

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001172	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/21/2013
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NAME OF PROVIDER OR SUPPLIER  ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 702 BARNHILL DR STE 201 INDIANAPOLIS, IN 46202
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 012347</p> <p>Survey Date: 11-18/21-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/04/13</p>	S000000		

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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S000110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(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.</p> <p>Based on document review and interview, the facility's governing board failed to review 1 contracted service and 1 directly-provided service during calendar year 2012 as part of the facility's quality assurance/performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the governing board meeting minutes for calendar year 2012 indicated the governing board failed to review QAPI for the contracted service of tissue transplant and the directly-provided service of housekeeping.</p> <p>2. In interview, on 11-21-13 at 2:45 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p>	S000110	The Clinical Manager is responsible for assuring that the Governing Board review Tissue Transplant and ROC directly provided housekeeping service. Tissue Transplant and ROC PSA duties were added to the monthly and quarterly reviews for QAPI for review by the governing board to begin 4th quarter 2013. See attached. The Clinical Manager will ensure ongoing compliance.	12/09/2013	

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S000116	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES</p> <p>410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</p> <p>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on document review and interview, the governing board failed to grant privileges to 1 of 1 allied health care practitioner.</p> <p>Findings:</p> <p>1. Review of 1 allied health credential file, AH#1, indicated there were no privileges granted to the practitioner by the governing board.</p>	S000116	The Clinical Manager is responsible for ensuring that allied health credential files includes proof of granted privileges as described in a job description of the requesting practitioner by the governing board. On December 16, 2013 a privilege form with the attached job description was reviewed, approved and signed by a member of the Credentials Committee and also the Medical Director. It was sent to members	12/16/2013

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S000156	<p>2. In interview, on 11-19-13 at 4:20 pm, employee #A1, confirmed the above and no other documentation was provided prior to exit.</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 follow its policy to maintain annual performance evaluations for 1 of 1 contracted employee.</p> <p>Findings:</p> <p>1. Review of Statement Number: HRM</p>	S000156	<p>of the Governing Board in a "Written Consent in Lieu of a Meeting" on 12/16/13 for approval.</p> <p>The Clinical Manager is responsible to provide input to the annual performance evaluation of contracted personnel. On 12/09/2013 the ROC Clinical Manager met with the Clinical Manager of Radiology. A Radiology Tech Sign in Log was developed to identify staff coming to the ROC Surgery Center and it's use was</p>	12/11/2013	

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	<p>3.00, entitled HUMAN RESOURCE POLICIES &amp; PROCEDURES, approved 10-29-2010, indicated ASC administration and staff follow the Human Resource policies established by IU Health.</p> <p>2. Review of IU Health Policy #: HR-156, indicated there would be an annual evaluation between the employee and their direct supervisor.</p> <p>3. Review of 1 contracted employee personnel files, #P1, indicated there was no performance evaluation by any authorized surgery center person.</p> <p>4. In interview, on 11-18-13 at 3:30 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p>		<p>begun on 12/11/2013. The log provides a mechanism to give input into the performance of the Radiology Staff. The log will be sent to the Radiology Manager at the end of each month beginning December 2013. The ROC Clinical Manager will ensure continued compliance.</p>		

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S000616	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on document review and interview, the facility failed to follow its policy for signing a statement that he or she is the only one who has the computer code or password and is the only one to use it for authentication of entries, for 4 of 7 physician credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of facility policies indicated anyone who uses a computer signature to authenticate entries must sign a statement that they are the only one who has the computer code or password and is the only one who will use it.</li> <li>2. Review of 7 physician credential files</li> </ol>	S000616	The Clinical Manager is responsible to ensure that a signed statement is present in each physicians file stating that he or she has a specific computer code (or password) and he or she is the only one who will use it. As of 12/16/2013, each credentialed physician has a signed statement included in their file, saying that he or she has a specific computer code (or password) and he or she is the only one who will use it. The Clinical Manager has provided the staff responsible for credentialing a checklist of documents required in each file to prevent this from occurring in the future.	12/16/2013			

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S000630	<p>indicated files MR#1, MR#2, MR#3 and MR#4 did not contain a signed statement that he or she is the only one who has the computer code or password and is the only one who will use it.</p> <p>3. In interview, on 11-19-13 at 4:20 pm, employee #A1 confirmed the above indicated no other documentation was provided by exit.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on document review and interview, the facility failed to ensure that the medical record (MR) contained sufficient information to document accurately the course of medication administration for the patients during the stay in the center for 4 of 25 MRs reviewed (Patient #10, 12, 16 &amp; 24).</p> <p>Findings include:</p>	S000630	The Clinical Manager will be responsible to ensure that medication documentation is entered correctly into the electronic medical record. A staff meeting was held on November 20, 2013 to enforce and re-educate the staff on the correct procedure for entering medications on the Electronic Medication Administration Record (MAR). The Clinical Manager assured that all staff were	12/05/2013	

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	<p>1. Review of policy / procedure Content of Medical Records indicated the following; "B. The medical record shall contain patient specific information including: 20. Doses of medication administered and any adverse drug reaction." This policy / procedure was last reviewed / revised on 10-29-10.</p> <p>2. Review of patient #10's MR indicated the patient was medicated for pain on 08-22-13 at 1058 hours. Patient #10's MR lacked documentation of what medication the patient was administered.</p> <p>3. Review of patient #12's MR indicated the patient was medicated for pain on 08-30-13 at 1354 hours. Patient #12's MR lacked documentation of what medication the patient was administered.</p> <p>4. Review of patient #16's MR indicated the patient was medicated for pain on 09-23-13 at 1330 hours. Patient #16's MR lacked documentation of what medication the patient was administered.</p> <p>5. Review of patient #24's MR indicated the patient was administered 650 mg of Tylenol po on 10-15-13 at 1251 hours. Patient #24's MR lacked documentation of a medication order for 650 mg of Tylenol.</p>		reeducated by 12/5/13. Periodic audits will be performed by the Clinical Manager to ensure continued compliance.		

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S000728	<p>6. On 11-21-13 at 1415 hours staff #42 confirmed the medications administered were not documented for patient # 10, 12 &amp; 16 and there was no physician order for 650 mg of Tylenol for patient #24.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 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: Based on document review and interview, the medical staff failed to adopt required rules.</p> <p>Findings:</p> <p>1. Review of required medical staff rules indicated there were medical staff rules including, but not limited to, provision for coverage of emergency care and medical histories and physicals being in accordance with medical staff requirements.</p> <p>2. Review of these rules and medical staff minutes indicated they were not</p>	S000728	The Clinical Manager is responsible for ensuring that the Medical Staff Rules and Regulations are reviewed and adopted by the Medical Staff. The Medical Staff rules were initially reviewed and approved on October 29,2010. See attached.The Medical Staff Rules will be presented for review and approval at the next quarterly Medical Staff Meeting to be held on January 16, 2014.The Clinical Manager will ensure that the Medical Staff Rules are reviewed by the Medical Staff every three years.	01/16/2014	

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	<p>adopted by the medical staff.</p> <p>3. In interview, on 11-20-13 at 3;30 pm, employee #A1 was requested to provide documentation of the medical staff rules having been adopted by the medical staff and no documentation was provided prior to exit.</p>				

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S000772	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review and interview, the facility failed to ensure that a medical history and physical examination was completed for each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff for 3 of</p>	S000772	The Clinical Manager is responsible for assuring that each physician is granted privileges for performing history and physicals. The Medical Staff Bylaws have been amended to state that all physicians who have been granted active, provisional and temporary privileges in the Center	12/16/2013			

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	<p>30 medical records (MR) reviewed (Patient #9, 12 &amp; 20).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of patient #9's MR indicated that MD #1 completed the patient's history &amp; physical.</li> <li>2. Review of patient #12's MR indicated that MD #2 completed the patient's history &amp; physical.</li> <li>3. Review of patient #20's MR indicated that MD #3 completed the patient's history &amp; physical.</li> <li>4. Review of MD #1, 2 &amp; 3's credential / privileging files lacked documentation that each had been granted privileges to perform history and physical examinations.</li> <li>5. On 11-21-13 at 1110 hours staff #41 confirmed that MD #1, 2 &amp; 3's credential /privileging files lacked documentation of being granted privileges to perform history and physical examinations.</li> </ol>		<p>have been granted privileges to perform a history and physical. (See Attached) This was sent to the Governing Board members in a "Written Consent in Lieu of a Meeting" on 12/16/13 for approval.</p>		

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S000788	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(R)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(R) A requirement that a physician shall be available to the center during the period any patient is present in the center.</p> <p>Based on document review and interview, the facility failed to ensure a policy approved by the medical staff requiring physician availability anytime a patient is present in the facility.</p> <p>Findings:</p> <p>1. Review of facility documents indicated there was no policy approved by the medical staff requiring physician availability anytime a patient is present in the facility.</p> <p>2. In interview, on 11-21-13 at 3:15 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p>	S000788	The Clinical Manager is responsible for assuring the compliance to all Center policies and procedures. The MS 2.18 Emergency Care Policy has been revised to include that a physician will be immediately available to the ASC during the period any patient is present in the Center. A "Written Consent in Lieu of a Meeting" was sent to the Governing Board members on 12/16/13 for approval.	12/16/2013	

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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. Based on document review and interview, the facility failed to provide documentation of safety training in areas where anesthetics are used for 7 of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of 7 medical staff credential files indicated files and 1 allied health credential file indicated MD#3, MD#4, and AH#1 did not contain any documentation of safety training in areas where anesthetics are used.</li> <li>In interview, on 11-19-13 at 4:20 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</li> </ol>	S000826	The Clinical Manager is responsible for ensuring that staff has on file, evidence of safety training in areas where anesthetics are used. As of 12/16/2013 all medical staff and allied health personnel have in their files documentation of safety training where anesthetics are used. The Clinical Manager will ensure that the credentialing staff includes the annual safety training documentation in each file.	12/16/2013			

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S000920	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following: Based on document review and interview, the facility failed to ensure that nursing staff followed written patient care policies and procedures for patient admission and post recovery care for 19 of 25 medical records (MR) reviewed (Patient #1, 2 5, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22 &amp; 23).</p> <p>Findings include:</p> <p>1. Review of policy / procedure Guidelines for Completion of Patient Admission indicated the following: "5. Complete Pre-Procedure Checklist in Cerner (NPO status, Pregnancy test results if applicable, body measurements, vital signs)" This policy / procedure was last reviewed / revised on 10-29-10.</p> <p>2. Review of patient #1, 3, 5, 7, 8, 13, 14, 17 &amp; 19's MR lacked documentation of an admission blood pressure being taken.</p>	S000920	<p>The Clinical Manager will be responsible to enforce and ensure compliance of the patient care policies and procedures for patient admission and post recovery care. A staff meeting was held on 11/20/13 to provide reeducation for staff members of these areas. The guidelines were revised to include more specific instruction for documentation in all circumstances. (See attached) These guidelines were reviewed and approved by the Medical Director on 12/5/13 and were posted for the staff. The Clinical Manager will conduct periodic audits to ensure compliance with these guidelines.</p>	12/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001172	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/21/2013
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	<p>3. Review of policy / procedure Discharge Criteria to the Care of a Responsible Adult indicated the following: "Criteria for Discharge from SDS (Same Day Surgery) (or PACU) to home Assess the patients readiness for discharge based on the following criteria: 1. Heart rate, respiratory rate, and blood pressure are within 10 % of preoperative values." This policy / procedure was last reviewed / revised on 10-29-10.</p> <p>4. Review of patient #5, 7, 9, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 21, 22 &amp;23's MR lacked documentation of a blood pressure being taken during recovery in Day Surgery area.</p> <p>5. On 11-21-13 at 1400 hours, staff #42 confirmed the patient blood pressures were not documented in the MRs for the admission phase and recovery phase.</p>				

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S001164	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</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>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule. Based on document review and interview, the facility did not have preventive maintenance (PM) of 1 piece of patient care equipment on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice.</p> <p>Findings:</p> <p>1. On 11-18-13 at 10:45 am, employee #A1 was requested to provide documentation of PM of the overhead operating room lights.</p>	S001164	The Clinical Manager is responsible for assuring compliance of all equipment requiring preventative maintenance within the facility. An initial waiver was requested on September 21, 2010 requesting to follow the contracted IU Health's Clinical Engineering Department's "Equipment Risk Assessment Analysis" method. Unfortunately we failed to follow up on the initial request but have submitted a second request for this waiver on 12/5/13. (See attached). The Clinical Manager will follow up with the ISDH by	12/05/2013	

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	2. In interview, on 11-21-13 at 2:45 pm, employee #A1 indicated the PM, conducted by a contracted service, was only done as needed. This was a schedule based on a risk assessment method used by the contractor. At that same time and date, employee #A1 was requested to provide documentation of a waiver to use such a method. In interview at that time and date, the employee indicated the facility did not have such a waiver.		12/21/13 if a waiver has not been received.		