

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTHWEST	STREET ADDRESS, CITY, STATE, ZIP CODE 8651 TOWNSHIP LINE ROAD INDIANAPOLIS, IN 46260
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005974</p> <p>Survey Date: 11-24/25-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 01/21/15</p>	S000000		
S000220	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)</p> <p>(e) 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: Based on document review and interview, the governing board failed to ensure the services of transfers and</p>	S000220	<p>1. The Center holds quarterly QA meetings. The review of variance reports for transfers and medication errors have been</p>	12/31/2014

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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S000226	<p>medication errors were provided in a safe and effective manner.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's Quality Assurance/Performance Improvement program and governing board meeting minutes for year 2014 indicated the governing board did not review reports for the services of transfers and medication errors. In interview on 11-24-14 at 12:30 pm, employee #A1, Executive Director, confirmed the above and no other documentation was provided prior to exit. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</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>(3) Ensure that the center maintains a</p>		<p>added as standing agenda items to these quarterly meetings. In addition, they will be audited if they occur along with any corrective action that must occur if warranted by the QA committee. See attached "Quality Assurance Nursing/Staff Services" Document Responsible parties: Executive Director, Clinical Director, QA committee</p>		

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	<p>list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to ensure a complete list, including the scope and nature, of all contracted services in 3 (housekeeping, tissue transplant and transcription) instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 11-24-14 at 9:45 am, employee #A1, Executive Director, was requested to provide documentation of a list of all contracted services, including the scope and nature of the services provided. Review of a document entitled Contract List indicated it did not have some of the facility contracted services as part of the list. These services were housekeeping, tissue transplant, and transcription. In interview, on 11-25-14 at 2:00 pm, employee #A2, Clinical Director, confirmed the above and no other documentation was provided prior to exit. 	S000226	<ol style="list-style-type: none"> A document of contracted services was in place. Added to this list was tissue transplant. Housekeeping and transcription were on the list. Attached is the updated list of Contracted services. See attachment: "community surgery center northwest contracted services" Responsible Party: clinical director 	11/28/2014

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S000228	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</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>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that podiatrists performing surgery in the facility maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located for 1 of 4 podiatrist credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 4 podiatrist credential files indicated files MD#6, a podiatrist, did not have documentation of admitting</p>	S000228	<p>1. The podiatrist who did not have documentation of admitting privileges has terminated her privileges at Community Surgery Center Northwest. See attached letter confirming. This will be reported at the next board meeting scheduled for February 12. Admitting privileges will be monitored and audited at each appointment and reappointment application. If the admitting privileges are not maintained the credentialing process will be delayed. Results will be presented during peer review and through the credentialing process and made available to the board</p>	02/12/2015

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S000320	<p>privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located.</p> <p>2. In interview, on 11-25-14 at 10:10 am, employee #A1, Executive Director confirmed the above and no other documentation was provided prior to exit.</p> <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 interview, the facility failed to include a monitor and standard for the activities of transfers and medication errors in its quality assessment and performance improvement (QAPI) program</p>	S000320	<p>at time of appointment/reappointment. Responsible Party: Executive Director</p> <p>1. The QA committee meets quarterly and has been added to their standing agenda items to review the activities of transfers and medication errors. If any are presented via variance report they will be comprehensively discussed</p>	01/30/2015

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S000328	<p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's QAPI program indicated it did not include the activities of transfers and medication errors. In interview on 11-24-14 at 12:30 pm, employee #A1, Executive Director confirmed the above and no documentation was provided prior to exit. <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 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> <ol style="list-style-type: none"> The action must be documented. The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care. <p>Based on document review and interview, the center failed to take appropriate action to address one (1) opportunity for improvement through its quality assessment and performance improvement (QAPI) program.</p>	S000328	<p>by this committee who will then provide decisive direction on corrective action that will follow. If none are reported in a quarter that will also be indicated in the meeting minutes.</p> <p>See attachment labeled: "Quality Assurance Nursing/Staff Services" Responsible Parties: Executive Director and Clinical Director</p> <p>1. During monthly outdates an inventory listing of drugs in anesthesia drawers will also be checked for accuracy of drug placement, location, quantity, and expiration. This monthly report will be presented to the QA committee</p>	01/30/2015	

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S000756	<p>Findings:</p> <ol style="list-style-type: none"> Review of a document entitled PHARMACY INSPECTION CHECKLIST, signed by contractor #A4, a contracted pharmacist, dated 6-12-14, indicated there was no quality assurance monitoring for the provision of anesthesia drug trays. On 11-25-14 at 1:15 pm, employee #A1, Executive Director, was requested to provide the quality assurance monitoring for the provision of anesthesia drug trays. In interview on 11-25-14 at 1:15 pm, employee #A1, indicated there was no documentation of quality assurance monitoring for the provision of anesthesia drug trays and no follow-up action based on the pharmacist's above-stated report. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(J)</p> <p>These bylaws and rules must be as follows:</p>		at quarterly meetings. If a discrepancy is noted at any time during a monthly check it will be immediately brought to the attention of the Clinical and Executive Directors and rectified. Responsible Party: Clinical Director				

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	<p>(3) Include, at a minimum, the following:</p> <p>(J) A requirement that each physician's services, , dentist's services, and podiatrist's services are to be reviewed and analyzed at specified intervals at regular meetings, including, but not limited to, the following:</p> <p>(i) Appropriateness of diagnoses and treatments rendered related to a standard of care and anticipated or expected results.</p> <p>(ii) Performance evaluation based on clinical performance indicated in part by the results or outcome of surgical intervention.</p> <p>(iii) Scope and frequency of procedures.</p> <p>Based on document review and interview, the facility failed to conduct outcome-oriented performance evaluations of 3 (MD#3, MD#4, MD#5) of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of the medial staff bylaws approved 11-7-12, indicated each recommendation of a person currently appointed to the medical staff ... shall be based upon the member's ability to demonstrate to the satisfaction of the Credentials Committee:</p>	S000756	<p>1. A new form has been developed that includes a checklist for recredentialing candidates. This form provides for review of outcome-oriented performance evaluations of applicants. In addition the following categories have been added: appropriateness of diagnosis and treatments rendered related to a standard of care and anticipated or expected results, performance evaluation based on clinical performance indicated in part by the results or outcome of surgical intervention, and scope and frequency of procedures.</p> <p>Responsible Party: Executive Director and Peer Review</p>	02/12/2015			

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	<p>(a) Such member's professional ethics, current competence and clinical judgement in the treatment of patients</p> <p>(c) His behavior and cooperation with Surgery Center personnel</p> <p>(d) His use of the Surgery Center's facilities for the patients, his cooperation and relations with others, and his general attitude toward patients, the Surgery Center and the public</p> <p>2. Review of 7 medical staff credential files indicated files MD#3, a podiatrist, MD#4, a podiatrist, and MD#5, a podiatrist had no documentation of outcome-oriented performance evaluations.</p> <p>3. Further review of the medical staff bylaws indicated they did not indicate the review to include: -appropriateness of diagnoses and treatments rendered related to a standard of care and anticipated or expected results. -performance evaluation based on clinical performance indicated in part by the results or outcome of surgical intervention -scope and frequency of procedures.</p> <p>4. In interview, on 11-25-14 at 10:10 am,</p>		Committee	

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S000826	<p>employee #A1, Executive Director, confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(E) Safety training required of personnel.</p> <p>Based on document review and interview, the facility failed to provide documentation of safety training in areas where anesthetics are used for 7 (MD#1, MD#3, MD#4, MD#5, MD#6, MD#7, MD#8) of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 7 medical staff credential files indicated files MD#1, an anesthesiologist, MD#3, a podiatrist, MD#4, a podiatrist, MD#5, a podiatrist, MD#6, a podiatrist, MD#7, an anesthesiologist and MD#8, an</p>	S000826	<p>1. Safety training learning including a quiz have been developed and distributed to all medical staff members. These completed quizzes are to be returned to the Center no later than Feb. 28. This safety training is material specifically related to the OR and areas where anesthetics are used. Satisfactory completion of the quiz will be required by all medical staff members.</p> <p>Responsible Party: Executive Director and Clinical Director</p>	02/28/2015

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S000850	<p>anesthesiologist, did not contain any documentation of safety training in areas where anesthetics are used.</p> <p>2. In interview, on 11-25-14 at 10:10 am, employee #A1, Executive Director, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4 (d)</p> <p>(d) Surgical services must be organized according to scope of the services offered, to meet the needs of the patient, in accordance with acceptable standards of practice and safety. Requirements for surgical services include: Based on policy review, observation and interview, the facility failed to ensure that 1 of 4 staff surgical mask was secured to prevent venting, failed to use equipment that could be appropriately disinfected between patients and failed to ensure surgical suite ceiling was free of cracks.</p> <p>Findings include:</p> <p>1. Review of policy and procedure, "Dress Code-Clinical Staff" last revised</p>	S000850	<p>1. 2 reusable positioners have been purchased and the 2 old reusable positioners were discarded. See attached receipt for purchase.</p> <p>2. The ceiling crack has been repaired. See the attached work order for work completed.</p> <p>3. The medical staff member who was wearing a mask inappropriately as it was not secured</p>	01/30/2015

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S001154	<p>07-19-2012 indicated:</p> <p>a. Under F. "The mask must completely cover the mouth and nose and be secured to prevent venting at the sides."</p> <p>2. During observations beginning at 10:30 a.m. on 11/25/14 in OR #3, the following observations were made:</p> <p>a. MD#1's mask was vented at the sides and at the chin.</p> <p>b. Patient was positioned with 2 reusable positioners. One had tape holding together a seam.</p> <p>Both positioners were observed to have numerous cracks in their coverings.</p> <p>c. The ceiling had a crack.</p> <p>3. At 11:45 a.m. on 11/25/14, staff member #1 (Nurse Manager) verified that the reusable positioners used during the surgical procedure on patient # 30 were repaired with tape and had cracks in their covering. He/she verified that there was a crack in the ceiling of OR #3.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(C)</p>		<p>to prevent venting has been counseled on the proper technique and the Dress code policy was reviewed with him at that time. See the attached policy with signature and date indicating that he is aware.</p> <p>Responsible Party: Clinical Director</p>		

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	<p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Operational and maintenance control records must be established and analyzed at least triennially. These records must be readily available on the premises. Based on interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 3 systems of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 11-24-14 at 9:45 am, employee #A1, Executive Director, was requested to provide documentation of the operational and maintenance control records for the heating, ventilation, and air conditioning (HVAC) system, fire alarm and/or smoke detector system, and emergency generator, having been analyzed at least triennially. In interview on 11-25-14 at 2:30 pm, 	S001154	<ol style="list-style-type: none"> The records of triennial inspection of HVAC system, fire alarm and/or smoke detector system, and emergency generator have been updated. Find those documents attached. Audits will be conducted annually to monitor the maintenance records are available and corespond with the appropriate preventative maintenance and service schedule. Results of audits will be reported to the QA committee and any issues addressed. Responsible Party: Clinical Director 	11/28/2014	

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	employee #A1 indicated there was no documentation of the operational and maintenance control records for the above-stated systems having been analyzed at least triennially. No documentation was provided prior to exit.				