

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001094	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/18/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER HAMILTON	STREET ADDRESS, CITY, STATE, ZIP CODE 9700 E 146TH ST NOBLESVILLE, IN 46060
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002578</p> <p>Survey Date: 6/17/13 through 6/18/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/25/13</p>	S000000		

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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S000230	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on documentation review and staff interview, the facility failed to provide for a periodic review of the center and its operation by three or more licensed physicians having no financial interest in the facility.</p> <p>Findings included:</p> <p>1. The Indiana Surgery Center Noblesville (d/b/a/ Community Surgery Center Hamilton) 2012 list of committees included the Utilization Review Committee. The committee consisted of 5 Physicians and 1 Registered Nurse.</p>	S000230	The Executive Director and Medical Director met on June 28, 2013 to restructure the committee. The Utilization Review Committee will be revised to exclude any physicians that have a financial interest in Community Surgery Center Hamilton. The committee will be comprised of 3 licensed physicians, with no financial interest in the center, and the Executive Director. Carol Wills RN, Executive Director, will present this format for approval at the Operations committee meeting and the Board of Managers meeting, both scheduled for August 5, 2013.	08/05/2013			

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	<p>2. Community Surgery Center Hamilton investors listing noted 3 of the five physicians listed on the 2012 list of committees had financial interest in the facility.</p> <p>3. At 1:15 PM on 6/17/13, staff member # 1 indicated the surgery center only has 2 physicians that are on the Utilization Review Committee that review physician charts that have no financial interest with Community Surgery Center Hamilton.</p> <p>4. At 3:00 PM on 6/18/2013, staff member #3 indicated the Utilization Review Committee only has two anesthesiologists with no financial ownership in the Surgery Center. The two physicians are the only two licensed physicians that review physician charts of Community Surgery Center Hamilton.</p>				

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S000310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 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.</p> <p>Based on document review and staff interview, the facility failed to ensure 5 services as part of its comprehensive quality assessment and improvement (QA&I) program: Blood Transfusion; Medical Records; Tissue Transplant; Infection Control; and Reportable Events.</p> <p>Findings included:</p> <p>1. Quality Risk Management, Assurance, and Improvement policy (Last approved 10/2/2012) indicates all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. The Quality Assurance Committee shall coordinate all activities designed to</p>	S000310	<p>The Executive Director and Medical Director met on June 28, 2013 to evaluate the Quality Assessment and Improvement Program. As part of the comprehensive Quality Assessment and Improvement Program, the Quality Assurance Committee will monitor and evaluate 5 additional services quarterly. The standing agenda for the Quality Assurance Committee meeting, will include Blood Transfusion; Medical Records; Tissue Transplant; Infection Control and Reportable Events. The Executive Director and the Business Office Manager will evaluate issues with medical records. The Executive Director and the center's Infection Control Preventionist will monitor processes with blood transfusions, tissue transplants, infection control and reportable events. These findings, with any associated variances, will be reported and discussed at the quarterly Quality Assurance Committee meeting. The next scheduled QA meeting is July 31, 2013. All quality assessment and improvement findings will be reported to the Operations Committee meeting and the Board of Managers meeting, both scheduled for August 5, 2013. QA findings are reported by the chair of the QA committee, Dr. Charles Wesley.</p>	06/28/2013			

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	<p>promote and attain the objectives of the Quality Assurance Plan. The Quality Committee serves as the focal point for integration of the quality activities conducted in the Center. It shall receive sufficient information from all sectors related to patient care and its evaluation to permit intelligent deliberation and to achieve the objectives of the Quality Assurance Plan.</p> <p>2. The 4 Quality Assurance Committee meeting minutes in 2012 and 1 meeting that was held in 2013 did not evidence the following 5 services were monitored and evaluated as part of the facility's QAPI program: Blood Transfusion; Medical Records; Tissue Transplant; Infection Control; and Reportable Events.</p> <p>3. At 2:30 PM on 6/17/2013, staff member #1 indicated the facility has a Tissue Committee and policies on how to handle Blood Transfusions; however, the facility has not monitored and evaluated</p>			

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	the services. The staff member indicated Infection Control has not been properly evaluated by the center as it should. The staff member confirmed the 5 services were not being monitored by the QAPI program as required: Blood Transfusion; Medical Records; Tissue Transplant; Infection Control; and Reportable Events.			

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S000320	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</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>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and staff interview, the facility failed to ensure discharge planning was made part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Quality Risk Management, Assurance, and Improvement policy (Last approved 10/2/2012) indicates all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. The QAPI conducts studies to evaluate</p>	S000320	<p>The Executive Director and Medical Director met on June 28, 2013 to evaluate the Quality Assessment and Improvement Program. As part of the comprehensive Quality Assessment and Improvement Program, the patient discharge services will be routinely monitored and evaluated. The discharge services of the center are clearly outlined in 3 established policies (attached). The 3 policies cover: Discharge Instructions; Discharge Criteria of Patients from PACU; and Discharge Criteria of Patients from Patient Rooms to Home. The discharge services will be discussed at the quarterly Quality Assurance Committee meetings. The next QA meeting is scheduled for July 31, 2013. Any pertinent findings will be reported to the Operations Committee and the Board of Managers at the next scheduled meeting, which is August 5, 2013. These findings will be reported by the chair of the QA Committee, Dr. Charles Wesley.</p>	06/28/2013	

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	<p>the appropriateness of discharge practices.</p> <p>2. The 4 Quality Assurance Committee meeting minutes in 2012 and 1 meeting that was held in 2013 did not evidence discharge services were monitored and evaluated as part of the facility's QAPI program.</p> <p>3. At 2:30 PM on 6/17/2013, staff member #1 confirmed the facility does not have documentation that identifies Discharge Services were being monitored by the QAPI program.</p>				

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S000408	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(d)</p> <p>(d) The center shall designate a person qualified by training or experience as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on facility documentation, policy and procedure review, and interview, the facility failed to designate one person to be responsible for the infection control program for the center.</p> <p>Findings included:</p> <p>1. The facility document "Committees-2012" indicated the Infection Prevention Committee was comprised of the executive director (A2), a registered nurse (RN) from patient rooms/PACU (A7), and an RN from OR (Operating Room) (A13). None was designated as the Infection Control Preventionist.</p> <p>2. The facility policy "Infection Prevention Program", last reviewed 08/06/12, indicated, "a. The Infection Prevention Program will include: 1. A qualified healthcare professional to plan and implement the program and to train other personnel. ...F. Investigation: a. All reported potential post-op infections</p>	S000408	<p>The Executive Director and Medical Director met on June 28, 2013 to review the Infection Prevention Program. The center's Infection Prevention Program had been staffed by an RN from the OR and an RN from the Patient Room's area. The intent was to have a nurse representative that is intimately involved with the functioning of a specific area. Tag #408 requires "a qualified healthcare professional to plan and implement the program and to train other personnel". Susan Dean, RN has agreed to accept the responsibility of this position. Susan's position as Infection Control Preventionist will be presented to the Operations Committee and the Board of Managers, for their approval, at the meeting scheduled for August 5, 2013.</p>	06/28/2013			

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	<p>will be investigated by the Executive Director in consultation with the Infection Control Representative."</p> <p>3. At 2:40 PM on 06/17/13, staff member A7 indicated he/she had worked at the facility since 2006, but just assumed the infection prevention responsibilities for the patient rooms/PACU area in June 2011. He/she indicated staff member A13 was responsible for infection prevention for the operating room area, but they did work together.</p> <p>4. At 4:25 PM on 06/18/13, the executive director, staff member A1, indicated the two nurses, A7 and A13, were in charge of the activities in their own area, but worked with him/her in the overall program. He/she indicated none had actually been named or approved by the board as the person in charge of the facility's infection control program.</p>			

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S000414	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on facility document review and interview, the facility failed to ensure the infection control committee was comprised of the required members.</p> <p>Findings included:</p> <p>1. The facility document "Committees-2012" indicated the Infection Prevention Committee was comprised of the executive director (A2), a registered nurse</p>	S000414	The Executive Director and Medical Director met on June 28, 2013 to review the Infection Prevention Program. The Infection Control Committee will include Susan Dean, RN, the Infection Control Preventionist, and all members of the Quality Assurance Committee. This committee includes 2 licensed physicians, department team leaders and the Executive Director. The Infection Control Committee will meet quarterly, in	07/31/2013			

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	<p>(RN) from patient rooms/PACU (A7), and an RN from OR (Operating Room) (A13). None was designated as the Infection Control Preventionist.</p> <p>2. Review of committee meeting minutes from January, March, April and May 2012 indicated the members of the infection prevention committee met with the safety committee, but neither committee included representation from the medical staff.</p> <p>3. At 4:25 PM on 06/18/13, the executive director, staff member A1, indicated two nurses, A7 from patient rooms/PACU and A13 from OR, were in charge of the activities in their own area, but worked with him/her in the overall infection prevention program. He/she indicated none had actually been named or approved by the board as the person in charge of the facility's infection control program. He/she also confirmed the committee lacked representation from the medical staff although all of the information was presented to the quality committee and the medical staff.</p>		<p>conjunction with the Quality Assurance Committee. The next scheduled meeting is July 31, 2013.</p>	

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S000418	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(A)</p> <p>(2) The infection control committee responsibilities must include, but are not limited to the following:</p> <p>(A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the center.</p> <p>Based on policy and procedure review, meeting minutes review, facility documentation, and interview, the infection control committee failed to follow their policy for identifying infections related to procedures performed at the center in 2013.</p> <p>Findings included:</p> <p>1. The facility policy "Infection Prevention Program", last reviewed 08/06/12, indicated, "C. Identification: ...iii. The Center provides the surgeon with a list of their patients from the previous month. Surgeons are asked to complete an infection surveillance form and return to the Center for review by QA [quality assurance] Committee. iv. All medical staff members will be encouraged to report to the [Center] any patient infections that occurred within 30 days post-operatively that could possibly be related to the procedure performed at the</p>	S000418	<p>The Executive Director and Medical Director met on June 28, 2013 to review the Infection Prevention Program. As part of the Infection Prevention Program, the center policy includes providing the surgeons with a list of their patients from the previous month, for feedback on any potential infections. The program also includes analysis of any variance reports and any re-admissions within 30 days. There was a short break in providing the surgeons with monthly patient lists due to implementation of a new EMR. The EPIC EMR is fully functional and the infection tracking documentation has been reestablished as of May 2013. The physician tracking documentation and any variances are reviewed at the quarterly QA/Infection Prevention Committee meeting. The next scheduled meeting is July 31, 2013.</p>	06/28/2013	

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	<p>[Center]. ...F. Investigation: a. All reported potential post-op infections will be investigated by the Executive Director in consultation with the Infection Control Representative."</p> <p>2. The Safety Committee Meeting Minutes from January 25, 2013 indicated, "ix. Infection Prevention [staff members A7 and A13]- Have you both been keeping up with your logs and audits? a. In progress."</p> <p>3. The Safety Committee Meeting Minutes from March 27, 2013 again indicated the audits and logs were in process for Infection Prevention.</p> <p>4. The Safety Committee Meeting Minutes from April 24, 2013 indicated staff members A7 and A13 were not present to report status on audits and logs.</p> <p>5. The Safety/Infection Prevention Committee Meeting Minutes from May 29, 2013 indicated, "7. Infection Prevention: a. Log Checks- Review/Check- Updated?.b. Bulletin Board c. Audits- Review/Check- Updated? d. Other."</p> <p>6. Review of the infection surveillance forms binder indicated no forms for 2013 and some of the forms for 2012 covered a</p>			

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	<p>2- 6 month period instead of each form covering only one month.</p> <p>7. At 3:40 PM on 06/17/13, staff member A1 indicated the implementation of the electronic medical record system had slowed them down as they had been unable to ascertain the physician log document with the new system. He/she confirmed the lack of infection tracking documentation for 2013 although the physicians would still notify the center if there was a problem.</p>			