

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/01/2013
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NAME OF PROVIDER OR SUPPLIER  SENATE STREET SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 N SENATE BLVD INDIANAPOLIS, IN 46202
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 006622</p> <p>Survey Date: 7-29-13/8-1-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Linda Dubak, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 08/14/13</p>	S000000	Agree	

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 3 activities during calendar year 2012 as part of the facility's quality assessment/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 activities for discharges, response to patient emergencies and reportable events.</p> <p>2. In interview, on 7-31-13 at 4:00 pm, employee #A6 confirmed the governing board had not reviewed any QAPI report for the above activities in calendar year 2012 and no further documentation was provided prior to exit.</p>	S000110	<p>1. QAPI committee activities, including but not limited to discharges, response to patient emergencies, and reportable events, will be added to the Governing Board meeting agenda as a standing item for discussion at every Governing Board meeting.2. Adding QAPI as a standing item on the Governing Board agenda will prevent oversight of reporting the QAPI committee reports.3. The Clinical Director is responsible to ensure correction and continual compliance with tag S0110.4. The Governing Board meeting agenda will have the standing QAPI item report added no later than August 26, 2013.</p>	08/26/2013			

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S000153	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review and interview, the facility failed to follow its policy to provide orientation of contracted employees to the facility for 3 of 3 contracted personnel files reviewed.</p> <p>Findings:</p> <p>1. Review of Policy Number: HRM 3.03, entitled ORIENTATION, approved July 2010, indicated all employees are required to attend ASC [Ambulatory Surgery Center] and department orientation at the first possible opportunity. days.</p> <p>2. Review of 3 contracted radiology personnel files, indicated file P#1 was first contracted in year 2006 and files P#2 and P#3 were first contracted in</p>	S000153	<p>1. All contracted radiology personnel who provide services will receive an orientation to the center and will sign the orientation check-sheet, which will be placed in their personnel files. All new contracted radiology personnel will be oriented to the center and the signed check-sheet will be placed in their file on the first day they work at the surgery center.2. The check-sheet will provide documented proof the orientation was received by the contracted radiology personnel.3. The OR and PACU Clinical Managers will be responsible to ensure compliance with tag S0153.4. Current contracted radiology personnel will have the documentation of their orientation to the center no later than 08/30/2013.</p>	08/30/2013

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S000156	<p>year 2007. Further review indicated none of the files contained documentation of orientation to the facility.</p> <p>3. In interview, on 7-30-13 at 2:20 pm, employee #A6 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 3 of 3 contracted</p>	S000156	1. The evaluations of the contracted services personnel providing services will be reviewed and signed by the Clinical Manager of the OR or the	08/30/2013			

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	<p>employees.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of Policy #: HR-156, entitled Performance Management, section VII.A.3., approved June 2013, indicated the direct supervisor completes the Direct Supervisor's Employee Annual Summary [performance evaluation form].</li> <li>2. Review of 3 contracted employee personnel files, P#1, P#2, and P#3, indicated there were no performance evaluations, per facility policy, by any authorized surgery center person.</li> <li>3. In interview, on 7-30-13 at 2:20 pm, employee #A6 confirmed the above and no other documentation was provided prior to exit.</li> </ol>		<p>Clinical Manager of the PACU annually. Comments may be added where appropriate.2. Education to the Clinical Managers of the OR and PACU will ensure compliance with this tag and prevent the deficiency from recurring.3. The Clinical Managers of the OR and PACU are responsible for consistent compliance with tag S0156.4. Current contracted personnel will have the above evaluation process completed with documentation of completion in their personnel files no later than 08/30/2013. New contracted personnel will receive an evaluation by the above process within 12 months of providing contracted services at the center.</p>		

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S000228	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</p> <p>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:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that podiatrists performing surgery in the facility maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located for 1 of 8 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 8 medical staff credential files indicated files MD#7, a podiatrist, did not have documentation of admitting</p>	S000228	<p>1. The application for membership to the Medical Staff will be amended to include the requirement that podiatrists will be required to provide an agreement with a physician with admitting privileges at a hospital in the same county or in an adjacent county in which the podiatrist has surgical privileges. The podiatrists currently on the Medical Staff will be required to provide an agreement with a physician as stated above no later than 9/27/2013 to be placed in their file at the surgery center.2. The addition of the requirement to the application for Medical Staff</p>	09/27/2013			

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S000432	<p>privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located.</p> <p>2. In interview, on 7-31-13 at 1:25 pm, employee #A3 confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(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:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, interview and policy review, the facility failed to clean and disinfect the OR#1 during terminal cleaning of the OR after hours.</p> <p>Findings include:</p> <p>1. On 7/30/13 at 4:40 pm, observation of employee #2 (house keeper) indicated the air exchange duct in the rear of the</p>	S000432	<p>membership will prevent the deficiency to tag S 0228 from recurring in the future.3. The Clinical Director is responsible to ensure compliance of the podiatrists with this requirement.4. The Clinical Director respectfully requests an extension in the timeframe for completing the deficiencies in the survey to allow sufficient time for the podiatrists to have the agreements completed and turned into the center.</p> <p>1. The ASC's Infection Control RN will provide re-education to the housekeepers who clean the surgical suites of the center, with emphasis placed on terminal cleaning. The house keepers will then be observed quarterly for compliance with the Environmental Cleaning in the Perioperative Setting policy. Documentation of the quarterly observation will be maintained by</p>	08/30/2013

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	<p>room, and several overhead panels and a portion of the north wall of the OR were missed during cleaning with the disinfectant.</p> <p>2. Interview with NP 1 and with employee #2, at 4:50 on 7/30/13 confirmed the employee should clean all of the panels of the ceiling and the walls from floor to ceiling and the air exchange ducts with disinfectant during terminal cleaning of the room.</p> <p>3. Facility policy, Environmental Cleaning in the Perioperative Setting, Approval date, May 2011, under definitions, "Terminal cleaning: cleaning that is performed in surgical/procedure rooms and scrub/utility area at the completion of the surgical practice settings' daily surgery schedules. An unused room should be cleaned once in every 24 hours during regular business days." "F. Terminal cleaning- 10. Walls, ceilings and ventilation duct interiors should be cleaned in each intraoperative and invasive procedural suites monthly by housekeeping. "</p>		<p>the Infection Control RN.2. If any breaches are observed, the Infection Control RN will intervene immediately and act in accordance with the regulations and the circumstances of the breach. The quarterly documentation will be reviewed by the QAPI committee. 3. The surgery center Infection Control RN is responsible for ensuring consistent compliance with tag S0432.4. The re-education for the housekeepers will be completed and the observation log will be developed no later than 08/30/2013.</p>				

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S000606	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(b)(1)</p> <p>(b) The organization of the medical record service must be appropriate to the scope and complexity of the services provided as follows:</p> <p>(1) The services must be directed by a registered record administrator (RRA) or an accredited record technician (ART). If a full-time and/or part-time RRA or ART is not employed, then a consultant RRA or ART must be provided to assist the qualified person in charge. Documentation of the findings and recommendations of the consultant must be maintained.</p> <p>Based on document review and interview, the facility failed to follow its contract for consultant medical record services by not documenting the consultant findings according to the contract for the consultant services in 1 instance.</p> <p>Findings:</p> <p>1. Review of a document entitled AGREEMENT HEALTH INFORMATION CONSULTANT SERVICES, between Senate Street Surgery Center and MED-REC SYSTEMS [Agency], dated 8-07-12, indicated in Section V. and VI.A., the</p>	S000606	<p>1. The Consultant Services reports are now maintained in a location where they can be easily located. The center will ensure that quarterly audits are completed by the Consultant Services. 2. The reports will be accessed in a timely manner upon request of the surveyors in the future. 3. The Clinical Director is responsible to ensure compliance with tag S 0606.4. The reports are attached to this plan of correction response on 8/27/2013.</p>	08/27/2013

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S000622	<p>Agency agrees to [provide] reports and health information consultation quarterly.</p> <p>2. Review of medical record consultant reviews for calendar year 2012 indicated there were only reports for 3 of 4 quarters.</p> <p>3. In interview, on 8-1-13 at 11:15 am, employee #A6 confirmed the above reviews and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(6)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(6) The center shall have a system of coding and indexing medical records which allows for timely retrieval of records by diagnosis and procedure, physician, and condition on discharge, in order to support continuous quality assessment and improvement activities. Based on document review and interview, the facility failed to have documentation of a log, index or</p>	S000622	<p>1. A log is maintained in the PACU department of the surgery center on every patient that receives surgical services at the</p>	08/12/2013			

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	<p>Freeport for timely retrieval of records by diagnosis, procedure, physician and condition on discharge in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 7-29-13 at 10:15 a, employee #A6 was requested to provide documentation of a log, index or report for timely retrieval of records for patients for the week of July 22, 2013, by diagnosis, procedure, physician and condition on discharge.</li> <li>Review of documents provided in response to the request were copies of medical record documents. Thus, the facility was not able to provide the requested document for timely retrieval.</li> <li>In interview, on 8-1-13 at 10:00 am, employee #A1 confirmed the above and no further documentation was provided by exit.</li> </ol>		<p>facility. The existing log contains all elements stated in the deficiency on this tag except the condition at discharge. The condition at discharge has since been added to the existing log and documentation of the condition at discharge has begun.2. Adding a column to the existing patient log will ensure compliance with this regulation.3. The PACU Clinical Manager is responsible for the implimentation and consistent compliance with tag S0622.4. The last component named in the deficiency, condition at discharge, was added to the existing patient log on 08/12/2013 and the center is now in compliance with this regulation.</p>		

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S000658	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(6)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(6) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review and interview, the facility failed to maintain evidence of an appropriate informed consent for one of five medical records of patients transferred after surgery (#15).</p> <p>Findings include:</p> <p>1. On 7/31/13 at 1:00 pm, during review of electronic medical record for patient #15, it was noted there was no consent in the record for transfer to another facility.</p> <p>2. Interview with N#2 at 1:05 pm on 7/31/13 indicated no consent could be found for this patient in the electronic medical record.</p>	S000658	<p>1. Employee education was provided to all employees who have responsibilities in maintaining the patient's clinical records. The education involved ensuring that the original records are kept by the surgery center and only copies are sent to the receiving facility during a transfer. 2. Sending only copies of the patient's medical records will ensure that the original is sent to be scanned and prevent any of the paper record from being lost.3. The Clinical Manager of the PACU is responsible for completion of the staff education and ensuring compliance with tag S 0658.4. The employee education was provided immediately following the ISDH survey beginning 08/02/2013 and was completed on 08/07/2013.</p>	08/07/2013			

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S000780	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on document review and interview, the facility failed to maintain evidence of an physician orders for one of five medical records of patients transferred after surgery (#19).</p> <p>Findings include:</p> <p>1. On 7/31/13 at 1:20 pm, during review of electronic medical record for patient #19, it was noted there were no physician orders available in the record.</p> <p>2. Interview with N#2 at 1:05 pm on 7/31/13 indicated no orders could be</p>	S000780	<p>1. Employee education was provided to all employees who have responsibilities in maintaining the patient's clinical records. The education involved ensuring that the original records are kept by the surgery center and only copies are sent to the receiving facility during a transfer. 2. Sending only copies of the patient's medical records will ensure that the original is sent to be scanned and prevent any of the paper record from being lost.3. The Clinical Manager of the PACU is responsible for completion of the staff education and ensuring compliance with tag S 0780.4. The employee</p>	08/07/2013
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S000834	<p>found for this patient in the electronic medical record.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(iii)</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>(F) The delineation of preanesthesia, intra-operative, and postanesthesia as follows:</p> <p>(iii) The completion of a postanesthetic evaluation for proper anesthesia recovery of each patient prior to discharge in accordance with written policies and procedures approved by the medical staff.</p> <p>Based on document review and interview, the facility failed to maintain a copy of post anesthetic evaluation for one of five medical records of patients transferred after surgery (#19).</p> <p>Findings include:</p> <p>1. On 7/31/13 at 1:15 pm, during review of electronic medical record for patient #19, it was noted there were no post anesthesia evaluation available in the record.</p>	S000834	<p>education was provided immediately following the ISDH survey beginning 08/02/2013 and was completed on 08/07/2013.</p> <p>1. Employee education was provided to all employees who have responsibilities in maintaining the patient's clinical records. The education involved ensuring that the original records are kept by the surgery center and only copies are sent to the receiving facility during a transfer. 2. Sending only copies of the patient's medical records will ensure that the original is sent to be scanned and prevent any of the paper record from being lost.3. The Clinical Manager of the PACU is responsible for completion of the staff education</p>	08/07/2013			

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S001146	<p>2. Interview with N#2 at 1:05 pm on 7/31/13 indicated no post anesthesia evaluation could be found for this patient in the electronic medical record.</p> <p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</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>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, interview and policy review, the facility failed to maintain OR#1 in the manner to promote safety of patients, during terminal cleaning of the OR after hours.</p> <p>Findings include:</p> <p>1. On 7/30/13 at 4:40 pm, observation of employee #2 (house keeper) indicated the air exchange duct in the rear of the room, and several overhead panel and a portion of the north wall of the OR were missed during cleaning with the</p>	S001146	<p>and ensuring compliance with tag S 0834.4. The employee education was provided immediately following the ISDH survey beginning 08/02/2013 and was completed on 08/07/2013.</p> <p>1. The ASC's Infection Control RN has provided re-education to the housekeepers who clean the surgical suites of the center, with emphasis placed on terminal cleaning. A process to observe the housekeepers quarterly for compliance with the Environmental Cleaning in the Perioperative Setting policy has been put in place. Documentation of the quarterly observation will be maintained by the Infection Control RN.2. If any breaches are observed, the Infection Control RN will intervene immediately and act in accordance with the regulations</p>	08/14/2013	

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	<p>disinfectant.</p> <p>2. Interview with NP 1 and with employee #2, at 4:50 on 7/30/13 confirmed the employee should clean all of the panels of the ceiling and the walls from floor to ceiling and the air exchange ducts with disinfectant during terminal cleaning of the room.</p> <p>3. Facility policy, Environmental Cleaning in the Perioperative Setting, Approval date, May 2011, under definitions, "Terminal cleaning: cleaning that is performed in surgical/procedure rooms and scrub/utility area at the completion of the surgical practice settings' daily surgery schedules. An unused room should be cleaned once in every 24 hours during regular business days." "F. Terminal cleaning- 10. Walls, ceilings and ventilation duct interiors should be cleaned in each intraoperative and invasive procedural suites monthly by housekeeping. "</p>		<p>and the circumstances of the breach. The quarterly documentation will be reviewed by the QAPI committee. 3. The surgery center Infection Control RN is responsible for ensuring consistent compliance with tag S0432.4. The re-education for the housekeepers was completed and the observation log will be developed no later than 08/14/2013.</p>		

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S001188	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on observation, interview and document review, the facility failed to respond appropriately to a fire signal in 1 instance.</p> <p>Based on document review and interview, the facility failed to follow its policy to conduct fire drills once per quarter, per shift in 3 instances.</p> <p>Findings:</p> <p>1. On 7-30-13 at 12:50 pm, in the presence of employee #A6, a signal was heard to be broadcast over the building intercom system. In interview on that date and time, employee #A6 was asked the meaning of the signal. The</p>	S001188	<p>1. The Clinical Director, Clinical Managers, and Safety Officer of the surgery center met with the management company of the connecting building in which the fire alarm was sounded. The alarm was not recognized because it was a new alarm sound and accompanying overhead page. The surgery center employees have been educated regarding the change in the alarm system. The surgery center Safety Officer will ensure quarterly fire drills for all shifts to include all employees. 2. The meeting with the building management company will ensure communication of any such changes in the future to prevent confusion when an alarm sounds. The Clinical Manager</p>	08/07/2013

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	<p>employee indicated she did not know what the signal meant.</p> <p>2. On 7-30-13 at 1:05 pm, employee #A2 indicated the signal was a fire alarm and all facility employees, patients and visitors in the building had been ordered by the local fire department to evacuate the building.</p> <p>3. Review of Policy Number FP 8.00, Section V., entitled FIRE ALARMS AND PRACTICE FIRE ALARMS, reviewed June, 2011, indicated upon audible notification of a fire alarm activation in the building, staff away from the fire vicinity, including all areas outside the alarm activation zone shall take the following actions [first]: recognize an alarm has been activated in the building.</p> <p>4. Employee #A6 did not follow the policy since the employee did not recognize an alarm had been activated in the building.</p> <p>5. Review of Policy Number FP 8.00, Section V., entitled FIRE ALARMS AND PRACTICE FIRE ALARMS, reviewed June, 2011, Section V.I., indicated Code Red [fire] drills will occur at scheduled intervals established by AAAHC [Accreditation Association</p>		<p>will ensure all employees participate in fire drills quarterly.3. The surgery center Safety Officer is responsible to provide fire drills quarterly for all shifts.4. The meeting with the building management company took place on 8/7/2013. Education to staff was provided on 8/9/2013.</p>				

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S001210	<p>for Ambulatory Health Care].</p> <p>6. Review of section 16.3, AAAHC document entitled Emergency Plan and Fire Drills, indicated drills are conducted quarterly for each working shift.</p> <p>7. In interview, on 7-29-13 at 10:45 am, employee #A6 indicated the facility had 2 nursing shifts.</p> <p>8. Review of fire drills for calendar year 2012, indicated there were no fire drills for quarters 1, 2 and 4 for the second shift.</p> <p>9. In interview, on 7-29-13 at 2:45 pm, employee #A4 confirmed the above relative to fire drills and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1)</p> <p>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:</p> <p>(1) Radiology services must be supervised by a radiologist or radiation oncologist.</p>				

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	<p>Based on document review and interview, the facility failed to document radiology services conducted in the facility were supervised by a radiologist or radiation oncologist in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of a facility document entitled Service Level Agreement, Radiology - Scope of Services, between Clarian Health Partners Radiology Department (CHPR) and Senate Street Surgery Center, dated August 24, 2007, indicated CHPR had the responsibility to provided the facility radiologist oversight of radiology activities.</li> <li>On 7-29-13 at 10:15 am, employee #A6 was requested to provide documentation of a written report of CHPR's oversight of the facility's radiology services for calendar year 2012. No documentation was provided.</li> <li>In interview, on 8-1-13 at 11:00 am, employee #A6 confirmed the above and no other documentation was provided prior to exit.</li> </ol>	S001210	<ol style="list-style-type: none"> <li>The uploaded documents were provided by IU Health (previously named Clarian Health Partners) on the date listed above. IU Health ensures oversight of the radiology equipment that is owned by IU Health and used in the surgery center. The radiation badge reports are another method in which the radiologist provides oversight for the center. <ol style="list-style-type: none"> <li>The reports will be located so, in future surveys, will allow timely access.</li> <li>The Clinical Director is responsible for compliance with tag S 1210.</li> <li>The reports were received from IU Health on 8/28/2013.</li> </ol> </li> </ol>	08/28/2013	