

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/30/2012
NAME OF PROVIDER OR SUPPLIER SURGICARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN 47403		
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility #: 009971</p> <p>Survey Dates: 10-29/30-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch RN, MSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>QA: claughlin 11/14/12</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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S0320	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the facility failed to include medication errors and the response to patient emergencies in the facility Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <p>1. Review of the facility QAPI documents on 10-30-12 lacked evidence that medication errors and the response to patient emergencies were included in the facility QAPI program.</p> <p>2. Interview with B#1 on 10-30-12 at 1315 hours confirmed medication errors and the response to patient emergencies are not included in the facility QAPI program.</p>	S0320	410 IAC 15-2.4 (a)(2) Medication errors and the response to patient emergencies have been added to the QAPI program. Monitored quarterly by administrator and QAPI committee. Responsible person: Administrator	11/01/2012			

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S0418	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(A)</p> <p>(2) The infection control committee responsibilities must include, but are not limited to the following:</p> <p>(A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the center.</p> <p>Based on document review and staff interview, the facility failed to ensure the infection control committee received infection surveillance information from all surgeons performing procedures at the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Surveillance logs completed by the surgeons for July 2012 did not include procedures performed by M.D. #1. Review of the procedure list for M.D. #1 for the month of July indicated that he/she performed forty three (43) procedures. Staff member #1 verified at 3:30 p.m. on 10/30/12 that M.D. #1 had not turned in the surveillance log for his/her procedures for the month of July. 	S0418	<p>410 IAC 15-2.5-1 (f)(2) (A)Infection Control (IC) will be completed in a timely manner by each provider.IC committee will monitor response monyhly.MDs reviewed policy on 11/1/2012Responsible person: Administrator</p>	11/01/2012			

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S0662	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(8)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(8) Medical history, chief complaint, and physical examination, including copies of laboratory, x-ray consultations, and other special reports or summary of those same findings by the admitting physician.</p> <p>Based on document review, observation, and interview, the facility failed to ensure a history and physical examination (H&P) was performed by the admitting physician for 27 of 30 medical records reviewed.</p> <p>Findings include:</p> <p>1. Facility bylaws approved on 9/25/12 states under 3.1B on page 6: "Application for and acceptance of membership shall constitute the Staff member's agreement to:.....(6) A History and Physical on each patient by the physician or where appropriate, another practitioner granted privileges by the medical staff in accordance with state law....." An addendum to 3.1B on page 6A states beside the section referencing preoperative assessments of a patient requiring no general anesthesia "Assessment can be performed by RN &</p>	S0662	<p>410 IAC 15-2.5-3 (f)(8) All medical records will contain medical history, chief complaint, and physical examination. Will be monitored by administrator at the end of each date of service. Responsible person: Administrator 2. Patients #N1, N3-N7, N9, N11, N13-18, N20-N21, N25, N29 and N30 had the H & P portion completed by Registered Nurse, provider indicated update was completed day of procedure by checking the appropriate area. New policy reflects change in procedure: physician will complete the updated H & P prior to the procedure. New policy to reflect this change has been formulated and will be approved at the Professional Staff meeting scheduled for February 22, 2013. Will be monitored by Administrator for three months in a Quality Assurance study for compliance. Responsible person:</p>	02/22/2013

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	<p>Co-signed by the M.D."</p> <p>2. Patients #N1, N3-N7, N9, N11, N13-N18, N20-N21, N25, N29, and N30 medical records had the history and physical portion completed by a Registered Nurse.</p> <p>3. Patients #N8, N10, N12, N19, N22-N24, and N26 medical records had the history and physical portion of the procedural record completed by a Radiology Tech.</p> <p>4. During observation of care provided to patient #N30, the following was observed: (A) Patient #N30 was brought back to the pre-operative bay by RN #1 at 12:35 p.m. on 10/30/12. (B) The history/physical portion of the procedural record was completed by RN #1. (C) The patient was taken to operating room #2 for his/her procedure at 1:20 p.m. The physician did not examine/assess the patient prior to the procedure. (D) The physician (M.D. #1) signed that the H&P was updated on the day of the procedure after the procedure was complete.</p> <p>5. Staff member #1 indicated in interview</p>		<p>Administrator 3. Provider will complete the H & P prior to the procedure. Will be monitored by Administrator Responsible person: Administrator 4. Patient #N30 (B-D), physician will complete the H & P prior to the procedure. Will be monitored by Administrator Responsible person: Administrator 5. Physician will complete the H & P prior to the procedure. a) Will be monitored by Administrator b) Responsible person: Administrator c) Will monitor x 3 months for compliance. 6. Physician will complete the H & P prior to the procedure. a) Will be monitored by Administrator b) Responsible person: Administrator c) Will monitor x 3 months for compliance.</p>				

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	<p>at 10:45 a.m. on 10/30/12 that the nurse completes the history and physical form and the physician signs as confirmation that it was completed in the section that indicates it was updated on the day of the procedure. He/she indicated in interview at 2:10 p.m. on 10/30/12 that a radiology tech (RT) nor a registered nurse (RN) is privileged to perform an H&P.</p> <p>6. Patient #N30 indicated in interview in the pre-operative area at 12:40 p.m. on 10/30/12 that he/she had not seen the surgeon performing his/her procedure since the previous week when he/she had a procedure performed at another facility.</p>				

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S1044	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(5)</p> <p>Pharmaceutical services must have the following:</p> <p>(5) A list of available emergency drugs.</p> <p>Based on document review, observation, and staff interview, the facility failed to ensure emergency drugs were available according to facility policy and list of crash cart contents.</p> <p>Findings include:</p> <p>1. Facility policy titled "EMERGENCY EQUIPMENT, SUPPLIES AND MEDICATIONS" last reviewed/revised 9/25/12 states under procedure: "A. An emergency cart containing the following items shall be available.....2. Emergency Medications....."</p> <p>2. Observation of the contents of the crash cart beginning at 1:45 p.m. on 10/30/12 indicated numerous medications including, but not limited to, Bretylium 50 mg, Epinephrine .1 mg, Procainamide 1 gm, NABicarb 1 mg, Calcium Chloride 10%, Heparin 1,000 units, Calcium Gluconate 10%, Furosemide 100 mg, and Adenocard 6 mg were not in the crash cart.</p>	S1044	<p>410 IAC 15-2.5-6 1. All emergency drugs have been obtained and placed on the crash cart. Will be monitored by monthly x 3 months by the Administrator Responsible person: Administrator 2. The following drugs have been replenished : Bretylium 50 mg Epinephrine 1 mg NABicarb 1 mg Calcium Chloride 10%, Heparin 1,000U Calcium Gluconate 10% Furosemide 100 mg Adenocard 6 mg Procainamide 1 GM (no longer available- deleted from crash cart contents) 3., 4., 5. see above. Will be monitored monthly by the Administrator Responsible person: Administrator</p>	11/06/2012

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	<p>3. The list of crash cart contents included the above medications.</p> <p>4. RN #1 verified in interview at 1:50 p.m. on 10/30/12 that the medications listed above were not in the crash cart.</p> <p>5. RN #2 indicated at 2:00 p.m. that medications had not been replaced when they expired in the crash cart.</p>				

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S1188	<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 document review and interview, the facility failed to follow the ASC's approved fire control plan for one of four quarters.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the facility's fire drills indicated the facility failed to conduct a fire drill during the 3rd quarter of 2012. Review of the facility's fire plan indicated the following on page 3: A test of the fire plan will be held at least once each quarter. Interview with B#1 on 10-30-12 at 1515 hours confirmed the facility fire plan requires one fire drill at least once every quarter and confirmed the facility failed to 	S1188	410 IAC 15-2.5-7 (c)(4) Policy was amended to read "fire drills will be done quarterly or 4 times/years due to schedule variations". Will be monitored quarterly/4 times/year by the QA Committee Responsible person: Administrator	11/08/2012			

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	conduct a fire drill during the 3rd quarter of 2012.			