STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY SURGERY CENTER SOUTH	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 0000 Bldg. 00	Survey Type: This visit was for a re-certification survey. Facility Number: 005396 Survey Date: 08/15/2016 - 08/17/2016 QA: 10/4/16 jlh	Q 0000		
Q 0121 Bldg. 00	416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel. Based on document review and interview, the governing board failed to ensure practitioners are granted appropriate privileges for 5 of 7 physician credential files reviewed (MD#1, Anesthesiologist, MD#2, Gynecologist, MD#3, Otolaryngologist, MD#4, Urologist, and MD#6, Pain Management). Findings include: 1. Review of physician credential files	Q 0121	1. The statement "Ability to perform procedures not on this list..." has been removed from the Delineation of Privileges. 2. The statement "All other procedures I bring to the Surgery Center..." will not be accepted/approved under the OTHER category on Delineation of Privileges. Only names of specific procedures will be accepted for consideration/approval. Responsible Person: Director of Nursing	10/17/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	indicated MD#1, anesthesiologist, approved 07-07-2015, MD#2, Gynecologist, approved 07-07-2015, MD#3, Otolaryngologist, approved 04-05-2016, MD#4, Urologist, approved 07-12-2016, and MD#6, Pain Management, approved 04-07-2016, each contained a document entitled **DELINEATION OF PRIVILEGES.** 2. Review of each of the above-stated documents indicated "Ability to perform procedures not on this list ... ." It could not be determined from that statement as to which other privileges the document was referring. 3. In interview, on 8-15-2016 at 4:00 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation defining the phrase "procedures on this list" was provided prior to exit. 4. Review of 7 physician credential files indicated MD#5, Podiatrist, approved 10-7-2014, contained a document entitled **DELINEATION OF PRIVILEGES.** 5. Review of this document indicated **OTHER**: "All other procedures I bring to the surgery center ... ." It could not be determined from that statement as to which other privileges the document was			

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	referring. In interview, on 8-15-2016 at 4:00 pm, employee #A1, Director of Nursing, confirmed the entry indicated and no other documentation defining the phrase "All other procedures I bring to the surgery center" was provided prior to exit.			
Q 0141 Bldg. 00	416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. Based on document review and interview, the facility failed to ensure that four (4) of sixteen (16) RN personnel files had current blood administration competencies or education Findings include: 1. Facility Policy: Employee Occupational Health (sic) files, last reviewed 01/13/2015, indicated: A. It is the policy of the Community Surgery Center to maintain on-site personnel records for each employee, which includes personal data, education and experience and evidence of participation in educational activities.	O 0141	1. An audit was performed on 10/6/2016 of Blood Administration Competencies. Those RNs missing the learning/competency will be assigned the epak with a mandatory completion of 10/31/2016. 2. Annual Blood Administration epak will be assigned to all RNs at the same time and monitored for completion by the OR and Patient Room's Nurse Managers. Responsible Person: Director of Nursing	10/31/2016

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	2. Personnel files #N7, #N10, #N16 and #N20 lacked documentation of current blood administration competencies. 3. 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	1. Center's Patient Rights and Responsibilities now includes: "If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may	10/10/2016

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	exercise the patient's rights, in 1 instance. Findings include: 1. Review of a facility document entitled **PATIENT RIGHTS & RESPONSIBILITIES**, approved 01-07-2016, indicated it did not include patient rights if the patient was incompetent, and not adjudged by a court, the patient's representative could exercise the patient's rights 2. In interview, on 08-16-2016 at 3:25 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.		exercise the patient's rights to the extent allowed by state law." Responsible Person: Director of Nursing	
Q 0222 Bldg. 00	416.50(a)(1)(i) NOTICE OF RIGHTS - POSTING (1)[...] In addition, the ASC must - (i) Post written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can 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 post a patient statement of rights that indicated if the patient was incompetent, but not	O 0222	Updated Patient Rights and Responsibilities that includes statement in POC Q221 has been posted in Center's lobby 10/10/2016.	10/10/2016

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	adjudged by a court, the appropriate representative could exercise the patient's rights, in 1 instance. Findings include: 1. Review of a document posted in the facility's reception area,entitled **PATIENT RIGHTS & RESPONSIBILITIES**, approved 01-07-2016, indicated it did not include patient rights if the patient was incompetent, and not adjudged by a court, the appropriate representative could exercise the patient's rights 2. In interview, on 08-16-2016 at 3:25 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.		Responsible Person: Director of Nursing	
Q 0230 Bldg. 00	416.50(e)(2)& (3) EXERCISE OF RIGHTS BY OTHERS (2) If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf. (3) If a State court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.			

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	Based on document review and interview, the facility failed to have a policy of patient rights if the patient was incompetent, and not adjudged by a court, the patient's representative could exercise the patient's rights, in 1 instance. Findings: 1. Review of a facility policy entitled **PATIENT RIGHTS & RESPONSIBILITIES**, approved 01-07-2016, indicated it did not include patient rights if the patient was incompetent, and not adjudged by a court, the patient's representative could exercise the patient's rights 2. In interview, on 08-16-2016 at 3:25 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit.	O 0230	Patient Rights and Responsibilities Policy has been updated to include "If a state court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law." Responsible Person: Director of Nursing	10/17/2016
Q 0241 Bldg. 00	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.			
		O 0241	Cleaning of pantry drawers and cabinets has been assigned to	10/17/2016

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	Based on document review, observation and interview the facility failed to provide an environment that minimizes risk to patients, healthcare workers and visitors in one (1) instance. Findings include: 1. Facility Infection Control Policy: Environmental Cleaning Services Specifications, (no date) does not indicate who is specifically responsible for cleaning pantry drawers. 2. On 8/15/2016 at 1500 hours, accompanied by staff member #N5, while on tour of the facility PACU, it was noted that the pantry drawers and cabinets had crumbs, coffee and other dust in them, in the areas where the patient food is kept. 3. On 8/15/2016 at 1500 hours, staff member #N5 indicated that he/she agreed with the finding, and needed to be sure nursing will clean the drawers and cabinets. Employee #N5 also indicated that there is no policy for who is to clean in the drawers and cabinets.		Patient Rooms Clinical Techs. A schedule for documentation has been created. This will be monitored by the Patient Rooms Nurse Manager. Responsible Person: Patient Rooms Nurse Manager	

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S 0000 Bldg. 00	This visit was for a state licensure survey. Facility Number: 005396 Survey Date: 08/15/2016 - 08/17/2016 QA: 10/4/16 jlh	S 0000		
S 0162 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G) Require that the chief executive officer develop and implement policies and programs for the following: (G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care. Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) for 1 of 7 medical staff credential files reviewed, in accordance with current standards of practice and facility policy. Findings include: 1. Review of a facility policy approved	S 0162	The Center's policy "Life Support Competence" has been changed to clarify competence by the virtue of their training includes Board eligible and Board certified. Responsible Person: Director of Nursing	10/05/2016

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	1-07-2016, entitled **SUBJECT: LIFE SUPPORT COMPETENCE** indicated "It is the policy of Community Surgery Center [Facility #1], that CPR [Cardiopulmonary Resuscitation] competence of the following health care workers: M.D. [Medical Doctor], D.O. [Doctor of Osteopathy], D.P.M. [Doctor of Podiatric Medicine], and D.D.S. [Doctor of Dental Surgery] is recognized by virtue of their training and/or board certification." 2. The above-stated policy did not indicate how "by virtue of their training" showed competence in accordance with current standards of practice. 3. Review of physician credential files indicated MD#7, an orthopedic surgeon, had no documentation of competence in accordance with current standards of practice, did not indicate how "by virtue of their training" showed competence in accordance with current standards of practice, and was not board certified, only board-eligible. 4. In interview, on 8-15-2016 at 4:00 pm, employee #A1, Director of Nursing confirmed all the above and no other documentation was provided prior to exit.			

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S 0172 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L) Require that the chief executive officer develop and implement policies and programs for the following: (L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable. Based on document review and interview, the facility failed to ensure that four (4) of sixteen (16) RN personnel files had current blood administration competencies or education. Findings include: 1. Facility Policy: Employee Occupational Health (sic) files, last reviewed 01/13/2015, indicated: A. It is the policy of the Community Surgery Center to maintain on-site personnel records for each employee, which includes personal data, education and experience and evidence of participation in educational activities.	S 0172	Audit performed 10/16/16 of Blood Administration competencies. Those RNs missing the learning/competency will be assigned the epak with a mandatory completion date of 10/31/16. Annual Blood Administration epak will be assigned to all RNs at the same time and monitored for completion by the OR and Patient Rooms Nurse Managers. Responsible Person: Director of Nursing	10/31/2016

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	2. Personnel files #N7, #N10, #N16 and #N20 lacked documentation of current blood administration competencies. 3. 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.			
S 0400 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on document review, observation and interview the facility failed to provide an environment that minimizes risk to patients, healthcare workers and visitors in one (1) instance. Findings include:	S 0400	Cleaning of the pantry drawers and cabinets has been assigned to Patient Rooms Clinical Techs. A schedule for documentation has been created. This will be monitored by the Patient Rooms Nurse Manager. Responsible Person: Patient Rooms Nurse Manager	10/17/2016

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	1. Facility Infection Control Policy: Environmental Cleaning Services Specifications, (no date) does not indicate who is specifically responsible for cleaning pantry drawers. 2. On 8/15/2016 at 1500 hours, accompanied by staff member #N5, while on tour of the facility PACU, it was noted that the pantry drawers and cabinets had crumbs, coffee and other dust in them, in the areas where the patient food is kept. 3. On 8/15/2016 at 1500 hours, staff member #N5 indicated that he/she agreed with the finding, and needed to be sure nursing will clean the drawers and cabinets. Employee #N5 also indicated that there is no policy for who is to clean in the drawers and cabinets.			
S 0676 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g) (g) All original medical records or legally reproduced medical records must be maintained by the center for a period of seven (7) years in			

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	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. Findings include: 1. In interview, on 08-17-2016 at 10:30 am, employee #A1, Director of Nursing, indicated medical records less than 7 years old were electronically stored in an offsite server. At that time, employee #A1 was requested to provide documentation that the facility had an approved waiver from the State to store them offsite. No documentation was provided prior to exit.	S 0676	A state waiver for offsite server storage of electronic medical records has been requested. Responsible Person: Executive Director	10/06/2016
S 0732 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2) These bylaws and rules must be as follows: (2) Be reviewed at least triennially. Based on document review and interview, the medical staff did not review the medical staff rules at least	S 0732	The medical staff bylaws and rules were reviewed at a Medical Staff Meeting on 10/4/16. These will be reviewed annually.	10/04/2016

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	once within the past three (3) years. Findings include: 1. Review of the medical staff bylaws and rules indicated there was no documentation of them having been reviewed by the medical staff within the past three (3) years. 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 rules within the past three (3) years and no other documentation was provided prior to exit.		Responsible Person: Executive Director	
S 0746 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(E) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (E) A statement of duties and privileges for each category of the medical staff. Based on document review and interview, the governing board failed to ensure practitioners are granted appropriate privileges for 6 of 7 physician credential files reviewed.	S 0746	1. The statement "Ability to perform procedures not on this list..." has been removed from the Delineation of Privileges. 2. The statement "all other procedures I bring to the Surgery	10/17/2016

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	15C0001015	A. BUILDING 00 B. WING	08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY SURGERY CENTER SOUTH	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. Review of 7 physician credential files indicated MD#1, Anesthesiologist, approved 07-07-2015, MD#2, Gynecologist, approved 07-07-2015, MD#3, Otolaryngologist, approved 04-05-2106, MD#4, Urologist, approved 07-12-2016, and MD#6, Pain Management, approved 04-07-2016, each contained a document entitled **DELINEATION OF PRIVILEGES.** 2. Review of each of the above-stated documents indicated "Ability to perform procedures not on this list ... ." It could not be determined from that statement as to which other privileges the document was referring. 3. In interview, on 8-15-2016 at 4:00 pm, employee #A1, Director of Nursing, confirmed the above and no other documentation defining the phrase "procedures on this list" was provided prior to exit. 4. Review of 7 physician credential files indicated MD#5, Podiatrist, approved 10-7-2014, contained a document entitled **DELINEATION OF PRIVILEGES.** 5. Review of this document indicated		Center..." will not be accepted/approved under the OTHER category on Delineation of Privileges. Only names of specific procedures will be accepted for consideration/approval. Responsible Person: Director of Nursing	

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	OTHER: "All other procedures I bring to the surgery center ... ." It could not be determined from that statement as to which other privileges the document was referring. In interview, on 8-15-2016 at 4:00 pm, employee #A1, Director of Nursing, confirmed the entry indicated and no other documentation defining the phrase "All other procedures I bring to the surgery center" was provided prior to exit.			
S 0756 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(J) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (J) A requirement that each physician's services, , dentist's services, and podiatrist's services are to be reviewed and analyzed at specified intervals at regular meetings, including, but not limited to, the following: (i) Appropriateness of diagnoses and treatments rendered related to a			

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	15C0001015	A. BUILDING 00 B. WING	08/17/2016

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	standard of care and anticipated or expected results. (ii) Performance evaluation based on clinical performance indicated in part by the results or outcome of surgical intervention. (iii) Scope and frequency of procedures. Based on document review and interview, the facility failed to include the scope and frequency of procedures as part of performance evaluations for 5 of 7 physician credential files reviewed and 3 of 3 allied health credential files reviewed. Findings include: 1. Review of 7 physician credential files indicated MD#1, anesthesiologist, reviewed 7-7-2015, MD#2, Gynecologist, reviewed 7-7-2015, MD#3, Otolaryngologist, reviewed 4-5-2016, MD#4, urologist, reviewed 7-12-2014, and MD#6, Pain Management, reviewed 4-7-2015,each included a document entitled **MEDICAL STAFF PEER REVIEW.** 2. Review of 2 allied health credential files indicated AH#1, Physician Assistant, reviewed 7-12-2016, and AH#3, Certified Surgical Tech, reviewed 7-7-2015, each included a document entitled ***Allied Health*** **Practitioner**	S 0756	Scope and frequency reports will be included for review in the reappointment process. This process was started for physicians that were up for reappointment at the Operation Committee meeting held on 10/4/2016. Responsible Person: Executive Director	10/04/2016

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	Review For Reappointment. 3. Review of 1 allied health credential file indicated AH#2, Nurse Practitioner, approved 4-29-2016, included a document entitled **2015 - Staff with Core Essential Function Performance Appraisal for AH#2.** 4. Review of all the above-stated documents indicated there was no data included as to the scope and frequency of procedures. 5. In interview, on 08-15-2016 at 4:00 pm, employee #A1 confirmed all the above and no other documentation was provided prior to exit.			