

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2015
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NAME OF PROVIDER OR SUPPLIER NAAB ROAD SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260
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S 000 Bldg. 00	This visit was for a State licensure survey. Facility Number: 010525 Survey Date: 05-04/07-2015 QA: cjl 05/21/15	S 000		
S 048 Bldg. 00	410 IAC 15-2.3-1 ISSUANCE OF LICENSE 410 IAC 15-2.3-1 (d) (d) All changes in ownership, name, and address must be reported in writing to the division. Reapplication must be filed when a change of fifty percent (50%) or greater ownership occurs. Based on document review and interview, the facility failed to notify, in writing to the Indiana State Department of Health (ISDH), Acute Care division, a change in ownership. Findings: 1. Review of the Board of Managers Meeting, June 4, 2014, indicated employee #A2, Executive Director, gave the BOM [Board of Managers] a brief	S 048	1. NRSC will notify ISDOH of ownership revisions. 2. It will be the responsibility of the Executive Director to ensure that this area is completed.	06/28/2015

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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	<p>update on the conversion of NRSC [Naab Road Surgery Center] to a Controlled Entity with St. Vincent [Hospital and Health Services of Indianapolis].</p> <p>2. Review of ownership documents indicated prior to this change, the majority owner was Naab Road Doctors and the minority owner was St. Vincent.</p> <p>3. Review of Board of Managers meeting minutes indicated the majority owner was now 60% St. Vincent, and 40% Naab Road Doctors.</p> <p>4. In interview on 5-04-2015 at 9:30 am, employee #A2 indicated there had been a change in ownership in calendar year 2014 whereby a majority entity had become a minority entity and minority entity had become a majority entity. At that same time and date, the employee was requested to provide documentation the ISDH Acute Care division had been informed of this ownership change.</p> <p>5. In interview, on 5-7-2015 at 9:35 am, employee #A2 indicated the facility could not provide any documentation of notifying the ISDH Acute Care division, of the change in ownership. No other documentation was provided prior to exit.</p>			

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S 708 Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(3)</p> <p>The medical staff shall do the following:</p> <p>(3) Make recommendations to the governing body on the appointment or reappointment of the applicant for a period not to exceed two (2) years. Based on document review and interview, the medical staff failed to make recommendations to the governing body on the reappointment of the applicant according to medical staff policy for 2 (MD#1 and MD#5) of 8 physician credential files reviewed.</p> <p>Findings:</p> <p>1. Review of medical staff Policy No. 2.01, approved by the governing board on 2-18-2014, indicated the following:</p> <p><u>Procedure for Reappointment</u> Application for reappointment to the</p>			S 708	<p>1. Policy 2.01 Medical Staff By-laws will be updated to reflect bi-annually as the process for reappointment to NRSC. 2. This update and change was approved at the Medical Staff meeting held on 5/28/2015 this will also be presented at the next Board of Managers meeting that will be held on August 19, 2015. 3. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves and is monitored.</p>		05/28/2015

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S 746	<p>medical staff shall be made annually on the prescribed form.</p> <p><u>Conditions and Duration of Appointment</u> Appointments to staff shall be for a period of twenty-four (24) months.</p> <p>2. The above-stated policy indicated the reappointment to be both annually and every twenty-four (24) months. Thus, the more stringent of the two is annually.</p> <p>3. Review of 8 medical staff credential files indicated files MD#1, a podiatrist, and MD#5, an anesthesiologist, each most recently received Medical Staff (Approval) on 10-24-2013 and there was no further reappointment. Thus, each was not reappointed annually.</p> <p>4. In interview, on 5-6-2015 at 10:30 am, employee #A1, Clinical Director, confirmed the above and no other documentation was provided prior to exit.</p>				
	410 IAC 15-2.5-4				

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Bldg. 00	<p>MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(E)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(E) A statement of duties and privileges for each category of the medical staff. Based on document review and interview, the facility gave privileges to 1 of 3 (AH#1) allied health practitioners for which the practitioner had no documentation of experience or had been trained by the facility to perform such privileges.</p> <p>Findings:</p> <p>1. Review of 3 allied health practitioner files indicated the file of AH#1, a radiology tech, had been granted privileges on 12-11-2014 to:</p> <p>chart medications given and sign according to procedure [do] History/Physician (sic) & Discharge Summary</p> <p>2. Review of the file of AH#1 indicated there was no documentation of the practitioner having had experience nor trained by the facility to chart</p>	S 746	<p>1. This citation was due to a clerical oversight on the part of the NRSC credentialing committee. By no means has this employee been allowed to present and H&P nor would they regardless. In the future the credentialing committee will try and review the completed forms in a more diligent manger. 2. No changes to policies needed or made. 3.It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves and is monitored.</p>	06/02/2015

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S 904 Bldg. 00	<p>medications and sign according to procedure, and performing History/Physician (sic) & Discharge Summary.</p> <p>3. In interview, on 5-6-2015 at 10:30 am, employee #A1, Clinical Director, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(a)(1)</p> <p>(a) Patient care services must require the following:</p> <p>(1) That the patient care services rendered are reviewed and analyzed at regular meetings of patient care personnel and used as a basis for evaluating the quality of services provided.</p> <p>Based on document review and interview, the facility failed to review and analyze the quality of patient care services provided at 11 regular meetings of patient care personnel.</p> <p>Findings:</p>	S 904	<p>1. QA & I will now be presented to NRSC staff on a quarterly basis. 2. This will be monitored at the Quarterly staff meetings 3. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves.</p>	06/23/2015

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S 010 Bldg. 00	<p>1. Review of regular meetings of patient care personnel in 2014 on 2-25, 3-25, 4-22, 6-24, 7-22, 8-7, 8-26, 9-13, 10-28, 11-25, and 12-23, indicated there was no review and analysis of the quality of patient care services provided.</p> <p>2. In interview, on 5-7-2015 at 12:15 pm, employee #A1, Clinical Director, 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 policy and procedure review, facility document review, observations and interview, the facility failed to ensure that medications were stored according to manufacturer recommendations in 1 of 1 blanket/fluid warmers. The facility failed to date medications when opened in 1 of</p>	S 010	<p>1. Policy 8.01 will be reviewed with NRSC staff and physicians to ensure all medication is dated. No medications will be stored in the blanket warmers. Policy 10.01 revised to include monitoring of the blanket warmers. 2. These updates will</p>	05/28/2015

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	<p>2 multidose vials.</p> <p>Findings:</p> <p>1. Review of policy/procedure number 8.01, Pharmacy Services, indicated the following: "Labeling: When multi-dose vials are initially used they shall be dated with the current date."</p> <p>2. Blanket warmer temperature log sheet for May 2015 indicated that the daily temperature recordings were 124-130 degrees on the days the facility was open.</p> <p>3. During tour of the Recovery Room beginning at 1335 hours with staff #1 (Clinical Director), a multidose vial of Versed 10 mg in the narcotic cabinet was observed to have been opened. The vial was not dated when opened. During tour of the Surgery Department beginning at 1330 hours with staff #1, the AMSCO dual chamber blanket/fluid warmer was observed to have 20 vials of Mannitol injectable medication in the upper chamber of the blanket/fluid warmer. The temperature of the warmer was 130 degrees. The label of the medication indicated that the manufacturer recommendation for storage was 68-77 degrees.</p> <p>4. On 5/7/15 at 1100 hours, staff #1</p>		<p>be reviewed at the Medical staff meeting on 5/28/2015 and will be taken to the quarterly staff meeting on 6/23/2015. 3. The center's Executive Director will be responsible for this action.</p>	

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S 020 Bldg. 00	<p>verified that the facility does not have a policy/procedure for storage of medications in the blanket/fluid warmer.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(D)</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>(D) Reporting of adverse reactions and medication errors to the practitioner responsible for the patient and the appropriate committee, and documented in the patient's record.</p> <p>Based on document review and interview, the facility failed to follow its policy to document in the patient's medical record a medication error in 1 instance (MR#35).</p> <p>Findings:</p> <p>1. Review of Policy No. 8.01, approved 2-19-2014, indicated any medication errors or drug reactions, ... the Nurse shall also identify this matter on the chart with her full name or full initials.</p>	S 020	<p>1. Policy 8.01 will be reviewed with NRSC staff members at the next staff meeting on 6/23/2015. 2. The center will monitor this through its incident reporting process. 3. It will be the responsibility of the Clinical Director to ensure this process improves.</p>	06/23/2015

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S 188 Bldg. 00	<p>2. Review of Quality Assurance Committee minutes of 3-20-2014, indicated a report of a medication error having occurred on a patient. Further review of documents indicated the patient was MR#35.</p> <p>3. Review of the medical record of #MR35 indicated on 11-25-2013, the patient had been given more medication than had been ordered by an anesthesiologist.</p> <p>4. Further review of the medical record of patient MR#35 indicated there was no indication a Nurse identified this matter on the chart with her full name or full initials.</p> <p>5. In interview, on 5-6-2015 at 3:30 pm, employee #A1, Clinical Director, confirmed the above and no further documentation was provided prior to exit.</p> <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>			

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	<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 evening shift fire drills in accordance with NFPA 101 Life Safety Code, 2000 Edition for 4 of 4 quarters in calendar year 2014.</p> <p>Findings:</p> <p>1. Review of NFPA 101 Life Safety Code, 2000 Edition, indicates fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. It is also required that all fire drills have to either be audible or overhead announcement and cannot be silent.</p> <p>2. Review of facility Policy No. 14.01, entitled EMERGENCY OPERATIONS, approved 2-19-2014, indicated ... an fire drill shall be conducted on a quarterly basis.</p> <p>3. In interview, on 5-4-2015 at 9:30 am,</p>	S 188	<p>1. Fire drills will be conducted on a quarterly basis to ensure 2nd shift coverage is included. 2. The Clinical Director will be responsible for ensuring this is completed and maintained.</p>	06/23/2015

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	<p>employee #A1, Clinical Director, indicated that periodically, the facility had 23 hour stays, thereby requiring a second shift of nursing staff.</p> <p>4. Review of fire drills conducted by the facility in calendar year 2014 indicated there were no fire drills conducted on the second shift.</p> <p>5. In interview, on 5-7-2015 at 9:45 am, employee #A1 confirmed there were no fire drills conducted on the second shift and no other documentation was provided prior to exit.</p>			