November 4 (3 of 4 quarters).</p>	S1188	<p>To ensure that The Center conducts random fire drills on a quarterly basis the Director will make a schedule at the beginning of each year as to what date each quarter the fire drill will be conducted. This information will only be shared with the pertinent individuals that need to know prior to the drill. This will be entered in her calendar. A schedule for the remainder of 2012 has also been established. Policy #8.16 was updated to indicate this procedure. These steps will assure this does not happen in the future. All changes were approved by the Medical Staff at an emergency meeting on 4/17/2012. This is the responsibility of the Director.</p>	04/17/2012			

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	3. On 4-3-12 at 2:45 pm, upon interview, employee #A1 indicated there were no fire drills conducted in April, May or June of calendar year 2011. No other documentation was provided prior to exit.			