STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001095	A. BUILDING 00 B. WING	03/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KLEINERT KUTZ SURGERY CENTER IN AFFILIATION W/ FLO	3605 NORTHGATE CT, STE 101 NEW ALBANY, IN 47150

(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	The visit was for a State licensure survey. Facility #: 002524 Date: 03-18/19-13 Surveyors: Billie Jo Fritch RN, MBA, MSN Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor QA: claughlin 03/22/13	S000000	This is a statement about the survey. Information appears to be correct.Virginia Ehrlich, Administrator.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S000106	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3) The governing body shall do the following: (3) Review the bylaws at least triennially. Based on document review and interview, the governing body failed to review their bylaws at least triennially. Findings included: 1. Review of the governing body bylaws on 3-18-13 indicated the bylaws were last documented as reviewed/approved on 12-20-06. 2. An interview was conducted with B#2 on 3-19-13 at 1350 hours and confirmed the governing body bylaws were last documented as reviewed/approved on 12-20-06.	S000106	Both parties reviewed the bylaws of the Governing Body. No revisions were made at this time.Approved at the Board of Directors meeting on April 25, 2013This will be done on a triennial basis--will be accomplished again in 2016.Responsible party is Facility Administrator.A checklist of items for completion is being done to make sure this is being done at correct times.	04/25/2013

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S000110	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5) The governing body shall do the following: (5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up. Based on document review and interview, the governing body failed to review reports of the management of the operations, which includes Quality Assurance and Performance Improvement (QAPI) reports, at least quarterly during 2012 and during the meeting held the first quarter of 2013. Findings included: 1. Review of the governing board meeting minutes indicated meetings were held 1-26-12, 4-19-12, 7-26-12, 12-5-12, and 2-18-13; documentation indicated QAPI reports were documented as discussed only at the 4-19-12 meeting. 2. An interview was conducted on 3-19-13 at 0935 hours with B#2 who confirmed QAPI reports are documented as provided at the 4-19-12 meeting and no QAPI discussion is documented as	S000110	The specific management report for the QAI program were reviewed by the Medical Staff on April 22, 2013, with review by the Governing Board on April 25, 2013. The QI report is reviewed at the quarterly Medical Staff meeting and this is now specifically reviewed and documented at the quarterly Governing Body meetings and minutes.Responsible party is FacilityAdministratorMinutes and specific study information will be discussed and documented at each meeting as required by standard.	04/25/2013

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	provided at the 1-26-12, 7-26-12, 12-5-12, and 2-18-13 meetings.			

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S000153	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review and staff interview, the facility failed to provide evidence of orientation of new employees for 1 of 4 Registered Nurse (RN) personnel files reviewed and failed to maintain a copy of orientation of new employees for 1 instrument tech personnel file reviewed. Findings include: 1. Review of staff member #N5 (RN) personnel file indicated the following: (A) He/she was hired 2/18/13. (B) The file lacked evidence of general or job specific orientation. 2. Review of staff member #N1 (instrument tech) personnel file indicated the following: (A) He/she was hired 11/26/12. (B) The file lacked evidence of job specific orientation.	S000153	These files are being completed with signed job descriptions, orientation checklists, titers, etc.Facility Operations Manager, is the responsible person.These will be accomplished according to policy and standard in future.	05/15/2013

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	3. Facility policy titled "Employee Orientation" last reviewed/revised 10/10 states under practices and procedures: "The orientation of new employees shall take place within the first week of employment beginning with the first day. The orientation checklists that are a part of this policy are intended to assure the completeness of this process. These checklists are to be included in the personnel file of the employee. 1. General orientation: All new employees shall receive a general orientation utilizing the appropriate checklist on or before their first day of employment. 2. Job orientation checklist: The orientation of new employees relative to their specific job a (known error) the Center will vary somewhat with the job and the training and experience of the employee. The designated nurse conducting the orientation is responsible for determining the overall content and depth of the orientation using the appropriate checklist....." 4. Staff member #5 provided an orientation checklist for staff member #N1 at time of exit (4:40 p.m. on 3/19/13) indicating that staff member #5 had the document in his/her possession. 5. Staff member #2 verified that staff			

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	members #N1 and N5 personnel file lacked evidence of orientation documents beginning at 3:30 p.m. on 3/19/13.			

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S000162	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G) Require that the chief executive officer develop and implement policies and programs for the following: (G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.			
	Based on document review and interview, the facility failed to follow facility policy related to cardiopulmonary resuscitation (CPR) competence for 1 of 2 certified registered nurse anesthetists (CRNA) and 1 of 1 CST/CSFA (AH#1 and AH#3). Findings included: 1. Review of facility policy titled CARDIOPULMONARY RESUSCITATION on 3-19-13 indicated all physicians practicing in the ASC must have a current CPR certification. 2. Review of the medical staff bylaws on 3-19-13 indicated courtesy staff, which includes allied health practitioners, must abide by the medical staff bylaws and policies of the ASC. 3. Review of the credential files of AH#1 and AH#3 on 3-19-13 lacked documented	S000162	The CPR documentation was obtained to complete the file according to policy.The Facility Administrator is responsible.A standard checklist of required items for provider files has been developed and will be reviewed annually.	04/12/2013

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	evidence of current CPR competency. 4. Interview with B#2 on 3-19-13 at 1540 hours confirmed AH#1 and AH#3 are required to maintain documentation of current CPR; B#2 confirmed the credential files of AH#1 and AH#3 lacked documented evidence of current CPR competency.			

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S000164	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H) Require that the chief executive officer develop and implement policies and programs for the following: (H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program. Based on document review and staff interview, the facility failed to provide post offer physical examinations according to facility policy for 2 of 4 Registered Nurse (RN) personnel files reviewed. Findings include; 1. Facility policy titled "ADMINISTRATIVE POLICY: EMPLOYEE EXAMS AND PHYSICALS" last reviewed/revised 9/12 states "All potential new employees must satisfactorily pass a pre-employment physical examination before the candidate will be employed with the company." 2. Review of staff member #N5 (RN) personnel file indicated the following: (A) He/she was hired 2/18/13. (B) The file lacked evidence of a pre-employment physical exam.	S000164	The policy is being reviewed.Copies of History and Physicals are now in employee files.The Facility Operations Manager is responsible.A checklist of required documentation items is being added to the Orientation Checklist.	05/15/2013

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	3. Review of staff member #N6 (RN) personnel file indicated the following: (A) He/she was hired 2/18/13. (B) The file lacked evidence of a pre-employment physical exam. 4. Review of the facility staff schedule for 3/4/13-3/29/13 indicated that both staff members #N5 and N6 have been working. 5. Staff member #2 verified the personnel files lacked evidence of a physical examination beginning at 3:30 p.m. on 3/19/13.			

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S000166	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I) Require that the chief executive officer develop and implement policies and programs for the following: (I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and staff interview, the facility failed to follow an approved policy related to criminal history checks for 4 of 6 staff members. Findings include; 1. Facility policy titled "CRIMINAL BACKGROUND CHECK" last reviewed/revised 9/12 states under policy: "Kleinert Kutz will obtain criminal background checks on prospective employees." and under procedure: "3. When a Director has a applicant ready to hire, a copy of the employment application and Disclosure and Authorization form will be forwarded to the Director of Human Resources who will notify the agency to conduct the investigation." 2. Review of staff member #N1 personnel file indicated the following:	S000166	Criminal Background checks have been done without documentation previously. The HR person would run the check and send a message of a clear check. That has been changed to include required documentation in all files.The Facility Operations Manager is responsible.	05/17/2013

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	(A) He/she was hired 11/26/12. (B) The file lacked a criminal background check. 3. Review of staff member #N2 personnel file indicated the following: (A) He/she was hired 11/24/03. (B) The file lacked a criminal background check. 4. Review of staff member #N3 personnel file indicated the following: (A) He/she was hired 4/7/09. (B) The file lacked a criminal background check. 5. Review of staff member #N4 personnel file indicated the following: (A) He/she was hired 8/21/00. (B) The file lacked a criminal background check. 6. Staff member #2 verified the above beginning at 3:30 p.m. on 3/19/13. He/she provided criminal background checks for staff members #N1, N2, and N4 that were conducted on 3/19/13.			

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S000230	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5) 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: (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. Based on document review and interview, the utilization review (UR) committee includes two physicians (MD#1 and MD#6) who are owners of the surgery center. Findings included: 1. Review of the UR committee meeting minutes on 3-19-13 indicated MD#1 and MD#6 attended the committee meeting as members on 2-20-12, 4-23-12, 7-30-12, 11-19-12, and 1-14-13. 2. Review of physician ownership documents on 3-18-13 indicated MD#1 and MD#6 are owners of the surgery center. 3. Review of the medical staff bylaws on 3-18-13 indicated the following: The Utilization Review Committee shall	S000230	The membership of the UR Committee was changed so that it is comprised of three (3) physicians who have no financial interest in the company. Dr. Y. Manon-Matos is the new Chair of this committee and he has no ownership in the company.The Facility Administrator is responsible.This will be monitored for compliance.	04/22/2013

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	consist of a chairperson and at least two members, none of whom have financial interest in the Center. 3. An interview was conducted with B#2 on 3-19-13 at 1345 hours and confirmed MD#1 and MD#6 are owners of the surgery center and members of the UR committee; B#2 confirmed the medical staff bylaws require at least 3 members, none with financial interest in the center.			

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S000334	410 IAC 15-2.4-2.2(a)(2) QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(2) (2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center. (b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner. (c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following: (1) The report shall: (A) be made to the department; (B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program; (C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any: (i) patient; (ii) individual licensed under IC 25; or (iii) center employee involved; or any other information. (2) A potential reportable event may be identified by a center that:			

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	(A) receives a patient as a transfer; or (b) admits a patient subsequent to discharge; from another health care facility subject to a reportable event requirement. In the event that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program. (3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures. (4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law. (d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually. (e) Any serious reportable listed in subsection (a)(1) that: (1) is determined to have occurred within the center between: (A) January 1, 2009; and (B) the effective date of this rule; and (2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)			

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	15C0001095	A. BUILDING 00 B. WING	03/19/2013

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	Based on document review and interview, the facility failed to report one wrong-site surgery to the Indiana State Department of Health (ISDH) as required by facility policy. Findings included: 1. Review of the medical staff meeting minutes dated 1-14-13 on 3-18-13 included discussion of a wrong site surgical procedure occurring 11-19-12. 2. Review of the 3rd and 4th quarter 2012 CQI meeting minutes, not dated, on 3-18-13 indicated the following: There was one wrong site surgery. It was for a Trigger Finger Release. The ring finger was done rather than the long finger. All consent, time outs, etc. had been done. This will be reported appropriately on the ISDH annual report. 3. An occurrence report, dated 12-7-12, was reviewed on 3-18-13 and indicated the error was not brought to the physician's attention until the follow-up appointment on 12-7-12. The occurrence report indicated the time out policy was followed. 4. Review of the facility policy titled ADVERSE/SENTINEL EVENTS on 3-18-13 indicated the following: The report shall be made to the Indiana Department of Health. The report shall be submitted as soon as reasonably and	S000334	This was submitted via fax on 3-19-13 then again electronically with the assistance of ISDH personnel on 4-20-13The Facility Administrator is responsible.Any future events will be reported according to policy and standard.	04/30/2013

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	practicably possible, but not later than fifteen (15) working days after the serious adverse event is determined to have occurred. Serious adverse events within the facility will be determined using the following process: Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. 5. Review of the medical record of Patient #1 on 3-18-13 indicated the consent was written/signed for a trigger release of the right long finger with the surgical procedure completed on 11-9-12.; documentation indicated the time out policy was followed. Medical record documentation indicated the patient returned on 12-17-12 for release of the right long finger trigger finger. 6. An interview was conducted with B#2 on 3-19-13 at 1345 hours who confirmed a wrong site surgical procedure occurred 11-19-12; B#2 confirmed the physician was unaware of the error until the patient's follow-up appointment on 12-7-12; B#2 confirmed a second surgical procedure was completed on 12-17-12 of the right long finger trigger release; B#2 confirmed the error was discussed in the QAPI and medical staff meetings; B#2 confirmed the facility policy requires the wrong site surgical procedure be reported to the ISDH no later than 15 days from			

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	the occurrence and the surgery center has not reported the wrong site surgical procedure as of 3-19-13.			
S000400	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, the facility failed to remove expired patient care items from the pediatric crash cart for 1 pediatric crash cart observed. Findings include: 1. During observation of the facility crash carts, the following expired items were observed in the pediatric crash cart at 11:15 a.m. on 3/19/13: (A) One (1) # 2 1/2 Laryngeal mask with an expiration date of 3/12. (B) One (1) # 1 1/2 Laryngeal mask with an expiration date of 10/12. (C) One (1) pack of electrodes with an expiration date of 10/12.	S000400	The supplies were listed and discarded. New supplies were ordered and have been replaced in proper location.The Facility Operations Manager is responsible.Supplies in hidden areas will be checked along with regular checks.	03/19/2013

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S000442	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii) The infection control committee responsibilities must include, but are not limited to: (E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies. Based on document review and staff interview, the facility failed to ensure documentation of the communicable disease history for 4 of 6 staff members and failed to develop policies for an employee health program. Findings include: 1. Staff members #N1, N2, N5 and N6 personnel files lacked documentation of immunity to Varicella. 2. Staff member #N5 personnel file lacked documentation of immunity to Rubella, Rubeola, and Hepatitis B. 3. Staff member #N6 personnel file	S000442	History and Physicals are done for employees upon employment and annually that includes communicable disease history. The employee policy now states this as required. The record of communicable disease or immunization must be from a physician or county health record, or school record. It can not be a self declaration only. This is required for Varicella, Rubella, Rubeola. An employee may decline the Hepatitis B immunization in the State of Indiana. The declination must be signed by the employee and kept in the Employee Health file.If acceptable records can not be obtained, then titers must be drawn and results kept in Employee Health fileThe Facility	05/17/2013

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	lacked documentation of immunity to Rubella and Rubeola. 4. Review of facility policies on 3/18/13 and 3/19/13 indicated the facility had no policy for a health program to determine the communicable disease history of employees. 4. Staff member #2 verified the above beginning at 3:30 p.m. on 3/19/13.		Administrator is responsible.This is being included in orientation checklist to make sure it is accomplished and documented.	

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S000444	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix) The infection control committee responsibilities must include, but are not limited to: (E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (ix) Requirements for personal hygiene and attire that meet acceptable standards of practice. Based on document review, observation, and staff interviews, the infection control committee failed to ensure the facility dress code policy was followed for 1 of 3 Registered Nurses (RNs) observed in the pre-operative area and failed to address dress code for central sterile processing in the dress code policy. Findings include; 1. Facility policy titled "DRESS CODE POLICY" last reviewed/revised 9/12 states under procedure: "....some examples of inappropriate items include: .....visible "body piercing" jewelry other than ear piercing;....." The policy did not address appropriate dress code for the central sterile processing area.	S000444	The body piercing was removed immediately and policy reviewed with the individual.Disposable aprons have been purchased. Policy has been reviewed and updated with emphasis on personal protection. Inservices have been done to communicate expectations. Random spot checks will be done to confirm policies and procedures are being followed.The Facility Operations Manager is responsible.Policies will be reviewed at least annually with staff.	03/19/2013

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	2. During observation of patient care beginning at 10:30 a.m. on 3/19/13 , RN #1 was observed in the pre-operative area providing patient care. He/she had a visible nasal piercing to the left nostril. 3. CDC document titled "Guideline for disinfection and sterilization in healthcare facilities...." states "Personnel working in the decontamination area should wear household-cleaning-type rubber or plastic gloves when handling or cleaning contaminated instruments and devices. Face masks, eye protection such as goggles or full-length faceshields, and appropriate gowns should be worn when exposure to blood and contaminated fluids may occur (e.g., when manually cleaning contaminated devices....." 4. Staff member #N1 observed working in the central sterile processing area beginning at 12:40 p.m. on 3/19/13 indicated in interview that he/she only applies gloves to go from the clean processing area to the soiled processing area. He/she was wearing cotton type scrubs and did not indicate that he/she would wear a water resistant apron or gown or apply goggles or faceshield to work on the soiled side of the central sterile department.			

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	5. Staff member #2 verified at 3:45 p.m. on 3/19/13 that the facility policy does not address the dress code for the central sterile processing area.			

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S000710	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4) The medical staff shall do the following: (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: (A) A completed, signed application. (B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable. (C) A current copy of the individual's: (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. (ii) Indiana controlled substance registration showing number as applicable. (iii) Drug Enforcement Agency registration showing number as applicable.			

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	(iv) Documentation of experience in the practice of medicine. (v) Documentation of specialty board certification as applicable. (vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C). (D) Category of medical staff appointment and delineation of privileges approved. (E) A signed statement to abide by the rules of the center. (F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements. (G) Other items specified by the center and medical staff. Based on document review and interview, the medical staff failed to maintain an accurate credential file for 1 of 2 (AH#1) certified registered nurse anesthetists (CRNA) and did not follow the approved medical staff bylaws in regard for board certification/board eligibility for 2 of 5 physician credential files reviewed (MD#2 and MD#4). Findings included: 1. Review of the credential file of AH#1 on 3-19-18 indicated the CRNA's first	S000710	The Medical Staff bylaws were reviewed and updated to include a statement regarding a physician being board certified and board eligible in the country of their education and training would be qualified for membership at the ASC.The letters regarding this were already in the providers' files.This was approved by the Governing Board on 4-25-13.The Facility Administrator is responsible.The CRNA who had a discrepancy in the spelling of her name was immediately notified that she could no longer practice at the facility and will not	04/22/2013

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	name was different on the application for allied health courtesy privileges than the name listed on other documents; the first name on the registered nurse (RN) license indicated the CRNA's first name was spelled one way; the CRNA certification documentation indicated the CRNA's first name is spelled differently than the nursing license; the documentation of malpractice insurance indicated the CRNA's first name is different than the nursing license; the CRNA's drivers license in Indiana indicated the CRNA's first name is spelled differently than the nursing license; information from the North Central Texas College indicated the CRNA's first name is the same as the nursing license. 2. Review of the credential files of MD#2 and MD#4 on 3-18-13 lacked evidence the physicians were board certified or board eligible. 3. Review of the medical staff bylaws on 3-18-13 indicated the following: MEDICAL STAFF MEMBERSHIP, BASIC QUALIFICATIONS FOR MEMBERSHIP: Must be Board Certified or Board eligible in their particular specialty. This Board shall be recognized by the American Medical Association, for the applicable specialty. 4. An interview was conducted with B#3 on 3-19-13 at 1215 hours and indicated the facility had not noticed the		be allowed to work in future.For all other providers, the credentialing will be reviewed closely at time of reappointment.Criminal background checks are accomplished through the CAPS process for credentialing and reappointment.	

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	discrepancy in the name of AH#1; B#3 confirmed the facility had not done an investigation to determine the correct name of AH#1 to clear up the discrepancy and a criminal background check for either name was not completed; B#3 indicated he/she called AH#1 on 3-19-13 and AH#1 indicated their legal name is name listed on the nursing license and they began using a second spelling a few years ago and did not legally change their first name. The application for privileges was approved by the governing board using a first name that is not the individual ' s legal name. 5. An interview was conducted with B#2 on 3-19-13 at 1345 hours and confirmed the discrepancy in the name of AH#1 was not investigated and the documents in the credential file contain both spellings of the first name; B#2 confirmed the name on the application, approved by the governing board, is not the legal name of the applicant (AH#1). B#2 confirmed the medical staff bylaws require physicians to be board certified or board eligible; B#2 confirmed MD#2 and MD#4 are not board certified or board			

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S000732	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2) These bylaws and rules must be as follows: (2) Be reviewed at least triennially. Based on document review and interview, the medical staff failed to review/approve their bylaws at least triennially. Findings included: 1. Review of the medical staff bylaws on 3-18-13 indicated the medical staff bylaws were last documented as reviewed/approved on 5-14-09. 2. An interview was conducted with B#2 on 3-19-13 at 1345 hours and confirmed the medical staff bylaws were last documented as reviewed/approved on 5-14-09.	S000732	The Medical Staff Bylaws were reviewed and updated at the Medical Staff meeting on 4-22-13. The were reviewed and approved by the Governing Board on 4-25-13The Facility Administrator is responsible.A checklist of the standards is being developed to assure compliance. This will be complete by 5-17-13.	05/17/2013

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S000752	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(H) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (H) A process for review of applications for staff membership, delineation of privileges in accordance with the competence of each practitioner, and recommendations on appointments to the governing body. Based on document review, observation, and interview, the facility failed to ensure governing body approval of privileges for 1 of 1 (AH#3) CST/CSFA. Findings included: 1. While touring the operating room on 3-19-13 at 1200 hours, it was observed that AH#3 was assisting the surgeon in the operating room for a patient's surgical procedure. 2. Review of credential files on 3-19-13 lacked evidence that the governing body had approved the privileges for AH#3; the privileges requested and approved by MD#2 and MD#7 included privileges outside the scope of practice for an CST/CSFA which included amputation of finger/wrist, bone fixation, muscle repair, primary nerve repair, joint arthroplasy of	S000752	The Delienation of Privileges was revised to reflect the responsibilities of the CST/CSFA for the surgery center. This was reviewed and approved at the Medical Staff meeting on 4-22-13. The full credentialing was approved at this meeting also. The credentialing and privileging was reviewed and approved at the Governing Body meeting on 4-25-13.The Facility Administrator is responsible.The credentialing files will be reviewed annually to assure compliance.	04/25/2013

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	the wrist, biopsy and excision of tumors..... 3. Interview with B#2 on 3-19-13 at 1540 hours confirmed AH#3 worked at the ASC on 3-19-13 assisting a surgeon in the operating room for a patient's surgical procedure; B#2 confirmed AH#3 assists the surgeons at the ASC and closes surgical sites for the surgeons; B#2 confirmed MD#2 and MD#7 approved the privileges for AH#3 which are outside the scope of practice for an CST/CSFA; B#2 confirmed the governing body has not approved privileges for AH#3.			

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	15C0001095	A. BUILDING 00 B. WING	03/19/2013

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S000836	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(iv) 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: (F) The delineation of preanesthesia, intra-operative, and postanesthesia responsibilities as follows: (iv) The requirement that all postoperative patients shall be discharged from the postanesthetic care unit by the practitioner described in clause (C) as responsible for the patient's care in accordance with center policy. Based on document review and staff interview, the facility failed to ensure patients were discharged from the post anesthesia unit by the practitioner providing anesthesia for 16 of 17 medical records reviewed. Findings include: 1. Patients #1-3, 5-7, 10-18 and #20 medical records contained a section for post anesthesia evaluation that included, but was not limited to a check box for no anesthesia complications and a check box to discharge from the area. The section was completed by an RN.	S000836	This practice was immediately terminated. The provider responsible for the care of the patient must be responsible and document the discharge of the patient from the facility.The Facility Administrator is responsible.Periodic reviews of the Medical Records will be conducted to assure compliance.	03/19/2013

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	2. Staff member #2 verified the above information beginning at 3:45 p.m. on 3/19/13 and indicated that the post anesthesia evaluation/discharge is always conducted/completed by an RN.			

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S000888	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F) Requirement for surgical services include: (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: (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. Based on document review and staff interview, the facility failed to ensure the surgeon completed an operative report immediately following surgery for 4 of 17 medical records reviewed. Findings include; 1. Patient #3 had surgery on 10/12/12. His/her operative report was not completed until 10/14/12. 2. Patient #6 had surgery on 9/7/12. His/her operative report was not completed until 9/11/12.	S000888	The members of the medical staff have been informed of the standards and necessity for compliance. This is being monitored daily by the Director responsible for transcription.The Facility Administrator is responsible.	04/22/2013

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	3. Patient #19 had surgery on 2/7/13. His/her medical record lacked an operative report. 4. Patient #20 had surgery on 2/7/13. His/her medical record lacked an operative report. 5. Staff member #2 verified the above information beginning at 3:45 p.m. on 3/19/13.			

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S001026	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)(i) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following: (i) Drug cabinets must be accessible only to authorized personnel. Based on observation and staff interview, the facility failed to ensure medications were accessible only to authorized personnel for 1 malignant hyperthermia cart observed. Findings include; 1. During observation of the pre-operative area beginning at 10:50 a.m. on 3/19/13, an unlocked malignant hyperthermia cart was observed in patient bay #11. A patient and spouse occupied bay #11. Medications observed in the unlocked cart included, but was not limited to, Physostigmine Salicylate, Furosemide, and Digoxin.	S001026	Breakable locks were immedicately placed on the Malignant Hyperthermia cart and the Pediatric cart for security as recommended by the surveyor. These are checked and documented along with the other checks that are done daily.The Facility Operations Manager is responsible.	03/19/2013

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	2. Staff member #2 indicated in interview at 11:05 a.m. on 3/19/13 that the cart is left unlocked.			