

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001091	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2012
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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF INDIANAPOLIS LLC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2007 N CAPITOL AVE INDIANAPOLIS, IN 46202
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002463</p> <p>Survey Date: 5-29/31-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/20/12</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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S0110	<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 during calendar year 2011 for quality assurance performance improvement (QAPI) activities.</p> <p>Findings:</p> <p>1. Review of the facility's governing board meeting minutes for calendar year 2011 indicated the governing board failed to review QAPI activities for the contracted services of agency nursing.</p> <p>2. Upon interview, on 5-31-12 at 11:35 am, employee #A2 indicated there were no governing board minutes for calendar year 2011 which included contracted agency nursing and no further documentation was provided by exit.</p>	S0110	<p>1. Deficiency is corrected by adding Nursing Agency to our QAPI Contract Grid. The Nursing Agency will be reviewed each quarter by our QI Committee, Staff meeting, Medical Advisory Committee(MAC) meeting, and Governing Board. 2. This Deficiency has been corrected by adding Nursing Agency to the Contract Grid and the grid will be reviewed and reported on quarterly. All new contracts will be added to the Grid on a monthly basis. 3. Responsible person is Nurse Managers and Administrator. They will report quarterly to the QI Committee, Medical Advisory Committee(MAC) and Governing Board. 4. Nursing Agency will be reviewed in Staff meeting June 29, 2012, MAC July 24, 2012 and Governing Board Aug 8.2012.</p>	08/08/2012			

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S0332	<p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the center:</p> <p>(A) The following surgical events:</p> <p>(i) 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. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention.</p>			

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	<p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide</p>			

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	<p>resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p>			

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	<p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on</p>			

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	<p>the grounds of the center.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p> <p>Based on document review and interview, the facility failed to include outcomes of some of the specific types of reportable events in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include outcomes of some of the types of reportable events, including but not limited to, patient death or serious disability associated with patient elopement, patient suicide or attempted suicide resulting in serious disability while being cared for in the center, any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider, abduction of a patient of any age, sexual assault on a patient within or on the grounds of the center, and death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p> <p>2. In interview, on 5-31-12 at 11:35 am, employee #A2 indicated several types of</p>	S0332	<p>1. Policy 118(Quality Improvement and Risk Management) was revised to report all reportable events per our QAPI program on a quarterly basis with our staff/QI Committee, MAC and Governing Board: The policy was discussed with Administrator and Medical Director on 6/22/12. Staff were in-serviced on Policy 118 on 6/29/12. MAC will review on July 24, 2012, and GB on 8/8/2012.</p> <p>2. All Reportable evernts were added to QAPI Program (Policy 118). The Events along with the incident reports will be discussed and approved each quarter at our Staff, MAC and Governing Board Meetings. 3. OR Manager, Administrator and Medical Director will be reponsible for reporting events to the appropriate staff. 4. June 29, 2012 Staff meeting July 24, 2012 MAC Meeting Aug 8, 2012 GB meeting</p>	06/22/2012			

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	reportable events, as stated above, were not included in the facility's QAPI program and no further documentation was provided prior to exit.				

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S0454	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(g)(2)</p> <p>Sterilization services must be directed by a qualified person or persons and must provide for the following:</p> <p>(2) Written policies and procedures must be available and followed by personnel responsible for sterilizing equipment and supplies, including, but not limited to, the following:</p> <p>(A) Minimum time and temperature for processing various size bundles and packs.</p> <p>(B) Instructions for loading, operating, cleaning, and maintaining sterilizers.</p> <p>(C) Instructions for cleaning packaging, storing, labeling, and dispensing of sterile supplies.</p> <p>(D) Procedure for maintaining and recording the particular sterilizing cycle.</p> <p>(E) Sterilization of heat labile reusable equipment.</p> <p>Based on observation and interview, the facility failed to ensure that written policies and procedures be available for personnel for operation of the Steris System 1E.</p> <p>Findings include:</p>	S0454	<p>1. Policy 329(System 1E Operation) was developed by OR manager and Administrator per manufacturer guidelines. Policy was reveiwed with staff per inservice and Medical Director on 6/12/12. The machine will be monitored monthly by infection controlIRN/OR Manager to make</p>	08/08/2012

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	<p>1. During the facility tour on 05-30-12 at 1220 hours, a Steris System 1E was observed in the substerile room.</p> <p>2. On 05-30-12 at 1220 hours, staff #41 confirmed that the facility did not have established policy/procedures for Steris System 1E.</p>		<p>sure policy is being adhered to.</p> <p>2. Ploicy 329 was developed and taped to machine on 6/12/12. Manufacturer Guidelines were followed. Inservice was given to all OR Staff and Physicians at the Facility on 6/12/12. Staff will have an annual inservice on policy at staff meeting. Infection control committee will monitor guidelines are followed monthly. All New equipment placed in the facility will have a policy developed within 30days from arrival. Policy was dicussed and reviewed by Infection control, MAC, and GB. 3.OR Manager/Infection RN will be responsible for developement and Inservice of all equipment. 4. Staff Inservice 6/12/12, approved in staff meeting 6/29/12. MAC approval 7/24/12 GB approval 8/8/12</p>		

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S0526	<p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on document review and interview, the facility failed to ensure that all nursing personnel performing laboratory testing were competency assessed annually with documentation of assessment maintained in the employee file for urine pregnancy test for 4 of 5 nursing personnel files reviewed (Staff #3, 5, 6 & 11).</p> <p>Findings include:</p> <p>1. Review of staff #3, 5, 6 and 11's personnel files lacked documentation of annual competency for urine pregnancy tests.</p> <p>3. On 05-29-12 at 1505 hours, staff #41 confirmed that there was no annual documented competency for nursing staff who perform urine pregnancy tests.</p>	S0526	<p>1. All staff members in OR and PACU were in-serviced on urine pregnancy tests on 6/8/12. Urine Pregnancy test were added to the Annual review sign off sheet per OR Manager. Annually at their evaluation staff members will be checked off on All lab test required annually for our Center.</p> <p>2. Annually at each staff members review the OR manager or PACU manager will sign off on the employees record that they have competency in each of the labs performed in the Center that are CLIA waived. 3. OR MANAGER is responsible person to monitor annual pregnancy training 4. Date Completed 6/8/12</p>	06/08/2012			

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S1164	<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.</p> <p>Based on document review and interview, the facility failed to conduct preventive maintenance (PM) on 4 pieces of equipment in accordance with acceptable standards of practice or in accordance with the manufacturer's recommended maintenance schedule.</p> <p>Findings:</p> <p>1. Review of the facility's biomedical engineering reports indicated there was no PM within the past 12 months conducted on a patient stretcher, suction machine,</p>	S1164	<p>1. Biomedical Engineer has been contacted to perform annual PM on the following items: Patient Stretcher x8, Suction Machine, surgical table x4, and wheel chairs x2. Trimedx new biomedical firm will inspect all equipment on (9/10/12). We signed a contract on 7/30/12 and our annual review will take place 9/10/12) 2. The above mentioned equipment has been added to the Biomedica List for inspection annually. Start date 9/10/12. 3. OR Manager is responsible person to monitor the deficiency 4.9/10/12 Biomedical</p>	09/10/2012			

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	<p>surgical table and wheelchair.</p> <p>2. In interview, on 5-31-12 at 9:50 am, employee #A2 indicated there was no documentation available for PM within the past 12 months conducted on the above-stated pieces of equipment and no further documented was provided by exit.</p>		inspection of equipment	