

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA SKIN CANCER AMBULATORY SURGICAL CENTER LL	STREET ADDRESS, CITY, STATE, ZIP CODE 701 E COUNTY LINE RD STE 208 GREENWOOD, IN 46143
---	--

(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	This visit was for a State licensure survey. Facility Number: 005648 Survey Date: 1-5/7-15 Surveyor: Jack I. Cohen, MHA Medical Surveyor QA: cloughlin 01/29/15	S000000		
S000176	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M) Require that the chief executive officer develop and implement policies and programs for the following: (M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures. Based on document review and interview, it could not be determined the facility followed the performance requirements in fulfilling assigned responsibilities for 1 (#P6) of 6 employee personnel files reviewed.	S000176	This deficiency will be corrected by updating documentation in our annual competency checklist to include assisting the surgeon with all surgical procedures and removing sutures/staples as needed for the aforementioned personnel. This deficiency will be prevented in the future by the	03/06/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA SKIN CANCER AMBULATORY SURGICAL CENTER LL	STREET ADDRESS, CITY, STATE, ZIP CODE 701 E COUNTY LINE RD STE 208 GREENWOOD, IN 46143
---	--

(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>Findings:</p> <ol style="list-style-type: none"> 1. Review of the job description of employee #P6 indicated the KEY PROCESSES of the job included assist physicians with all surgical procedures. Under direction of the physician, remove sutures/staples. Further review of the document indicated under PERFORMANCE REQUIREMENTS, Equipment Used, properly trained to use equipment such as surgical instruments 2. Review of the personnel files of 6 employees indicated the file of #P6 did not have any documentation of job orientation, Competency Assessment - Key Processes, and Performance Appraisal, regarding surgical procedures and use of surgical instruments and removal of sutures/staples. 3. In interview, on 1-7-15 at 10:45 am, employee #A1, Administrative Director, indicated employee #P6 did assist in surgery and could remove sutures. 4. At the above date and time, employee #A1 was requested to provide documentation of job orientation, Competency Assessment - Key Processes, and Performance Appraisal, regarding use of surgical instruments and removal of sutures/staples for employee 		<p>update on the competency checklist which is reviewed annually for all personnel. Dr. Michael Murphy - the medical director is responsible for the above changes. The deficiency will be corrected by 3/6/15.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIANA SKIN CANCER AMBULATORY SURGICAL CENTER LL	STREET ADDRESS, CITY, STATE, ZIP CODE 701 E COUNTY LINE RD STE 208 GREENWOOD, IN 46143
---	--

(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
S000644	<p>#P6. No other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 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> <p>Based on document review and interview, the facility failed to comply with its policy to authenticate entries in the medical record for 2 of 30 medical record files reviewed.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled GENERAL RULES, POLICY: indicated the following rules apply to medical records at the ASC</p> <p>PROCEDURE:</p> <p>A. All clinical entries in the patient's medical record shall be accurately dated and</p> <p style="padding-left: 40px;">authenticated. Authenticated means to prove authorship by written signature, identifiable initials or computer key.</p>	S000644	<p>This deficiency will be correctly by ensuring that all personnel are double checking to ensure that they are documenting under the correctly logged electronic medical record source. This has been discussed with our staff.</p> <p>This deficiency will be prevented in the future by staff education and double checking for accuracy during our daily audit of all medical records. Dr. Michael Murphy the Medical Director is responsible for the change. This deficiency has already been corrected as of 2.2.2015</p>	02/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001156		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2015	
NAME OF PROVIDER OR SUPPLIER INDIANA SKIN CANCER AMBULATORY SURGICAL CENTER LL				STREET ADDRESS, CITY, STATE, ZIP CODE 701 E COUNTY LINE RD STE 208 GREENWOOD, IN 46143			
(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>2. Review of 30 medical record files indicated file MR#19 had a document entitled Summary View for [MR#19]. Review of this document indicated there was an entry that the patient was discharged to SELF AT 1020 [P#3] RN. The document had no authentication by P#3.</p> <p>3. In interview, on 1-6-15 at 10:30 am, employee #A1, Administrative Director, indicated the authentication would be documented on a document for MR#19 entitled Progress Notes log. Review of that document indicated the entry was authenticated by P#6, Medical Assistant and not by P#3.</p> <p>4. Review of 30 medical record files indicated file MR#23 had a document entitled Summary View for [MR#23]. Review of this document indicated there was an entry Discharge assessment performed by: [P#3] RN. The document had no authentication by P#3.</p> <p>5. In interview, on 1-6-15 at 10:30 am, employee #A1 indicated the authentication would be documented on a document for MR#23 entitled Progress Notes log. Review of that document indicated the entry was authenticated by P#6, Medical Assistant and not by P#3.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001156	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2015
NAME OF PROVIDER OR SUPPLIER INDIANA SKIN CANCER AMBULATORY SURGICAL CENTER LL			STREET ADDRESS, CITY, STATE, ZIP CODE 701 E COUNTY LINE RD STE 208 GREENWOOD, IN 46143		
(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	
	6. In interview, on the above date and time, employee #A1 indicated there was no other means of documentation of authentication and no other documentation was provided prior to exit.				