

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2014
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NAME OF PROVIDER OR SUPPLIER NAAB ROAD SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260
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Q000000	<p>This visit was for a Federal recertification survey.</p> <p>Facility Number: 010525</p> <p>Survey Date: 1-7/10-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 01/17/14</p>	O000000		
Q000043	<p>416.41(c) DISASTER PREPAREDNESS PLAN</p> <p>(1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC.</p> <p>(2) The ASC coordinates the plan with State and local authorities, as appropriate.</p> <p>(3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.</p> <p>Based on document review and interview, the facility failed to</p>	O000043	1. The center's Clinical Director will work with St. Vincent Hospital	02/03/2014

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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Q000061	<p>coordinate emergency disaster and preparedness with an appropriate governmental agency.</p> <p>Findings:</p> <p>1. Review of facility documents indicated there were none in year 2013 regarding the coordination of emergency disaster and preparedness with an appropriate governmental agency.</p> <p>2. In interview, on 1-10-14 at 11:15 am, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p> <p>416.42(a)(1) ANESTHETIC RISK AND EVALUATION A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Based on document review and interview, the facility failed to ensure that a physician examined the patient immediately before surgery to evaluate the risk of the procedure to be performed for 4 of 30 medical records (MR) reviewed (Patient #2, 8, 15 and 23).</p> <p>Findings include:</p> <p>1. Review of patient #2's MR indicated</p>	O000061	<p>to ensure yearly disaster preparedness training. 2. The Clinical Director and Executive Director will be responsible for ensuring this training is completed. checks are performed.</p> <p>1. The center will use a blank stamp to stamp all H&P's for local and IV cases with ASA standing. 2. This will be added to the center's Medical Records review process. The Clinical Director and Executive Director will be responsible for ensuring this will be completed.</p>	02/03/2014			

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	<p>the patient had a procedure done on 11-22-13 and the MR lacked documentation of the risk of the procedure.</p> <p>2. Review of patient #8's MR indicated the patient had a procedure done on 10-10-13 and the MR lacked documentation of the risk of the procedure.</p> <p>3. Review of patient #15's MR indicated the patient had a procedure done on 10-30-13 and the MR lacked documentation of the risk of the procedure.</p> <p>4. Review of patient #23's MR indicated the patient had a procedure done on 09-18-13 and the MR lacked documentation of the risk of the procedure.</p> <p>5. On 01-07-14 at 1505 hours, staff #40 confirmed that if no anesthesia involved the surgeon is to document the procedure risk in the history & physical.</p>				

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Q000121	<p>416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES 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 facility failed to document physicians had current board certification for 1 of 7 (MD#2) medical staff credential files reviewed, the governing board failed to ensure that criteria for selection for medical staff membership are demonstrated ability and judgement for 1 of 1 (AH#1) allied health credential files reviewed and for 1 of 7 medical staff credential files reviewed, the facility failed to include documentation the physician, (MD#4), had privileges to perform surgical procedures in a hospital in accordance with facility policy.</p> <p>Findings:</p> <p>1. Review of facility Policy No. 2.01, approved 6-17-13, indicated applicants for privileges shall as a minimum meet the following criteria: Board Certification ... by the appropriate certifying association for the privileges requested.</p>	O000121	<p>1. The center will review and update policy 2.01 Medical Staff Bylaws Article VII Determination of Clinical Privileges to reflect that Board Certification may be required when applicable. This will accommodate physicians who do not have Board Certification offered in their area of specialty. 2. This change was approved at the Medical Staff meeting on 1/29/2014 and will be taken to the Board of Manager meeting on 2/19/2014. 3. The center's Executive Director will be responsible for this action. 1. All new Allied Health application will include letters of recommendation. 2. These letters of recommendation and application will be reviewed by the Credentialing Committee as appropriate. 3. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves.</p>	02/19/2014			

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	<p>2. Review of 7 medical staff credential files indicated file MD#2 had no documentation of current board certification and no other documentation was provided prior to exit.</p> <p>3. In interview, on 1-9-14 at 9:20 am, employee #A2 confirmed there was no documentation of board certification and no further documentation was provided prior to exit.</p> <p>4. Review of facility Policy No. 2.01, approved 6-17-13 indicated requests for clinical privileges shall be evaluated on the basis of the practitioner's ... demonstrated ability and judgement.</p> <p>5. Review of 1 medical staff credential file indicated file AH#1 did not contain any documentation in the initial application file indicating their demonstrated ability and judgment via letters of reference and/or referral or other means.</p> <p>6. In interview, on 1-9-14 at 1:20 pm, employee #A2 confirmed there was no documentation of AH#1's initial application file indicating demonstrated ability and judgment via letters of reference and/or referral or other means and no other documentation was</p>			

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	<p>provided prior to exit.</p> <p>7. Review of facility Policy No. 2.01, approved 6-17-13, indicated applicants for privileges shall at a minimum meet the following criteria: Granted similar privileges at a hospital within Marion or a contiguous [Indiana] county.</p> <p>8. Review of MD#4's credential file indicated the practitioner requested Pain Management privilege and the Management Committee granted MD#4 this privilege on 10-18-13.</p> <p>9. Pain management is a surgical procedure.</p> <p>10. Review of MD#4's credential file indicated the practitioner was not granted similar privileges at a hospital within Marion or a contiguous [Indiana] county.</p> <p>11. In interview on 1-9-14 at 9:20 am, employee #A2 confirmed MD#4 requested and was granted pain management privileges, was not granted similar privileges at a hospital within Marion or a contiguous [Indiana] county, and no further documentation was provided prior to exit.</p>				

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Q000201	<p>416.49(a) LABORATORY SERVICES</p> <p>If the ASC performs laboratory services, it must meet the requirements of Part 493 of this chapter. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of this chapter. The referral laboratory must be certified in the appropriate specialties and subspecialties of services to perform the referral test in accordance with the requirements of Part 493 of this chapter. Based on document review and interview, the facility failed to have a written procedure for requesting routine and emergency procedures from a contracted laboratory.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of facility documents indicated there was not a written procedure for requesting routine and emergency procedures from a contracted laboratory. In interview on 1-10-14 at 11:30 am, employee #A2 confirmed the lack of a written procedure and no further 	O000201	<ol style="list-style-type: none"> The center will develop a policy on proper completion of the lab requisition form. The Clinical Director and Executive Director will be responsible for ensuring this will be completed. 	02/19/2014			

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S000000	documentation was provided prior to exit. This visit was for a standard licensure survey. Facility Number: 010525 Survey Date: 1-7/10-14 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor QA: claughlin 01/17/14	S000000		
S000126	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(5) The governing body shall do the following: (5) Ensure that criteria for selection for medical staff membership are individual character, competence, education, training, experience, and judgement.			

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	<p>Based on document review and interview, the governing board failed to ensure that criteria for selection for medical staff membership are demonstrated ability and judgement for 1 of 1 allied health credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of facility Policy No. 2.01, approved 6-17-13 indicated requests for clinical privileges shall be evaluated on the basis of the practitioner's ... demonstrated ability and judgement. 2. Review of 1 medical staff credential files indicated file AH#1 did not contain any documentation in the initial application file indicating their demonstrated ability and judgment via letters of reference and/or referral or other means. 3. In interview, on 1-9-14 at 1:20 pm, employee #A2 confirmed the above and no further documentation was provided prior to exit. 	S000126	<ol style="list-style-type: none"> 1. All new Allied Health application will include letters of recommendation. 2. These letters of recommendation and application will be reviewed by the Credentialing Committee as appropriate. 3. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves. 	02/03/2014	

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S000154	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (D)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(D) Ensuring that all health care workers, including contract and agency personnel, for whom a license, registration, or certification is required, maintain current license, registration, or certification and keep documentation of same so that it can be made available upon request. Based on document review and interview, the facility failed to follow its Position Description for an Operating Technician, for whom certification is required, and maintain a copy of the certification for 1 of 1 certified surgical tech files reviewed (Staff #2).</p> <p>Findings include:</p> <p>1. Review of the Position Description for an Operating Technician indicated the following: "Qualifications Completion of Operating Room Technician course and appropriate certification." This was last reviewed/ revised on 06-17-13.</p>	S000154	<p>1. Policy 3.0132 Operating Room Technician job description will be reviewed and updated to reflect completion of Operating Room Technician Course will be completed. 2. This update and change was approved at the Medical Staff meeting held on 1/29/2014 this will also be presented at the next Board of Managers meeting that will be held on February 19, 2014. 3. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves and is monitored.</p>	02/19/2014			

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S000156	<p>2. Review of staff #2's personnel file indicated he/she was hired as a Certified Surgical Tech (CST) on 09-23-08 and lacked documentation of having current CST certification.</p> <p>3. On 01-09-14 at 1405 hours, staff #40 confirmed that staff #2 did not have current CST certification.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 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 maintain a current job description for instrument technicians for 1 of 1 instrument technician personnel file reviewed (Staff</p>	S000156	<p>1. The center will create a job description for Instrument Technician. 2. This update and change was approved at the Medical Staff meeting held on 1/29/2014 this will also be</p>	02/19/2014

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S000622	<p>#1).</p> <p>Findings include:</p> <p>1. Review of staff #1's personnel file indicated that he/she was hired on 08-04-03 as an instrument technician.</p> <p>2. On 01-09-14 at 1405 hours staff #40 confirmed that the facility had no job description for instrument technicians.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(6)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(6) The center shall have a system of coding and indexing medical records which allows for timely retrieval of records by diagnosis and procedure, physician, and condition on discharge, in order to support continuous quality assessment and improvement activities. Based on document review and interview, the facility failed to ensure documentation of a log or index that included condition on discharge.</p> <p>Findings:</p>	S000622	<p>presented at the next Board of Managers meeting that will be held on February 19, 2014. 3.It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves and is monitored.</p> <p>1. The center will add condition on discharge the computerized patient log. 2. The center will this check to its Medical Records review. 3. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves.</p>	02/03/2014			

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	<p>1. Review of a document presented by the facility as a patient log indicated it did not include the condition on discharge for each patient.</p> <p>2. In interview, on 1-10-14 at 10:00 am, employee #A2 confirmed the above and no further documentation was provided by exit.</p>			

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S000710	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p>				

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	<p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on document review and interview, for 1 of 7 medical staff credential files reviewed, the facility failed to document the physician had current board certification (MD#2) and failed to include documentation the physician (MD#4) had privileges to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>Findings:</p> <p>1. Review of facility Policy No. 2.01, indicated applicants for privileges shall</p>	S000710	<p>1. The center will review and update policy 2.01 Medical Staff Bylaws Article VII Determination of Clinical Privileges to reflect that Board Certification may be required when applicable. This will accommodate physicians who do not have Board Certification offered in their area of specialty. Physicains on staff at NRSC of Anesthesia priveleges which includes Pain Management at a local hospital. 2. This change was approved at the Medical Staff meeting on 1/29/2014 and will be taken to the Board of Manager meeting on 2/19/2014. 3. The</p>	02/19/2014

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NAME OF PROVIDER OR SUPPLIER NAAB ROAD SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260			
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	<p>as a minimum meet the following criteria: Board Certification ... by the appropriate certifying association for the privileges requested.</p> <p>2. Review of 7 medical staff credential files indicated file MD#2 had no documentation of current board certification.</p> <p>3. Review of 7 medical staff credential files indicated file MD#4 did not have documentation, in accordance with IC 16-18-2-14(3)(C); i.e. have hospital privileges to perform surgical procedures from at least one hospital within the county or an Indiana county adjacent to the county in which the ambulatory surgical center is located.</p> <p>4. Review of MD#4's credential file indicated the practitioner requested Pain Management privilege and the Management Committee granted MD#4 this privilege on 10-18-13.</p> <p>5. Pain management is a surgical procedure.</p> <p>6. In interview on 1-9-14 at 9:20 am, employee #A2 confirmed all the above and no further documentation was provided prior to exit.</p>		center's Executive Director will be responsible for this action.				

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S000826	<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 8 (MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, and MD#7 and file AH#1) of 8 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 8 medical staff credential files indicated files MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, and MD#7 and file AH#1 did not contain any documentation of safety training in areas where anesthetics are used.</p>	S000826	<p>1. The Center will implement safety training for the Medical Staff. 2. The center will monitor this through its medical records process to ensure this is completed. 3. It will be the responsibility of the Clinical Director to ensure this process improves.</p>	02/19/2014	

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S000888	<p>2. In interview, on 1-9-14 at 9:20 am, employee #A2 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)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review, the facility failed to ensure an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery for 5 of 30 medical records (MR) reviewed (Patient #14, 15, 24, 27 & 28).</p>	S000888	<p>1. The center will work with and monitor its medical records to try and ensure the operative notes are dictated immediately following the completed procedure. The center will also work to educate all physicians on our Medical Staff to the importance of completing their Operative notes immediately following the procedure. 2. The Clinical</p>	02/19/2014

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	<p>Findings include:</p> <p>1. Review of the Medical Staff Rules & Regulations indicated the following: "D. The patient's medical record must also contain an operative summary with a complete description of the operative procedure, any complications, indications for surgery and discharge summary by the surgeon and with the surgeon's signature." The Medical Staff Rules & Regulations were last reviewed/revise on 02-28-12.</p> <p>2. Review of the following MRs indicated the following: patient #14 had surgery on 10-25-13 and the Operative Report was dictated on 10-31-13. patient #15 had surgery on 10-30-13 and the Operative Report was dictated on 11-08-13. patient #24 had surgery on 09-06-13 and the Operative Report was dictated on 09-17-13. patient #27 had surgery on 10-18-13 and the Operative Report was dictated on 10-22-13. patient #28 had surgery on 05-31-13 and the Operative Report was dictated on 06-13-13.</p>		Director will be responsible for ensuring this is completed and maintained.				

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S001198	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the facility failed to coordinate emergency disaster and preparedness with an appropriate governmental agency.</p> <p>Findings:</p> <p>1. Review of facility documents indicated there were none in year 2013 regarding the coordination of emergency disaster and preparedness with an appropriate governmental agency.</p> <p>2. In interview, on 1-10-14 at 11:15 am, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p>	S001198	<p>1. The center's Clinical Director will work with St. Vincent Hospital to ensure yearly disaster preparedness training. 2. The Clinical Director and Executive Director will be responsible for ensuring this training is completed. checks are performed.</p>	02/19/2014	