

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001013	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGERY CENTER AT THE INDIANA EYE	STREET ADDRESS, CITY, STATE, ZIP CODE 30 N EMERSON AVE GREENWOOD, IN 46143
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Q000000	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 005394</p> <p>Survey Date: 2-9/11-15</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/20/15</p>	0000000		
Q000121	<p>416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES</p> <p>Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.</p> <p>Based on document review and interview, the governing board failed to follow the medical staff by-laws and ensure that criteria for selection for medical staff membership are demonstrated ability and judgment for 1</p>	0000121	<p>The Medical Staff By-Laws have been revised under Article V to read as follows: SECTION3. Criteria for Selection The review process to be considered for Medical Staff membership will also consider the individual</p>	03/04/2015

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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PRINTED: 03/06/2015
FORM APPROVED
OMB NO. 0938-0391

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Q000162	<p>(MD#7) of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a document entitled Medical Staff By-Laws, ARTICLE VI, DETERMINATION OF CLINICAL PRIVILEGES, SECTION 2. Delineation of Privileges in General, part 2. Basis for Privileges Determination, approved 12-31-14, indicated requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, and demonstrated ability and judgement. Review of 9 medical staff credential files indicated file MD#7, an ophthalmologist, did not contain any documentation in the file of initial appointment, such as letters of reference or referral, indicating their demonstrated ability and judgment. In interview, on 2-10-15 at 3:15 pm, employee #A1, a staff RN, confirmed the above and no further documentation was provided prior to exit. <p>416.47(b) FORM AND CONTENT OF RECORD</p>		<p>character, competence, education, training, experience and judgment. It is required to solicit the opinion of qualified medical personnel on the competence of applicants for privileges. The recommendation provided must be in writing, and should include a supporting rationale. This revision was sent to the Governing Body on 3/3/15 for approval. It will be the responsibility of the Governing Body to assure that medical staff privileges are granted only to professionally qualified practitioners. Letters of recommendation/reference will be obtained from qualified medical personnel who have observed MD#7 indicating his demonstrated ability and judgment. Peer evaluations have been performed and were sent to the Medical Staff and Governing Body for review. The failure to obtain recommendation/reference documentation will be monitored by the ASC Director and to prevent reoccurrence recommendation/reference forms will be added to the credentialing packets as a reminder when a prospective physician is to be added to the medical staff.</p>	

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	<p>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ul style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on policy/procedure review, medical record review and interview, the facility failed to ensure the accuracy of 23 (#N 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 18, 20, 21, 22, 24, 25, 28, 29 and 30) of 23 medical records that required anesthesia and the date the operative report was authenticated on 30 (#N1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30) of 30 medical records.</p> <p>Findings include:</p> <ul style="list-style-type: none"> 1. Facility policy titled "Authentication 	0000162	<p>After conferring with the Physicians and Anesthesiologist, changes on the Physician order sheet in the Medical record have been divided into Physician and Anesthesiologist orders, and will be authenticated accordingly. The ASC Director reviewed with each physician the change in protocol with the operative record in the medical record. The operative record will now be authenticated by date, time and signature of the Physician to be in compliance with the State and Federal regulations. These changes were implemented 3/3/15 and will be audited daily by ASC staff to prevent</p>	03/04/2015

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	<p>of Medical Records Entries" approved on 12/31/14 states on page 1: II....B. Every entry, including transcribed reports, is dated and authenticated by the author.</p> <p>2. Medical records #N 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 18, 20, 21, 22, 24, 25, 28, 29 and 30 had pre-printed orders that combined both the surgeon and anesthesiologist pre-op, intra-op and post-op orders. It could not be determined which physician originated each order. Both the surgeon and anesthesiologist authenticated all of the orders.</p> <p>3. Medical records #N1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30 did not include a date that operative record was authenticated by the physician.</p> <p>4. Staff member # 40 (Staff Nurse) indicated in interview at 12:00 PM on 2/11/15, it could not be determined which physician originated each order or the date the physician authenticated the operative record.</p>		<p>reoccurrence. The ASC Director will monitor the daily chart audits on a monthly basis. An in-service was held on 3/4/15 to update staff of all the changes in protocol. The revisions were sent to the Governing Body for approval on 3/3/15.</p>	

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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005394</p> <p>Survey Date: 2-9/11-15</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/20/15</p>	S000000		
S000126	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(5)</p>			

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	<p>The governing body shall do the following:</p> <p>(5) Ensure that criteria for selection for medical staff membership are individual character, competence, education, training, experience, and judgement.</p> <p>Based on document review and interview, the governing board failed to follow the medical staff by-laws and ensure that criteria for selection for medical staff membership are individual character, competence and judgment for 1 (MD#7) of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of a document entitled Medical Staff By-Laws, ARTICLE VI, DETERMINATION OF CLINICAL PRIVILEGES, SECTION 2. Delineation of Privileges in General, part 2. Basis for Privileges Determination, approved 12-31-14, indicated requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, and demonstrated ability and judgement,</p> <p>2. Review of 9 medical staff credential files indicated file MD#7, an ophthalmologist, did not contain any documentation, such as letters of</p>	S000126	<p>The Medical Staff By-Laws have been revised under Article V to read as follows: SECTION 3. Criteria for Selection The review process to be considered for Medical Staff membership will also consider the individual character, competence, education, training, experience and judgment. It is required to solicit the opinion of qualified medical personnel on the competence of applicants for privileges. The recommendation provided must be in writing, and should include a supporting rationale. This revision was sent to the Governing Body on 3/3/15 for approval. It will be the responsibility of the Governing Body to assure that medical staff privileges are granted only to professionally qualified practitioners. Letters of recommendation/reference will be obtained from qualified medical personnel who have observed MD#7 indicating his demonstrated ability and judgment. Peer evaluations have been performed and were sent to the Medical Staff and Governing Body for review. The failure to obtain recommendation/reference</p>	03/04/2015

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S000612	<p>reference or referral, in the file of initial appointment indicating their individual character, competence and judgment.</p> <p>3. In interview, on 2-10-15 at 3:15 pm, employee #A1, a staff RN, confirmed the above and no further 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(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on policy/procedure review, medical record review and interview, the facility failed to ensure the accuracy of 23 (#N 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 18, 20, 21, 22, 24, 25, 28, 29 and 30) of 23 medical records that required anesthesia and the date the operative report was authenticated on 30 (#N1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30) of 30 medical records.</p>	S000612	<p>documentation will be monitored by the ASC Director and to prevent reoccurrence recommendation/reference forms will be added to the credentialing packets as a reminder when a prospective physician is to be added to the medical staff.</p> <p>After conferring with the Physicians and Anesthesiologist, changes on the Physician order sheet in the Medical record have been divided into Physician and Anesthesiologist orders, and will be authenticated accordingly. The ASC Director reviewed with each physician the change in protocol with the operative record in the medical record. The operative record will now be authenticated by date, time and signature of the Physician to be in compliance with the State and Federal</p>	03/04/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "Authentication of Medical Records Entries" approved on 12/31/14 states on page 1: II....B. Every entry, including transcribed reports, is dated and authenticated by the author. 2. Medical records #N 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 17, 18, 20, 21, 22, 24, 25, 28, 29 and 30 had pre-printed orders that combined both the surgeon and anesthesiologist pre-op, intra-op and post-op orders. It could not be determined which physician originated each order. Both the surgeon and anesthesiologist authenticated all of the orders. 3. Medical records #N1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30 did not include a date that operative record was authenticated by the physician. 4. Staff member # 40 (Staff Nurse) indicated in interview at 12:00 PM on 2/11/15, it could not be determined which physician originated each order or the date the physician authenticated the operative record. 		<p>regulations. These changes were implemented 3/3/15 and will be audited daily by ASC staff to prevent reoccurrence. The ASC Director will monitor the daily chart audits on a monthly basis. An in-service was held on 3/4/15 to update staff of all the changes in protocol. The revisions were sent to the Governing Body for approval on 3/3/15.</p>	

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S000732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based on document review and interview, the medical staff did not review the medical staff rules and regulations at least once every three (3) years in 1 instance.</p> <p>Findings:</p> <p>1. Review of the medical staff rules and regulations indicated they were last reviewed by the medical staff on 12-13-11.</p> <p>2. In interview, on 2-11-15 at 1:45 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p>	S000732	<p>The Medical Staff rules and regulations were reviewed and sent to the Governing Body for approval on 3/3/15. It will be the responsibility of the ASC Director to ensure that the Medical Staff rules and regulations are reviewed every three years and a notation has been listed on an Excel spread sheet titled "Time Requirements" to assist with compliance. The "Time Requirements" is a quick reference tool that will be checked by ASC Director on a monthly basis.</p>	03/04/2015

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S001188	<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> <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 include in its written fire control plan a provision for cooperation with firefighters in 1 instance.</p> <p>Findings:</p> <p>1. Review of a facility POLICY NO. 14.01, entitled EMERGENCY OPERATIONS FOR, FIRE, BOMB OR ANY OTHER THREAT/EMERGENCY, approved 12-31-14, did not indicated a</p>	S001188	<p>Policy #14.01 has been revised to include that "ASC staff will cooperate with firefighting authorities". The policy was sent to the Governing Body on 3/3/15 for review and approval of the revision. An in-service on 3/4/15 was given to the staff to inform them of the change in the policy. It will be the responsibility of the ASC Director to complete this task and monitor the change.</p>	03/04/2015

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	<p>provision for cooperation with firefighting authorities.</p> <p>2. In interview, on 2-10-15 at 3:15 pm, employee #A1, staff RN, confirmed the above and no further documentation was provided prior to exit.</p>			