STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 08/17/2016			ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG Q 0000	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
Bldg. 00	Survey Type: Tre-certification s	•	Q 00	000			
	, and the second	/15/2016 - 08/17/2016					
Q 0121 Bldg. 00	legally and profess positions to which the performance of ASC grants privile recommendations personnel. Based on docum interview, the government practition appropriate privile physician creden (MD#1, Anesthe Gynecologist, MMD#4, Urologis Management). Findings include	edical staff must be sionally qualified for the they are appointed and for f privileges granted. The ges in accordance with from qualified medical ent review and verning board failed to ers are granted leges for 5 of 7 tial files reviewed siologist, MD#2, D#3, Otolaryngologist, t, and MD#6, Pain	00	121	1. The statement "Ability to perform procedures not on this list" has been removed from Delineation of Privileges. 2. The statement "All other procedures I bring to the Surge Center" will not be accepted/approved under the OTHER category on Delineatic of Privileges. Only names of specific procedures will be accepted for consideration/approval. Responsible Person: Director Nursing	the ery on	10/17/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED	
		15C0001015	B. W	B. WING 08/17/2016			/2016	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹			COUNTY LINE RD STE 100			
COMMU	NITY SURGERY CI	ENTED SOLITH			APOLIS, IN 46227			
					AI OLIO, IIV 40221			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG	DEFICIENCY)		DATE	
		, anesthesiologist,						
	approved 07-07-	2015, MD#2,						
	Gynecologist, ap	pproved 07-07-2015,						
	MD#3, Otolaryn	gologist, approved						
	04-05-2016, MI	D#4, Urologist, approved						
	07-12-2016, and							
		proved 04-07-2016, each						
	contained a docu	•						
		N OF PRIVILEGES.						
	DELINEATION	NOT INVILEGES.						
	2 Prince Control (deceler or sected)							
	2. Review of each of the above-stated							
		ated "Ability to perform						
		on this list" It could						
		ed from that statement as						
	to which other p	rivileges the document						
	was referring.							
	3. In interview,	on 8-15-2016 at 4:00						
	pm, employee #	A1, Director of Nursing,						
	* * * *	oove and no other						
		lefining the phrase						
		his list" was provided						
	prior to exit.	ms nst was provided						
	prior to exit.							
	A Paviam of 7	physician aradential files						
		physician credential files						
		, Podiatrist, approved						
		ained a document entitled						
	DELINEATION OF PRIVILEGES.							
	5. Review of thi	is document indicated						
	OTHER: "All o	other procedures I bring						
	to the surgery ce	enter" It could not be						
		that statement as to						
		ileges the document was						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KZB911

Facility ID: 005396

If continuation sheet Page 2 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		15C0001015	B. W	B. WING 08/17/2016			2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1550 E	COUNTY LINE RD STE 100		
	NITY SURGERY CE				APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓΕ	COMPLETION DATE
TAG			+	TAG			DAIL
	•	erview, on 8-15-2016 at					
	4:00 pm, employee #A1, Director of Nursing, confirmed the entry indicated						
	_	-					
		umentation defining the					
	-	r procedures I bring to					
		er" was provided prior to					
	exit.					ļ	
						ļ	
Q 0141	416.46(a)						
	ORGANIZATION A						
Bldg. 00	Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in						
		ecognized standards of					
		ust be a registered nurse					
	available for emer	gency treatment whenever					
	there is a patient in	n the ASC.					
			0.0	141	An audit was performed on 10/6/2016 of Blood Administra		10/31/2016
	Based on docum				Competencies. Those RNs	uon	
		cility failed to ensure that			missing the learning/competer	ісу	
	* *	en (16) RN personnel			will be assigned the epak with a		
		blood administration			mandatory completion of 10/31/2016.		
	competencies or	education			2. Annual Blood Administratio	'n	
					epak will be assigned to all RN		
	Findings include	:			at the same time and monitore	:d	
					for completion by the OR and Patient Room's Nurse Manage	are	
	1. Facility Polic				Responsible Person: Director		
	•	ealth (sic) files, last			Nursing	-	
	reviewed 01/13/2						
	•	policy of the Community					
		o maintain on-site					
	personnel record	s for each employee,					
	which includes p	ersonal data, education					
	and experience a	nd evidence of					
	participation in e	educational activities.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KZB911

Facility ID: 005396

If continuation sheet Page 3 of 19

PRINTED: 11/07/2016 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15C0001015	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/17/2016			
	PROVIDER OR SUPPLIER NITY SURGERY CENTER SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	 Personnel files #N7, #N10, #N16 and #N20 lacked documentation of current blood administration competencies. On 8/16/2016 at 1500 hours, staff 					
	member #A2 indicated that he/she was unable to provide documentation of the missing blood administration competencies for the 4 RNs mentioned above.					
Q 0221 Bldg. 00	416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the					
	representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.					
	Based on document review and interview, the facility failed to verbally and in writing, give patents a statement of patient rights that indicated if the patient was incompetent, but not adjudged by a court, the patient's representative could	O 0221	Center's Patient Rights and Responsibilities now includes: a state court has not adjudged patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law management.	"If Ja		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KZB911

Facility ID: 005396

If continuation sheet

Page 4 of 19

PRINTED: 11/07/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015		A. BUILDING B. WING	00	COMPLETED 08/17/2016			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	exercise the patient's rights, in 1 instance. Findings include:			exercise the patient's rights to extent allowed by state law." Responsible Person: Director Nursing			
	PATIENT RIG RESPONSIBIL 01-07-2016, indipatient rights if t incompetent, and court, the patient exercise the patient 2. In interview, pm, employee #4 confirmed the ab	ITIES, approved cated it did not include he patient was I not adjudged by a 's representative could					
Q 0222 Bldg. 00	place or places winoticed by patients if applicable) waitin ASC's notice of rigname, address, ar representative in table patients can report the Web site for the Beneficiary Omburbased on docum interview, the fact patient statement	otice of patient rights in a thin the ASC likely to be so (or their representatives, and for treatment. The solution include the and telephone number of a the State agency to whom to complaints, as well as the Office of the Medicare dsman.	O 0222	Updated Patient Rights and Responsibilities that includes statement in POC Q221 has posted in Center's lobby 10/10/2016.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KZB911

Facility ID: 005396

If continuation sheet

Page 5 of 19

PRINTED: 11/07/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/17/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
		ourt, the appropriate buld exercise the patient's nee.			Responsible Person: Director Nursing	of	
	Findings include:						
	facility's reception PATIENT RIG RESPONSIBIL 01-07-2016, indipatient rights if to incompetent, and court, the appropriously exercise the second exercise that the second exercise the second exercise that the second exercise the second exercise that the second exercise that the second exercise	HTS & ITIES, approved cated it did not include he patient was I not adjudged by a briate representative					
Q 0230 Bldg. 00	(2) If a patient is a under applicable S laws by a court of rights of the patier person appointed the patient's behalf (3) If a State court patient incompete representative or sthe patient in account the patient the patient in account the patient the patient in account the patient in account the patient the patient the patient in account the patient the pat	GHTS BY OTHERS djudged incompetent State health and safety proper jurisdiction, the at are exercised by the under State law to act on f. has not adjudged a ant, any legal surrogate designated by urdance with State law may					
	(3) If a State court patient incompete representative or the patient in accordance.	has not adjudged a nt, any legal surrogate designated by ordance with State law may nt's rights to the extent					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KZB911

Facility ID: 005396

If continuation sheet

Page 6 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15C0001015		(X2) MULTIPLE (A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 08/17/2016	
	PROVIDER OR SUPPLIER		1550	FADDRESS, CITY, STATE, ZIP CODE E COUNTY LINE RD STE 100 NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
Q 0241	policy of patient incompetent, and court, the patient exercise the patient. Findings: 1. Review of a final patient rights if the incompetent, and court, the patient exercise the patient. 2. In interview, pm, employee #4 confirmed the above the patient.	rights if the patient was d not adjudged by a t's representative could ent's rights, in 1 instance. Facility policy entitled HTS & LITIES, approved icated it did not include the patient was d not adjudged by a t's representative could	Q 0230	Patient Rights and Responsibilities Policy has be updated to include "If a state court has not adjudged a pat incompetent, any legal representative or surrogate designated by the patient in accordance with state law me exercise the patient's rights te extent allowed by state law." Responsible Person: Directo Nursing	ay o the
Bldg. 00	SANITARY ENVIF The ASC must pro sanitary environm surgical services to	ovide a functional and ent for the provision of	O 0241	Cleaning of pantry drawers a cabinets has been assigned	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KZB911

Facility ID: 005396

If continuation sheet

Page 7 of 19

PRINTED: 11/07/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO UILDING	00	(X3) DATE COMPL		
		15C0001015	B. W	ING		08/17/	2016
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD STE 100		
сомми	NITY SURGERY C	ENTER SOUTH			APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	Based on docum	ent review, observation			Patient Rooms Clinical Techs.		
		e facility failed to			schedule for documentation had been created. This will be	as	
	•	onment that minimizes			monitored by the Patient Roor	ns	
	risk to patients, healthcare workers and visitors in one (1) instance.				Nurse Manager. Responsible Person: Patient Rooms Nurse Manager		
	Findings include	:			resine reales intallage		
	Facility Infection Control Policy:						
	Environmental Cleaning Services						
	Specifications, (no date) does not indicate						
	who is specifically responsible for cleaning pantry drawers.						
	g panay						
	2. On 8/15/2016						
		staff member #N5, while					
		cility PACU, it was noted rawers and cabinets had					
		nd other dust in them, in					
	-	the patient food is kept.					
l	3. On 8/15/2016	at 1500 hours, staff					
		licated that he/she agreed					
	_	and needed to be sure					
	_	n the drawers and					
	_	yee #N5 also indicated olicy for who is to clean					
	in the drawers ar						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KZB911

Facility ID: 005396

If continuation sheet

Page 8 of 19

PRINTED: 11/07/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/17/2016	
	ROVIDER OR SUPPLIER		•	1550 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD STE 100 APOLIS, IN 46227		
(X4) ID		FATEMENT OF DEFICIENCIES	1	ID	APOLIS, IN 40221		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
S 0000							
Bldg. 00	This visit was fo	r a state licensure survey.	S 00	000			
	Facility Number	: 005396					
	Survey Date: 08	/15/2016 - 08/17/2016					
	QA: 10/4/16 jlh						
S 0162 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BOI DUTIES 410 IAC 15-2.4-1	DY; POWERS AND (c)(5) (G)					
	Require that the confficer develop and and programs for	d implement policies					
	practice and center health care worker contract and agen provide direct pating Based on docum interview, the factor cardiopulmonary 1 of 7 medical st	R) competence in urrent standards of er policy for all rs including cy personnel, who ent care. ent review and cility failed to ensure resuscitation (CPR) for aff credential files	SO	162	The Center's policy "Life Supp Competence" has been chang to clarify competence by the virtue of their training includes Board eligible and Board certif Responsible Person: Director	ed ïed.	10/05/2016
	standards of prac	ordance with current etice and facility policy.			Nursing	OI	
	Findings include	:					
	1. Review of a f	acility policy approved					

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 9 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/17/2016	
	PROVIDER OR SUPPLIEF		1550 E	ADDRESS, CITY, STATE, ZIP CODE E COUNTY LINE RD STE 100 NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	SUPPORT CO. "It is the policy of Center [Facility [Cardiopulmona competence of the workers: M.D. [In Doctor of Oster of Podiatric Medical Doctor of Dental by virtue of their certification." 2. The above-straindicate how "by showed competed current standard. 3. Review of phasing indicated MD#7 had no document accordance with practice, did not of their training accordance with practice, and was only board-eligit. 4. In interview, pm, employee #4 confirmed all the confirmed	ry Resuscitation] ne following health care Medical Doctor], D.O. Opathy], D.P.M. [Doctor licine], and D.D.S. nl Surgery] is recognized retraining and/or board ated policy did not virtue of their training" ence in accordance with s of practice. ysician credential files , an orthopedic surgeon, tation of competence in current standards of indicate how "by virtue showed competence in current standards of s not board certified,			

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 10 of 19

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMPLETED 08/17/2016	
	ROVIDER OR SUPPLIER		1550 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD STE 100 NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
S 0172 Bldg. 00	DUTIES 410 IAC 15-2.4-1 Require that the confficer develop an and programs for (L) Maintaining pereach employee of include personal conceptions of experience, evide in job related educant records of employee of to post offer and sexaminations, impute the confidence of the post offer and sexaminations, impute the confidence of the post offer and sexaminations, impute the confidence of the post offer and sexaminations, impute the confidence of the post of th	hief executive d implement policies the following: resonnel records for the center which lata, education and nee of participation cational activities, aployees which relate subsequent physical nunizations, and chest x-rays, as sent review and cility failed to ensure that en (16) RN personnel blood administration education. Exercise the property of the Community of maintain on-site is for each employee, personal data, education	S 0172	Audit performed 10/16/16 of Blood Administration competencies. Those RNs missing the learning/competer will be assigned the epak with mandatory completion date of 10/31/16. Annual Blood Administration ewill be assigned to all RNs at same time and monitored for completion by the OR and Par Rooms Nurse Managers. Responsible Person: Director Nursing	epak the tient

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 11 of 19

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015		A. BUILDING B. WING	00	COMPLETED 08/17/2016			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
S 0400 Bldg. 00	#N20 lacked doc blood administra 3. On 8/16/2016 member #A2 ind unable to provide missing blood ad competencies for above. 410 IAC 15-2.5-1 INFECTION CON 410 IAC 15-2.5-1(a) The center sha and healthful envir minimizes infection to patients, health visitors. Based on docum and interview the provide an environ envi	TROL PROGRAM a) Il provide a safe ronment that a exposure and risk care workers, and ent review, observation a facility failed to comment that minimizes healthcare workers and instance.	S 0400	Cleaning of the pantry drawer and cabinets has been assign to Patient Rooms Clinical Tec A schedule for documentation has been created. This will b monitored by the Patient Roo Nurse Manager. Responsible Person: Patient Rooms Nurse Manager	ned chs. n		

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 12 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015 NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER SOUTH		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/17/2016				
		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Environmental C Specifications, (who is specifical cleaning pantry of 2. On 8/15/2016 accompanied by on tour of the far that the pantry d crumbs, coffee a the areas where 3. On 8/15/2016 member #N5 ind with the finding, nursing will clean cabinets. Employed	6 at 1500 hours, 2 staff member #N5, while 3 cility PACU, it was noted 3 trawers and cabinets had 4 and other dust in them, in 5 at 1500 hours, staff 6 dicated that he/she agreed 6, and needed to be sure 6 and needed to be sure					
S 0676 Bldg. 00	ADMIN. 410 IAC 15-2.5-3(
	(g) All original me legally reproduced must be maintained period of seven (7	d medical records ed by the center for a					

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 13 of 19

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015		l í	JILDING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 08/17/2016		
	PROVIDER OR SUPPLIER			1550 E	ADDRESS, CITY, STATE, ZIP CODE COUNTY LINE RD STE 100 IAPOLIS, IN 46227		
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure. Based on interview, for records that were less than 7 years old, the facility failed to have an approved waiver to store electronic medical records at an offsite server in 1 instance.		S 00	676	A state waiver for offsite serve storage of electronic medical records has been requested. Responsible Person: Executiv Director		10/06/2016
	am, employee #A indicated medicated years old were electronic offsite server. A #A1 was request documentation that approved waiver	on 08-17-2016 at 10:30 A1, Director of Nursing, al records less than 7 lectronically stored in an at that time, employee and to provide that the facility had an ar from the State to store of documentation was	arsing, 7 d in an yee an store				
S 0732 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF SURGICAL 410 IAC 15-2.5-4(These bylaws and rules must be						
			S 0	732	The medical staff bylaws and rules were reviewed at a Medi Staff Meeting on 10/4/16. The will be reviewed annually.		10/04/2016

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 14 of 19

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 00			(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU B. WII		00				
		15C0001015	B. WII	_		08/17/	2016		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE				
			1550 E COUNTY LINE RD STE 100						
СОММОГ	NITY SURGERY CE	ENTER SOUTH	INDIANAPOLIS, IN 46227						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION			
TAG		<u> </u>		TAG			DATE		
once within the past three (3) years.				Responsible Person: Executiv Director	е				
	TO: 1:				566.61				
	Findings include	:							
		e medical staff bylaws							
	and rules indicate								
		f them having been							
		medical staff within the							
	past three (3) year	ars.							
2. In interview, on 08-17-2016 at 11:55 am, employee #A1, Director of Nursing,									
	confirmed there	was no documentation of							
	the medical staff	having reviewed the							
	medical staff rule	es within the past three							
	(3) years and no	other documentation was							
	provided prior to exit.								
C 0746	410 100 15 25 4								
S 0746	410 IAC 15-2.5-4 MEDICAL STAFF	ANESTHESIA AND							
Bldg. 00	MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(E)								
3									
	T								
	These bylaws and rules must be as follows:								
	and rules must be	as follows.							
	(3) Include, at a m	ninimum, the following:							
	(-)								
	(E) A statement o								
	privileges for each medical staff.	category or the							
	Based on docum	ent review and	S 07	46	1. The statement "Ability to		10/17/2016		
	interview, the go	verning board failed to			perform procedures not on this	DATE DATE 10/17/2016 Sthe			
	ensure practition	-			list" has been removed from	the			
	appropriate privi	•			Delineation of Privileges. 2. The statement "all other				
		•			procedures I bring to the Surger				
physician credential files reviewed.				1.					

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 15 of 19

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001015		ľ í	ULTIPLE CO JILDING ING	COMPL) DATE SURVEY COMPLETED 08/17/2016		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227					
(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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Findings included 1. Review of 7 pindicated MD#1 approved 07-07-Gynecologist, apmD#3, Otolaryn 04-05-2106, MI 07-12-2016, and Management, apmontained a documents indicated more determined to which other particles was referring. 3. In interview, pm, employee #2 confirmed the abdocumentation of procedures on the procedures on the procedures on the procedures on the prior to exit. 4. Review of 7 indicated MD#5 10-7-2014, contained	chysician credential files Anesthesiologist, 2015, MD#2, proved 07-07-2015, gologist, approved D#4, Urologist, approved MD#6, Pain proved 04-07-2016, each ament entitled N OF PRIVILEGES. ch of the above-stated ated "Ability to perform on this list" It could ed from that statement as rivileges the document on 8-15-2016 at 4:00 A1, Director of Nursing, bove and no other lefining the phrase his list" was provided physician credential files physician credential files Podiatrist, approved ained a document entitled N OF PRIVILEGES.			Center" will not be accepted/approved under the OTHER category on Delineati of Privileges. Only names of specific procedures will be accepted for consideration/approval. Responsible Person: Director Nursing			
	5. Review of thi	is document indicated						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION	(X3) DATE COMPL				
AND PLAN	OF CORRECTION	15C0001015	B. W		00	08/17/			
		1000001010	2. ,,		DDDEGG CITY OT TO CORE	00/17/	2010		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100						
COMMUI	NITY SURGERY CE	ENTER SOUTH	INDIANAPOLIS, IN 46227						
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE		
TAU		other procedures I bring	+	TAG			DATE		
		nter" It could not be							
		that statement as to							
		ileges the document was							
	-	erview, on 8-15-2016 at							
	_	ree #A1, Director of							
		ned the entry indicated							
	and no other doc	umentation defining the							
	phrase "All other	procedures I bring to							
	the surgery cente	er" was provided prior to							
	exit.								
S 0756	410 IAC 15-2.5-4	ANIFOTHEOUA AND							
Bldg. 00	SURGICAL STAFF;	ANESTHESIA AND							
Diag. 00	410 IAC 15-2.5-4(b)(3)(J)							
	There had								
	These bylaws and rules must be	as follows:							
	and raise mast se	do followo.							
	(3) Include, at a m	ninimum, the following:							
	(J) A requirement								
	physician's service podiatrist's	es, , dentist's services, and							
	services are to be	reviewed and							
	analyzed at specif								
	regular meetings, limited to, the follo	•							
	minica to, the follo	wing.							
		ss of diagnoses and							
	treatments rendere	ed related to a							
			1				ı		

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 17 of 19

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001015		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/17/2016				ETED	
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					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	clinical performant by the results or contervention. (iii) Scope and free procedures. Based on documinaterview, the fasscope and frequency of performance physician creder of 3 allied health reviewed. Findings included 1. Review of 7 indicated MD#1 reviewed 7-7-20 reviewed 7-7-20 Otolaryngologis MD#4, urologis and MD#6, Paint 4-7-2015, each intentitled MEDIC REVIEW. 2. Review of 2 files indicated A Assistant, review AH#3, Certified 7-7-2015, each intentitled MEDIC REVIEW.	evaluation based on ce indicated in part butcome of surgical quency of the review and cility failed to include the ency of procedures as part evaluations for 5 of 7 thial files reviewed and 3 in credential files e: physician credential files physician credential files anesthesiologist, 15, MD#2, Gynecologist, 15, MD#3, t, reviewed 4-5-2016, t, reviewed 7-12-2014, Management, reviewed ancluded a document CAL STAFF PEER	S 07	756	Scope and frequency reports to be included for review in the reappointment process. This process was started for physicians that were up for reappointment at the Operatio Committee meeting held on 10/4/2016. Responsible Person: Executiv Director	n	10/04/2016	

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 18 of 19

PRINTED: 11/07/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
		15C0001015	B. Wl	NG		08/17/	2016
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	C		1550 E	COUNTY LINE RD STE 100		
COMMUI	NITY SURGERY CI	ENTER SOUTH		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Review For Rea	appointment.					
	3. Review of 1	allied health credential					
	file indicated AI	H#2, Nurse Practitioner,					
	approved 4-29-2	016, included a					
	document entitle	ed 2015 - Staff with					
	Core Essential	Function Performance					
	Appraisal for A						
	1-pp: w.s 101 11						
	4 Review of all	the above-stated					
		ated there was no data					
		e scope and frequency of					
	procedures.	e scope and frequency of					
	procedures.						
	5 In intervior	on 00 15 2016 at 4:00					
	· · · · · · · · · · · · · · · · · · ·	on 08-15-2016 at 4:00					
		A1 confirmed all the					
	above and no other documentation was						
	provided prior to exit.						
			1				

State Form Event ID: KZB911 Facility ID: 005396 If continuation sheet Page 19 of 19