

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001015	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227
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(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
S 0000 Bldg. 00	This visit was for a State licensure survey. Facility Number: 005396 Survey Date: 8/11-13/2015 QA: cjl 09/10/15	S 0000		
S 0826 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E) 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: (E) Safety training required of personnel. Based on document review and interview, the facility failed to follow its policy and failed to provide documentation of safety training in areas where anesthetics are used for 3 (MD#3, AH#1 and AH#2) of 10 credential files reviewed. Findings:	S 0826	1- Will do an audit of all credentialed providers/allied health and require those who are deficient to complete the safety training 2- This training requirement will be added to the credentialing checklist and will be a mandatory requirement for approval 3- Responsible person: Director of Nursing	10/30/2015

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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	<p>1. Review of a facility policy entitled ORIENTATION POLICY, approved 1-13-2015, indicated the policy was to provide a consistent and organized method for the orientation of new staff.</p> <p>2. Review of a policy entitled General Orientation, approved 1-13-2015, indicated to review manuals and know location of Fire & Safety Manual, and [the staff would be] instructed on location and operations of Fire Extinguisher.</p> <p>3. Review of 10 credential files indicated files MD#3, an endoscopist, AH#1, a Physician Assistant, and AH#2, a Certified Surgical Tech, did not contain any documentation of the above-stated activities and no safety training in areas where anesthetics are used.</p> <p>4. In interview, on 8-13-2015 at 9:55 am, employee #A1, Clinical Director, confirmed all the above and no other documentation was provided prior to exit.</p>		4- Completion Date: October 31, 2015	