

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/28/2011
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NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN46256
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005973</p> <p>Survey Date: 9-26/28-11</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Tretter, Karilyn, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/17/11</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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S0153	<p>410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on review of documents and interview, the facility failed to follow its policy to provide orientation of all new employees to the employee's specific job for 2 of 5 personnel files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a facility entitled EMPLOYMENT - EMPLOYMENT AND RECRUITMENT, indicated each manager is responsible for coordinating department orientation for new staff members. 2. Review of 5 personnel files, indicated files P#1 and P#3 contained no documentation of department orientation. 3. On 9-27-11 at 2:30 pm, upon interview, employee #A1 indicated there was no documentation of job orientation on employees P#1 and P#3 and none was provided prior to exit. 	S0153	The current orientation process ensures and monitors for all new employees the receipt and documentation of orientation. In the instances where the center was cited, there were long standing employees whose roles had changed and documentation of orientation was overlooked. The two employees in question now have updated orientation documentation in their files. Moving forward, direct managers will be responsible for providing orientation documentation as roles change. Responsible party: Shannon Arrendale	11/30/2011	

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S0156	<p>410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to follow its policy to maintain annual performance evaluations for 2 of 5 employee files reviewed.</p> <p>Findings:</p> <p>1. Review of a contract between Community Hospital Indianapolis (CHI) and Visionary Enterprises (VEI), Section VII., entitled CHI Employees, indicated CHI shall provide VEI with copies of annual performance evaluations, specific to the intraoperative radiological performance and competencies, of any personnel employed by CHI but performing Services at the Centers.</p>	S0156	<p>The current contract for radiation services and supervision will be amended to state that the performance appraisal done by the radiology technicians direct supervisor will serve as the centers performance review. The updated contract will prevent any recurrence. Responsible Party: Shannon Arrendale</p>	11/30/2011	

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S0172	<p>2. On 9-27-11 at 2:30 pm, upon interview, employee #A1 indicated the CHI employees referred to above were radiological technologists employed by Community Hospital North who performed radiological services at the Indiana Surgery Center North.</p> <p>3. Review of 5 employee files indicated 2 contracted radiological employee files, P#4 and P#5, had no performance evaluation conducted by or reviewed by any authorized surgery center person. No further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review and interview, the facility failed to follow its policy and</p>	S0172	This citation is confusing as the center does not have a policy by this name. However, all personnel files	11/01/2011	

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	<p>did not document evidence of participation in job related educational activities for 2 of 5 employee files reviewed.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled TRIENNNUAL TRAINING, indicated each employee of the Indiana Surgery Center is responsible for completing the above listed inservices on an annual basis or as otherwise indicated. It further indicted it is each employee's responsibility to record the completion of each inservice and to present this record to the designated staff person responsible for tracking inservice completion.</p> <p>2. Review of 5 personnel files, indicated files P#4 and P#5 had no documentation of evidence of current annual participation in listed inservices.</p> <p>3. On 9-27-11 at 2:30 pm, upon interview, employee #A1 indicated there was no documentation of current annual inservice on employees P#4 and P#5 and none was provided prior to exit.</p>		<p>have been reviewed to ensure all employees are current with required mandatory training. Moving forward, the administrative assistant will continue to track compliance of required training. Direct supervisors will be alerted if a particular employee is noncompliant. Responsible Party: Shannon Arrendale</p>		

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S0310	<p>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 1 service 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 the contracted dietary service.</p> <p>2. On 9-27-11 at 3:25 pm, upon interview, employee #A1 indicated there was no documentation of the above-mentioned contracted service and no documentation was provided prior to exit.</p>	S0310	<p>Dietary services have been added to the quarterly quality review of all center services. Monitored criteria includes: 1) delivery received included items ordered; 2) order was delivered within twenty four hours of placing the order. Moving forward, this process will occur quarterly.</p> <p>Responsible Party: Shannon Arrendale</p>	11/01/2011	

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S0328	<p>410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the facility failed to have a quality assessment program that was effective and appropriately addressed the outcome of the actions for follow-up and impact patient care for 4 of 4 incidents of medication errors.</p> <p>Findings:</p> <p>1. Review of a document entitled 2011 - 1st QUARTER OTHER VARIANCE REPORT ISSUES indicated there were 4 Medication Errors of various types. Further review of the document indicated the Comments were each Diagnosed and treated appropriately.</p> <p>2. On 9-27-11 at 3:25 pm, upon interview, employee #A1 indicated there was no other documentation of follow-up activities to the above-mentioned medication errors to ensure there would</p>	S0328	<p>At the quarterly quality assurance meeting on October 25, this issue was discussed. The information below shows how variances will be coded moving forward. Each code represents a certain follow up action that was taken. This will be the process at all future meetings.</p> <p>A. Results of Review</p> <p>1. No issue and no action required – 1</p> <p>2. No issue but needs referral to another department for review – 1a</p> <p>3. Educational letter of intervention; obtain additional training / continued monitoring - 2</p> <p>4. Focus review monitoring; watch and make sure it is not a problem with a defined focus and time period - 3</p> <p>5. Immediate threat to patients and employees; sever issues requiring</p>	11/01/2011			

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S0400	<p>be no future medication errors to impact patient care and no other documentation was provided prior to exit.</p> <p>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 the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients for 1 facility.</p> <p>Findings include:</p> <p>1. During the facility tour on 09-27-11 at 0930 hours the following was observed; 5 packages of 2.0 coated vicryl suture with an expiration date of 07-2011. 1 nasopharygeal 9 mm kit with an expiration date of 06-2011. 1 yellow top and 1 green top laboratory tubes with an expiration date of 07-2011.</p>	S0400	<p>immediate action and possible privilege intervention - 4</p> <p>Responsible Party: Shannon Arrendale</p> <p>All expired items have been removed. Staff will be reeducated on the outdate check processes at staff meetings on November 21. Moving forward, quarterly infection control audits will include spot checking expiration dates. Any found outdated items will be given to the area manager to review with staff.</p> <p>Responsible Party: Shannon Arrendale</p>	11/21/2011
S0644	<p>410 IAC 15-2.5-3(e)(2)</p> <p>All entries in the medical record must be as follows:</p> <p>(2) Made only by authorized individuals as specified in center and medical staff policies.</p>			

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	<p>Based on document review and interview, the facility failed to follow its policy to authenticate entries in the medical record for 1 of 15 medical records reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a facility policy entitled MEDICAL RECORDS - ENTRY - AUTHORIZATION TO AND AUTHENTICATION OF, indicated physicians with medical staff privileges are authorized to make "entries" into the medical record and each entry is to be authenticated with first initial, last name, and credentials. 2. Review of 15 medical records indicted the record of Patient #26 had a document entitled PRE-OP OUTPT ORDERS DOCTORS ORDER SHEET. Review of the document indicated this document contained various pre-operative orders to be carried out on the patient. Further review of the document indicated it was not authenticated by a physician. 3. On 9-28-11 at 12;30 pm, upon interview, employee #A1 indicated the orders had been carried out but there was no authentication as to which physician had written the orders. The employee was requested to provide documentation of the orders having been authenticated or 	S0644	<p>Record number 26 has been completed for authentication by acquiring missing physician signature. The list of documents for review for authentication was reviewed with the chart analysis staff. Moving forward, medical records auditor has been asked to pay specific attention to order authentication for the next two quarters.</p> <p>Responsible Party: Shannon Arrendale</p>	11/15/2011	

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S0840	<p>documentation of the orders having been previously approved by the medical staff and no documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4(c)(2)</p> <p>(c) The anesthesia service is responsible for all anesthesia administered in the center as follows:</p> <p>(2) A requirement that anesthesia equipment must be checked for operational readiness and safety prior to patient administration. Documentation to that effect shall be included in the patient's medical record.</p> <p>Based on document review, the facility did not follow its policy that required all anesthesia machines to be checked for operational readiness and safety prior to patient administration and documented in the patient's medical record for 1 of 15 medical records reviewed.</p> <p>Findings:</p> <p>1. Review of of facility policy entitled ANESTHESIA - GENERAL GUIDELINES, indicated anesthesia machine will be checked out prior to administration of each anesthetic and documented on "Long Form".</p> <p>2. Review of 15 medical records</p>	S0840	Anesthesia services has been added to the quarterly service review. Each quarter 30 charts will be reviewed for appropriate documentation of the anesthesia equipment check. Identified failures will be followed up with the individual anesthesiologist. Responsible Party: Shannon Arrendale	11/15/2011	

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S0920	<p>indicated the medical record of Patient #22 was anesthetized. Review of a document in the patient's medical record entitled ANESTHESIA RECORD indicated the area labeled Pre-Anesthesia Inpatient Checklist was not appropriately completed.</p> <p>3. On 9-28-11 at 11:45 am, upon interview, employee #A1 indicated the above-stated medical record document did not have the equipment checklist appropriately documented and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-5(b)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following: Based on document review the facility failed to ensure that personnel follow written patient care policies and procedures for blood transfusions for 2 of 5 blood transfusion medical records (MR) reviewed (Patient #5 & 6).</p> <p>Findings include:</p> <p>1. Review of policy/procedure Blood and</p>	S0920	<p>Staff reeducation for the appropriate documentation for blood administration will occur on November 21 at the staff meetings. Due to the infrequency of blood administration, each clinical area will have a folder that walks the employee through the steps of administration and needed documentation. Moving forward, all blood transfusions will be reviewed quarterly for appropriate</p>	11/21/2011

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	<p>Blood Products - Administration Of indicates the following:</p> <p>"D. An informed consent for blood product transfusion should be obtained before T&C, but must be signed before blood product administered. (Exception: Physician Order can be given to administer blood without the patient's consent in an emergency situation.) If blood is administered in an emergency without consent, reason must be documented in patient's chart.</p> <p>G. All blood (LPPC's, Packed Cells, Whole) must be started within 30 minutes from the time it leaves CHN Blood Bank." This policy/procedure was last reviewed/revised on 09/09.</p> <p>2. Review of patient #5's MR indicates that a unit of fresh frozen plasma was signed out of the CHN Blood Bank on 08-11-10 at 1140 hours and infusion was started on 08-11-10 at 1234 hours.</p> <p>3. Review of the Transfusion Record indicates the following to be completed for emergency release; "The patient is in an Emergency Life Threatening condition. I accept responsibility and release the blood bank Director and Personnel of the responsibility for any adverse reaction</p>		<p>documentation. Individual staff members will be followed up with if audit reveals a deficiency. Responsible Party: Shannon Arrendale</p>		

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	<p>which may have been prevented by routine pretransfusion testing. Compatibility testing will be performed as soon as possible and I will be informed of any incompatibility. The Transfusion Form has an area for the physician to sign and date."</p> <p>4. Review of Patient #6's MR the Operative Report indicated the following; "As I was dissecting this away, suddenly there was a significant gush of blood. This surprised me. I attempted to see where the bleeding was coming from. It was apparent that this was coming from the area of the medial edge of the femoral vein. The patient tolerated this procedure and was taken to the recovery area in satisfactory condition. He will be transfused in the recovery area and then we will admit him to the hospital after recovery."</p> <p>Review of the patient's MR indicates the patient received 4 units of Packed Red Blood Cells. The patient's MR lacked documentation of a Blood Transfusion Consent. The Blood Transfusion Record lacked documentation of the physician signing for Emergency Release"</p>				

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S1026	<p>410 IAC 15-2.5-6(3)(E)(i)</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>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(i) Drug cabinets must be accessible only to authorized personnel.</p> <p>Based on document review, observation and interview the facility failed to ensure that drug cabinets be accessible only to authorized personnel according to facility policy/procedure for 1 of 2 anesthesia machines.</p> <p>Findings include:</p> <p>1. Review of policy/procedure Medications - Administering, Storage and Ordering / Receiving indicates the following; "C. Storage</p> <p>2. All medications will be accurately and clearly labeled and stored in designated cabinets and / or storage rooms.</p> <p>(i) All medication storage areas will have</p>	S1026	<p>All gasses were removed from the anesthesia machines and placed in a locked medication area.</p> <p>Anesthesiologists will request gasses as needed.</p> <p>Responsible Party: Shannon Arrendale</p>	11/01/2011	

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NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN46256		
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	<p>the ability to be locked.</p> <p>(v) Anesthesia medication drawers will be kept in each anesthesia cart in each O.R. and will be outfitted with a lock. Drawers will be unlocked immediately prior to use and locked when not in use." This policy/procedure was last reviewed/revised on 08/11.</p> <p>2. During the facility tour on 09-27-11 at 1000 hours the following was observed in an unsecured anesthesia machine in Operating Room #8; 2 bottles of Suprane. 2 bottles of Ultane.</p> <p>3. On 09-27-11 at 1000 hours staff #40 confirmed that the drawer on the anesthesia machine should have been locked.</p>				