

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2013
NAME OF PROVIDER OR SUPPLIER NAAB ROAD SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260		
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 010525</p> <p>Survey Date: 3/26/2013 through 3/27/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 04/05/13</p>	S000000			

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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S000418	<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 interview and meeting minutes review, the infection control committee failed to document systems for identifying infections related to procedures performed at the center.</p> <p>Findings included:</p> <p>1. At 2:45 PM on 03/27/13, the Infection Control Nurse, staff member #A1, indicated the facility relied on the physicians performing the surgical procedures notifying them of any infections in their patients. He/she indicated faxes were sent to the physicians quarterly to request this information, but could not provide any documentation of this process. He/she indicated they were unsure of whether or not all of the infections were being reported and were considering implementing some other method.</p> <p>2. Review of the Infection Control</p>	S000418	<p>1.The center will develop a tracking tool for monthly reports from physicians of any post-op infections. The report will show how many cases each physician performed that month and will track the number of infections. If there were any infections an explanation of follow up will be included. Physician will then sign the report. 2. This report will be reviewed at the Infection Control Meetings to ensure we are tracking all possible infections. 3. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves.</p>	05/15/2013	

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	<p>Meeting Minutes from November 16, 2012 indicated, "[Physician] will send out quarterly reminders to the Medical Staff regarding the reporting of post-op infections to the Clinical Director or the Medical Director. There continues to be concern that we may not be getting reports from the Physician offices when a post-op infection occurs. [Physician] is continuing to collect information from the Physicians about a contact person in their office that we might contact directly on a monthly basis in regards to infection rates."</p> <p>Upon further review of the Infection Control Meeting Minutes for the Center, this same paragraph was included in the minutes for each meeting from June 19, 2007 through the above mentioned meeting. No further documentation was provided regarding addressing this concern prior to exit.</p>			

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S000432	<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, policy and procedure review, manufacturer's directions, and interview, the infection control committee failed to ensure the patient care areas were cleaned according to policy to prevent cross-contamination between patients and failed to ensure the appropriate rinsing procedures for high level disinfection were followed in the instrument room.</p> <p>Findings included:</p> <p>1. While touring the pre/post area at 1:55 PM on 03/26/13 with staff member #A1, turnover cleaning of a bay was observed. Staff member #A11 used a Cavicide XL wipe to disinfect the patient cart and one siderail, but did not wipe the siderail that was up against the wall. When questioned, staff member #A11 indicated</p>	S000432	<p>1. Staff training to be reinforced regarding the proper use of Cavicide wipes for cleaning patient carts and equipment. We will also review the policy regarding what equipment is wiped down between cases. We will review the use of Metricide and the instructions for the rinsing of the agent. We will make sure that staff is properly trained on these instructions and staff will be periodically monitored and spot inspections will be performed. The policy on cold sterilization will be reviewed and updated as needed. We will also monitor and spot check to ensure these specifications are followed. 2. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves and is monitored.</p>	04/23/2013			

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	<p>he/she waited one minute for the surface to dry before applying clean linens.</p> <p>2. At the completion of the case observation in operating room 4 at 3:35 PM on 03/26/13, the cleaning procedure for room turnover was observed. Staff members used Cavicide XL wipes for surface disinfection, but failed to wipe the anesthesia cart that had been touched by the anesthesiologist wearing gloves. Staff also failed to ensure all surfaces remained wet for 3 minutes (per manufacturer's directions) before setting up for the next case.</p> <p>3. The facility policy "Routine Cleaning of Operating Rooms", last approved October 25, 2012, indicated, "6. Damp clean the back table, the mayo stand, OR table, and any other equipment which could have become soiled during the case, if deemed necessary."</p> <p>4. The facility policy "Infection Control Procedures- PAR Area", last approved October 25, 2012, indicated, "1. Patient carts are washed with germicidal solution after each patient."</p> <p>5. The manufacturer's label on the Cavicide XL wipes indicated surfaces wiped with the disinfectant needed to remain visibly wet for 3 minutes for</p>						

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	<p>appropriate effectiveness against the various organisms.:</p> <p>6. During the tour of the facility at 3:50 PM on 03/26/13, accompanied by staff member #A1, two covered containers of Metricide 14-day were observed in the instrument room. Staff member #A12, the charge nurse of the area, indicated some instruments, especially urology scopes, were soaked in the solution for 12 minutes, removed and put in a basin of sterile water, then carried to the procedure room and put into another basin of water before use.</p> <p>7. The facility policy "Cold Sterilization", last approved October 25, 2012, indicated, "Procedures- Solution: Cidex or comparable agent. 1. Pans for this procedure are autoclaved prior to filling with Cidex or equivalent product. 2. A rinse pan is necessary due to the caustic nature of Cidex or equivalent. Rinse pan must be autoclaved and filled with sterile water prior to each use. 3. Immerse instruments in Cidex solution according to manufacturers recommended length of time. 4. Rinse instruments thoroughly in sterile water."</p> <p>8. The manufacturer's directions for Metricide indicated, "c) Rinsing Instructions: Following immersion in</p>			

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	<p>Metricide solution, thoroughly rinse the equipment or medical device by immersing it completely in three separate copious volumes of water. Each rinse should be a minimum of one minute in duration unless otherwise noted by the device or equipment manufacturer. Use fresh portions of water for each rinse. Discard the water following each rinse. Do not reuse the water for rinsing or any other purpose, as it will be contaminated with glutaraldehyde. ...Sterile Water Rinse: The following devices should be rinsed with sterile water, using sterile technique when rinsing and handling. ...3. When practicable, bronchoscopes, due to a risk of atypical Mycobacteria contamination from potable water supply. Potable Water Rinse: For all other devices a sterile water rinse is recommended when practicable, otherwise a high-quality potable tap water rinse is acceptable. ...When using potable water for rinsing, the user should be aware of the increased risk of recontaminating the device or medical equipment with Pseudomonas and atypical Mycobacteria often present in potable water supplies."</p> <p>9. At 9:30 AM on 03/27/13, staff member #A1 confirmed there were no other facility policies regarding the use of the Metricide and confirmed the</p>			
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	manufacturer's directions were not being followed for the Metricide and for the Cavicide XL wipes.			

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S000442	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on policy review, employee medical file review, and interview, the facility failed to ensure all of their employees had documentation of immunization status in 13 of 14 employee medical files reviewed (A13 A14, A15, A16, A17, A18, A19, A20, A21, A22, A24, A25, and A26).</p> <p>Findings included:</p> <p>1. The facility policy "Employment Application and Record", last approved October 25, 2012, indicated, "C. Personnel Health Record: ...3. The personnel health record shall contain: a. Results of employee physical examinations. b. Results of diagnostic</p>	S000442	<p>1. The center will have all staff members provide proof of vaccination and/or disease for Rubella, Rubeola, Hepatitis and Varicella. If they are unable to produce evidence then a titer will be drawn for proof of immunity.</p> <p>2. Proof of vaccination or titer will be added to the new employee orientation checklist. 2. It will be the responsibility of the Executive Director to ensure this is completed.</p>	05/17/2013			

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	<p>tests. c. Declination of Hepatitis Vaccination or Communicable Disease Tests."</p> <p>2. The medical file for staff member A13, with a hire date of 06/05/12, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization. The file indicated self reporting history of having the Varicella disease.</p> <p>3. The medical file for staff member A14, with a hire date of 07/10/07, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization. The file indicated self reporting history of having the Varicella disease. The file lacked any documentation of Hepatitis status or a declination form.</p> <p>4. The medical file for staff member A15, with a hire date of 04/18/11, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization. The file indicated self reporting history of having the Varicella disease.</p> <p>5. The medical file for staff member A16, with a hire date of 06/26/12, failed to indicate any documentation of the Rubella, Rubeola, or Varicella status</p>						

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	<p>other than the self-reported history of immunization.</p> <p>6. The medical file for staff member A17, with a hire date of 05/22/00, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization for Rubella and immunization and history of the disease for Rubeola. The file indicated self reporting history of having the Varicella disease.</p> <p>7. The medical file for staff member A18, with a hire date of 09/18/06, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization. The file indicated self reporting history of having the Varicella disease.</p> <p>8. The medical file for staff member A19, with a hire date of 03/16/98, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization to both and self reported history of the disease for both Rubella and Varicella.</p> <p>9. The medical file for staff member A20, with a hire date of 04/18/06, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization.</p>			

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	<p>The file indicated self reporting history of having the Varicella disease.</p> <p>10. The medical file for staff member A21, with a hire date of 08/23/04, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization. The file indicated self reporting history of having the Varicella disease. The file lacked any documentation of Hepatitis status or a declination form.</p> <p>11. The medical file for staff member A22, with a hire date of 08/29/12, failed to indicate any documentation of the Rubella, Rubeola, or Varicella status other than the self-reported history of immunization to Rubeola and self reported history of having the Rubella and Varicella diseases. The file lacked any documentation of Hepatitis status or a declination form.</p> <p>12. The medical file for staff member A24, with a hire date of 11/04/03, failed to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization. The file indicated self reporting history of having the Varicella disease.</p> <p>13. The medical file for staff member A25, with a hire date of 09/08/98, failed</p>				

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	<p>to indicate any documentation of the Rubella or Rubeola status other than the self-reported history of immunization. The file indicated self reporting history of having the Varicella disease.</p> <p>14. The medical file for staff member A26, with a hire date of 10/24/06, failed to indicate any documentation of the Rubella, Rubeola, or Varicella status other than the self-reported history of having had all three diseases. The file lacked any documentation of Hepatitis status or a declination form.</p> <p>15. At 2:20 PM on 03/27/13, staff member #A1 confirmed the medical file findings and indicated he/she thought the self reporting was acceptable and they had never required verification of immunization. He/she did not provide any Hepatitis documentation for staff members #A14, A21, A22, or A26 prior to exit..</p>			

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S000672	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(13) A copy of the transfer form, if the patient is referred to a hospital or other facility.</p> <p>Based on policy review, medical record review, and interview, the facility failed to follow their documentation policy for 2 of 3 patients who were transferred from the facility (#N4 and N5).</p> <p>Findings included:</p> <p>1. The facility policy "Patient Transfer to Another Healthcare Facility", last approved October 25, 2012, indicated, "5. Initiate a 'Patient Transfer Form' by filling out the 'Patient Information' portion of the form. 6. The attending physician will complete the 'Physician's Orders' and 'Major Diagnosis' portions of the form."</p> <p>2. The medical record for patient #N4, who had a procedure on 09/28/12 and was transferred to the hospital, indicated a "Patient Transfer Form" with a physician's signature, but with no documentation in the "Physician's Orders and Diagnosis" portion.</p>	S000672	<p>1. The center's Clinical Director will work with the staff to ensure that the center's policy for transfers is followed completely and all forms completed. 2. We will add this check to our Medical Records review on a quarterly basis. 3. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this area improves.</p>	04/23/2013	

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	<p>3. The medical record for patient #N5, who had a procedure on 11/16/12 and was transferred to the hospital, indicated a "Patient Transfer Form" with a physician's signature, but with no documentation in the "Physician's Orders and Diagnosis" portion.</p> <p>4. At 12:15 PM on 03/27/13, staff member #A1 confirmed the medical record findings.</p>			

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S000888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval. Based on medical staff rules and regulations review, policy and procedure review, medical record review, and interview, the facility failed to ensure the operative report/discharge summary was written/dictated immediately following surgery in 8 of 25 medical records reviewed (#N1, N3, N4, N6, N7, N13, N15, and N21) and failed to ensure the dictated reports were authenticated within 30 days in 25 of 25 medical records reviewed (#N1- N25).</p> <p>Findings included:</p>	S000888	<p>1. The center will review it's policy on authentication of Medical Records to ensure that Dictation of Operative Notes are completed immediately after sugery and that it meets the ISDOH requirments. The center will add the authentincation to it's Medical Record Audit to ensure the policy is follwed. 2. Once policy is reviewed it will be taken to the next Board of Managers Meeting in May 2013. 3. The center's Executive Director will be responsible for this action.</p>	05/15/2013			

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	<p>1. The medical staff rules and regulations, last approved October 25, 2012, indicated, "Section II. Medical Record Requirements: D. The patient's medical record must also contain an operative summary with a complete description of the operative procedure, any complications, indications for surgery and discharge summary by the surgeon and with the surgeon's signature." The document did not discuss or define any time frame for the report.</p> <p>2. The facility policy "Medical Record Delinquencies", last approved October 25, 2012, indicated, "Medical records shall be completed within thirty days after surgery."</p> <p>3. The facility policy "Medical Records-General", last approved October 25, 2012, indicated, "Authentication: The center has a method for identification of the author of each entry. An entry in the medical record is defined as legible documentation by a physician and other licensed health care professionals, who record the patient's history, assessments, progress, prescribed care, and treatment. These entries are authenticated and dated by the author. ...II. Authentication of Signatures: ...b. Every entry, including transcribed reports, is dated and authenticated by the author."</p>			

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	<p>4. The medical record for patient #N1, who had a procedure performed on 08/22/12, indicated an Operative Report/Discharge Summary, dictated 08/23/12, that lacked a date for the physician's signature.</p> <p>5. The medical record for patient #N2, who had a procedure performed on 11/28/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>6. The medical record for patient #N3, who had a procedure performed on 01/16/13, indicated an Operative Report/Discharge Summary, dictated 01/17/13, that lacked a date for the physician's signature.</p> <p>7. The medical record for patient #N4, who had a procedure performed on 09/28/12, indicated an Operative Report/Discharge Summary, dictated 10/15/12, that lacked a date for the physician's signature.</p> <p>8. The medical record for patient #N5, who had a procedure performed on 11/16/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p>			

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	<p>9. The medical record for patient #N6, who had a procedure performed on 12/04/12, indicated an Operative Report/Discharge Summary, dictated 01/23/13, that lacked a date for the physician's signature.</p> <p>10. The medical record for patient #N7, who had a procedure performed on 01/23/13, indicated an Operative Report/Discharge Summary, dictated 01/25/13, that lacked a date for the physician's signature.</p> <p>11. The medical record for patient #N8, who had a procedure performed on 01/22/13, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>12. The medical record for patient #N9, who had a procedure performed on 08/14/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>13. The medical record for patient #N10, who had a procedure performed on 09/07/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>14. The medical record for patient #N11, who had a procedure performed on</p>				

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	<p>10/16/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>15. The medical record for patient #N12, who had a procedure performed on 08/02/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>16. The medical record for patient #N13, who had a procedure performed on 08/08/12, indicated an Operative Report/Discharge Summary, dictated 08/09/12, that lacked a date for the physician's signature.</p> <p>17. The medical record for patient #N14, who had a procedure performed on 09/07/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>18. The medical record for patient #N15, who had a procedure performed on 09/13/12, indicated an Operative Report/Discharge Summary, dictated 09/14/12, that lacked a date for the physician's signature.</p> <p>19. The medical record for patient #N16, who had a procedure performed on 10/05/12, indicated an Operative Report/Discharge Summary that lacked a</p>						

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	<p>date for the physician's signature.</p> <p>20. The medical record for patient #N17, who had a procedure performed on 10/18/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>21. The medical record for patient #N18, who had a procedure performed on 11/06/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>22. The medical record for patient #N19, who had a procedure performed on 11/20/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>23. The medical record for patient #N20, who had a procedure performed on 12/03/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>24.. The medical record for patient #N21, who had a procedure performed on 12/21/12, indicated an Operative Report/Discharge Summary, dictated 12/22/12, that lacked a date for the physician's signature.</p> <p>25. The medical record for patient #N22,</p>				

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	<p>who had a procedure performed on 12/14/12, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>26. The medical record for patient #N23, who had a procedure performed on 01/24/13, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>27. The medical record for patient #N24, who had a procedure performed on 01/29/13, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>28. The medical record for patient #N25, who had a procedure performed on 01/21/13, indicated an Operative Report/Discharge Summary that lacked a date for the physician's signature.</p> <p>29. At 2:20 PM on 03/27/13, the medical record findings were confirmed with staff member #A1 who also confirmed the facility policy did not define a time frame for the operative report to be dictated to adhere to the "written or dictated immediately following surgery" verbiage in the state regulation. He/she indicated the Center had never required the physicians to date their authentications on the operative reports although he/she</p>						

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	<p>agreed it could not be determined if they were signed within 30 days if they were not dated.</p> <p>30. At the exit conference at 3:45 PM on 03/27/13, staff member #A2 disagreed that the reports needed a date with the physicians' authentications because the reports already had a date on them. However, the dates on the reports were dates of surgery and dates of dictation, not dates of authentication.</p>			

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S001008	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: Based on documentation review and staff interview, the facility failed to ensure monthly pharmaceutical inspections were conducted by the the Pharmacy Consultant as defined in the Agreement for Services and per policy.</p> <p>Findings included:</p> <p>1. The Agreement for Services between the ASC and the Pharmacy Consultant signed March 3rd, 1998 states, "Consulting Pharmacist shall perform the following services for the Center: Monthly inspection of pharmaceutical supplies and documentation as indicated on the checklist."</p> <p>2. Naab Road Surgery Center, LLC Pharmacy Services policy #8.01 (last approved 10/25/2012) states, "The Pharmacist shall make a monthly inspection of the Drug Storage Cabinet and Emergency Drug Containers using the</p>	S001008	<p>1. The center will work with contracted pharmacy service to ensure that the number of visits made by contracted pharmacy service matches the executed contract. 2. The center will audit its pharmacy reports to make sure the contract is followed. 3. It will be the responsibility of the Executive Director and the Clinical Director to ensure that this done.</p>	04/30/2013	

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	<p>Inspection Check List (See attached Exhibit III)."</p> <p>3. Staff member #1 provided the previous Exhibit III Pharmacy Inspection Checklists. The previous inspections by the Consulting Pharmacist were dated: 2/1/13, 11/30/12, and 10/11/12. The documentation that was provided did not evidence the inspections were conducted monthly. December 2012 and January 2013 monthly inspections were not provided.</p> <p>4. At 1:00 PM on 3/27/2013, staff member #1 indicated the Pharmacy Consultant conducts quarterly pharmacy audits for the facility. The staff member confirmed the policy and the agreement with the Consultant requires the audits to be conducted monthly.</p>				

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S001010	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, policy review, and interview, the facility failed to follow their policies regarding multi-dose vials in 3 of 3 anesthesia carts inspected.</p> <p>Findings included:</p> <p>1. During the tour of the surgical area at 3:00 PM on 03/26/13 with staff member #A1, the following observations were made:</p> <p>A. Twenty milliliter (ml) vial of Labetalol, open and dated 01/30/13, and a ten ml. vial of Esmolol Hydrochloride, open and dated 01/09/13, in the anesthesia cart in OR #6.</p> <p>B. One single-dose vial of Naloxone HCl, open and partially full, 2 five ml. vials of Dexamethasone, open and not dated, and one ten ml. vial of Esmolol, open and not dated, in the anesthesia cart in OR#2.</p>	S001010	<p>1. The Center will review the policy on multi-dose vials and the proper labeling and disposal of those vials with all staff members. 2. We will add a check of all anesthesia carts for outdated meds to our daily chores for the OR staff. 3. It will be the responsibility of the Clinical Director to ensure this process improves.</p>	04/23/2013			

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	<p>C. One twenty ml. vial of Labetalol, open and dated 01/22/13, in the anesthesia cart in OR #4.</p> <p>2. The facility policy "Pharmacy Services", last approved October 25, 2012, indicated, "Labeling: All drugs stored in the Center shall be properly labeled including drug name, class, strength, lot number and expiration date. When multi-dose vials are initially used they shall be dated with the current date. Multi-dose vials will be disposed of after 28 days of their first use."</p> <p>3. At 4:00 PM on 03/26/13, staff member #A1 confirmed the outdated medications and the open, but not dated medications. He/she indicated nursing staff should check all areas for outdates monthly.</p>			

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S001146	<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 review of nationally recognized guidelines, the facility failed to ensure patient safety by monitoring the fluid and blanket warmers and following manufacturer guidelines for warming fluids.</p> <p>Findings included:</p> <p>1. During the tour of the pre/post area at 1:50 PM on 03/26/13 with staff member #A1, a warming cabinet containing blankets was observed with the top portion registering 149 degrees Fahrenheit (F) and the bottom portion registering 150 degrees F. Staff member #A1 indicated the temperature of the warmer was not monitored and recorded.</p> <p>2. During the tour of the surgical area at</p>	S001146	<p>1. A log of daily temperatures in the warming cabinets will be maintained and monitored. A thermometer will be added to the cabinets to assure the proper temperature is maintained per manufacturer guidelines. 2. The Clinical Director will be responsible for ensuring this is completed and maintained.</p>	04/23/2013			

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	<p>2:15 PM on 03/26/13 with staff member #A1, a warming cabinet was observed in the hallway. The bottom portion contained blankets and the top portion contained four 1000 milliliter (ml) containers of 0.9% Normal Saline and four 500 ml. containers of Sterile Water for irrigation. A knob inside the top cabinet was set at 140 degrees F., but the unit lacked any thermometer or other temperature monitoring device to indicated the actual temperature of either chamber. The fluids inside lacked any date marking or other indications to determine their length of time in the warmer. Staff member #A1 indicated the temperature of the warmer was not monitored and recorded.</p> <p>3. At 2:45 PM on 03/26/13, staff member #A1 indicated the facility did not have any policies or procedures regarding fluid or blanket warming, including monitoring, date marking, or specific temperature requirements. He/she indicated the fluid manufacturer had never been contacted for recommendations. He/she confirmed the facility did follow AORN (Association of periOperative Registered Nurses) guidelines.</p> <p>4. AORN recommendations indicated the temperature of blanket or linen warming</p>				

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	cabinets should not exceed 130 degrees F. and should be checked at regular intervals and documented on a log or electronically. AORN also indicated the solution manufacturer should be contacted for maximum temperature and length of time fluids could remain in a warming cabinet.			

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S001170	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to discharge and perform daily operational inspections of the facility's Defibrillator Monitor as required by the manufacturer's recommendations.</p> <p>Findings included:</p> <p>1. The Olla AM-series</p>	S001170	<p>1. The center will perform daily operational inspections of the facility's Defibrillator Monitor as required by the manufacturer's recommendations. The center will also purchase a spare battery for the Olla AM series Defibrillator. 2. The Clinical Director will be responsible for ensuring all checks are performed.</p>	04/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2013
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NAME OF PROVIDER OR SUPPLIER NAAB ROAD SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260
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	<p>Defibrillator Operator's Guide requires on a every shift operational checks which include; perform a test routine operation(discharge); visual inspection of all cables, fully charged battery with a spare fully charged battery located with the machine, paddles, and controls. The Operational Checks for the defibrillator includes: 1) Multi-function cable connected to test connector; 2) Press ANALYZE button; 3) Press and hold SHOCK button; 4) Attach MFC to ECG Simulator; 5) Verify 'Check Patient' message is displayed; 6) Press ANALYZE Verify unit charges to 200J; and 7) Press SHOCK, verify shock was delivered.</p> <p>2. At 11:00 AM on 3/26/2013, the facility was toured. The facility only had 1 fully operating shift with 1 Olla AM-series Defibrillator was on hand. The Operator's Shift Checklist for the AM-series were reviewed for the March 2013. The logs that were used by the facility were the checklists the</p>			
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	<p>manufacturer recommends. Each log that was reviewed in the month of March had 'N/A' noted for the fully charge spare battery available and 'N/A' for 4 of 7 defibrillator operational checks: Attach MFC to ECG Simulator; Verify 'Check Patient' message is displayed; Press ANALYZE Verify unit charges to 200J; and Press SHOCK, verify shock was delivered.</p> <p>3. At 1:15 PM on 3/26/2013, staff member #1 indicated the facility does not have a spare battery for the Olla AM-series Defibrillator. The staff ember confirmed the facility was not performing all the operational defibrillator checks that are required by the manufacturer.</p>				