

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 02/01/2012
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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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 010525</p> <p>Survey Date: 1-30/2-1-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 02/14/12</p>	S0000			

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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S0300	<p>410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review, the facility failed to develop an effective quality assessment and performance improvement (QAPI) program in that the actions taken in response to a need for improvement in an activity showed a downward trend and no appreciable improvement for a period of 2 years.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated for outcomes of a monitor of physicians completing a History and Physical in line with State Board regulations, the following:</p> <table border="1"> <thead> <tr> <th>Report Period</th> <th>Outcome</th> </tr> <tr> <th>Target</th> <th>Action taken</th> </tr> </thead> <tbody> <tr> <td>Quarter 1, 2010</td> <td>90%</td> </tr> <tr> <td>>92%</td> <td>Yes</td> </tr> <tr> <td>Quarter 2, 2010</td> <td>83%</td> </tr> <tr> <td>>92%</td> <td>No</td> </tr> <tr> <td>Quarter 3, 2010</td> <td>90%</td> </tr> <tr> <td>>92%</td> <td>No</td> </tr> </tbody> </table>			Report Period	Outcome	Target	Action taken	Quarter 1, 2010	90%	>92%	Yes	Quarter 2, 2010	83%	>92%	No	Quarter 3, 2010	90%	>92%	No	S0300	<p>The Center will ensure that the History and Physicals are completed according to the state regulations and in accordance with the center's QA&I program. This will be accomplished by the following steps: 10 Charts per week will be audited by the Clinical Director for proper completion of the H&P. Any defeniencies will be addressed directly with the physician to remedy the defenciency. This will continue until the center achieves its 90% compliance rate. Once compliance is achieved the will be audited bi-monthly by the centers medical records auditor to ensure continued compliance. It will be the responsibility of the Executive and Clinical Directors to ensure that this area improves.</p>		03/01/2012
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	<p>Quarter 4, 2010 97% >92% None needed</p> <p>Quarter 1, 2011 87% >90% Yes</p> <p>Quarter 2, 2011 93% >90% None needed</p> <p>Quarter 3, 2011 83% >90% Yes</p> <p>Quarter 4, 2011 77% >90% Yes</p> <p>Analysis of the above indicated for the 2 year period, the average compliance was 87.5% compared to the lower standard of 90%. For the 2 year period, the trend was in a downward direction.</p> <p>2. Further review of the program indicated the actions taken were working with physicians, Med. Director to speak with physicians, Med. Director to look at H&P and try to speak with surgeons and Admin. team to work on ways to improve H&P's to present plan 1st qtr mtg of 2012.</p> <p>3. Based on the above outcomes and actions taken (or no actions in 2 instances), the data showed a downward trend and no appreciable improvement for a period of 2 years.</p>						

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S0400	<p>410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, document review and interview the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients.</p> <p>Findings include::</p> <p>1. During the facility tour of the surgery area with staff #40 on 01-31-12 at 1045 hours the following was observed: 1 box of 5.0 monocryl suture with an expiration date of 07-11. 1 box of 0 monocryl suture with an expiration date of 01-11. 1 box of 3.0 ethibond suture with an expiration date of 07-11. 1 box of 1.0 ethibond suture with an expiration date of 07-11. 1 box of 3.0 PDS II suture with an expiration date of 07-11. 1 box of 0 PDS II suture with an expiration date of 07-11.</p> <p>2. Review of the enzymatic solution manufacturer's recommendations indicated that a 1/2 ounce of enzymatic solution per gallon of water.</p>	S0400	<p>The checking of outdated suture will be added to the monthly chore list of the center's staff. It will be the responsibility of the Executive Director and the Clinical Director to ensure that these items are reviewed and corrected.</p> <p>The Clinical Director will work with the instrument room staff to ensure proper mixing of cleaning solutions. The Center will conduct a periodic review of the mixing process. It will be the responsibility of the Executive Director and the Clinical Director to assure that this plan is completed.</p>	02/15/2012			

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	3. On 01-31-12 at 1110 hours staff #44 confirmed that he/she adds 2-3 squirts of enzymatic solution to the water, but is not sure of the quantity of the water in the sink.			
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S0728	<p>410 IAC 15-2.5-4(b)</p> <p>(b) The medical staff shall adopt and enforce bylaws to carry out its responsibilities. These bylaws and rules must be as follows:</p> <p>Based on document review, it could not be determined the medical staff followed its rules for a quorum at 3 of 4 medical staff meetings.</p> <p>Findings:</p> <p>1. Review of the medical staff bylaws Article XII, Section C, entitled <u>Quorum</u>, indicated the presence of fifty percent of the total membership of the active staff at any regular or special meeting shall constitute a quorum for purposes of amendment to these by-laws, the rules and regulations, and for all other actions permitted by these by-laws.</p> <p>2. Review of documents entitled MEDICAL STAFF MINUTES, dated March 24, 2011, September 19, 2011 and December 15, 2011, indicated [those] Present: Various members of the medical staff. Therefore, it could not be determined how many medical staff members attended these meetings and thus, if a quorum was achieved.</p>	S0728	<p>1. The Center will assure that Medical Staff minutes include a roster of Medical Staff present. 2. It will be the responsibility of the Medical Director and Clinical Director to assure that this correction is completed.</p>	03/01/2012			

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S0746	<p>410 IAC 15-2.5-4(b)(3)(E)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(E) A statement of duties and privileges for each category of the medical staff.</p> <p>Based on document review and interview, the facility 's medical staff failed to follow the medical staff bylaws by not conferring on the applicant specific privileges for 7 (MD#1, MD#2, MD#3, MD#5, MD#7, AH#1 and AH#2) of 9 credential files reviewed.</p> <p>Findings:</p> <p>1. Review of the medical staff bylaws, Article VII., section B, entitled Delineation of Privileges in General, indicated each application for appointment and reappointment to the medical staff must contain a request for the specific clinical privileges desired by the application.</p> <p>2. Review of 7 medical staff and 2 allied health credential files indicated files MD#1, MD#2, MD#3, MD#5, MD#7, AH#1 and AH#2 did not have documentation of specific privileges requested by the application.</p>	S0746	<p>The Center will update its medical staff reapplication form to include question on whatprivileges recredentialing physicians wish to maintain or adjust. It will be the responsibility of the Medical Director and Clinical Director to assure that this correction is completed.</p>	02/15/2012
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	3. On 1-31-12 at 2:15 pm, upon interview, employee #A2 indicated the applications did not have privileges requested or to be approved as previously requested and no other documentation was provided prior to exit.			
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S0888	<p>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 that Operative Reports were dictated immediately following surgery for 10 of 29 medical records (MR) reviewed (Patient # 12, 15, 16 and 29).</p> <p>Findings include:</p> <p>1. Review of the following MRs indicated the following: Patient #12 had surgery on 11-09-11 and the Operative Report was dictated on 11-10-11. Patient #15 had surgery on 12-12-11 and the Operative Report was dictated on 12-13-11. Patient #16 had surgery on 12-07-11 and</p>			S0888	Center will work with physicians to ensure that operative reports are completed immediately following surgery and authenticated by the surgeon. Charts will be audited and actions taken as needed to improve the completion of Operative Notes. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves.		03/01/2012

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	<p>the Operative Report was dictated on 12-08-11. Patient #29 had surgery on 03-18-11 and the Operative Report was dictated on 03-22-11.</p>			
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S1008	<p>410 IAC 15-2.5-6(3)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>Based on document review and interview, the facility failed to follow its policy on how often to have monthly inspections by a pharmacist for 5 of 12 months in calendar year 2011.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a contract between the facility and P1 dated March 3, 1998 indicated the pharmacist shall perform monthly inspection of pharmaceutical supplies and documentation. 2. Review of the above pharmacist's reports for calendar year 2011, indicated there were seven (7) monthly documented inspections: January 12, February 14, April 13, June 24, August 19, October 27 and December 2. 3. On 1-31-12 at 2:45 pm, upon interview, employee #A2 indicated the above reports were all those for calendar year 2011 and no further documentation was provided. 	S1008	The center will work with contracted pharmacy service to ensure that the number of visits made by contracted pharmacy service matches the executed contract. The center will audit its pharmacy reports to make sure the contract is followed. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this done.	03/01/2012	

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S1170	<p>410 IAC 15-2.5-7(b)(4)(B)(iv)</p> <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>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to document defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator.</p> <p>Findings:</p> <p>1. Review of the facility's defibrillator manual, indicated recommended checks and procedures to be performed at the start of each shift according to a document entitled Operator's Shift Checklist for M Series Products (Semi-Automatic). The Checklist indicated the facility was to perform checks that included, but were not limited</p>	S1170	The center will adjust its defibrillator check list to match the defibrillator manufacturers guidelines. This check will be reviewed through the QA&I program of the center. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this is completed.	02/15/2012			

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	<p>to, clean the paddles, inspect cables for cracks, broken wires, connector, and the battery and spare battery.</p> <p>2. Review of a document entitled DEFIBRILLATOR/CODE CART MONTH 1/YR12, indicated a column entitled DEFIB. but it did not indicate what checks were performed.</p> <p>3. On 2-1-12 at 10:00 am, upon interview, employee #A2 indicated the checks were not done according to the Checklist and no other documentation was provided prior to exit.</p>				