

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005973</p> <p>Survey Date: 6/23-24/15</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 06/26/14</p>	S000000		
S000228	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one</p>			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
	<p>(1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that podiatrists performing surgery in the facility maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located, or, failed to have a written agreement, signed by both parties, with another facility-credentialed physician who did have admitting privileges at a hospital in the same or adjacent county in which the ambulatory surgery center is located, that the physician would admit patients to the hospital, if needed, for 1 of 1 podiatrist credential file reviewed.</p> <p>Findings:</p> <p>1. Review of medical staff credential file MD#3, a podiatrist, indicated the practitioner did not have documentation of admitting privileges at one (1) or more hospitals in the same county or in an</p>	S000228	<p>The attached letter of explanation and agreement template will be sent to each podiatrist on the medical staff that is not currently meeting this requirement. Each podiatrist will be responsible for executing an agreement with an admitting physician specific to a hospital the podiatrist has surgery privileges at. If documentation has not been received by 7/31/2014, the podiatrist will not be allowed to schedule cases until such time documentation of an executed agreement has been provided. Responsible Party: Executive Director</p>	07/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
S000400	<p>Indiana county adjacent to the county in which the facility is located. Further review indicated the practitioner did not have a written agreement, signed by both parties, with another facility-credentialed physician who did have admitting privileges at a hospital in the same or adjacent county in which the ambulatory surgery center is located, that the physician would admit patients to the hospital, if needed.</p> <p>2. In interview, on 6-24-14 at 2:30 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, facility cleaning policy and housekeeping</p>	S000400	1. Each environmental service employee will document the completion of their assigned cleaning schedule on a daily	07/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
	<p>schedule review, and interview, the facility failed to ensure that it maintains a safe and healthful environment that minimizes infection exposure and risk to patients, healthcare workers, and visitors.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During tour on 6/23/2014 (Day 1), at 1:40 p.m., it was observed that the clean surgery supply room floor was soiled with brownish substance around most of the perimeter of the room, and under 2 cabinets in the room. There was dust and a wooden necklace type bead observed on the floor. On 6/24/2014 (Day 2) at 8:30 a.m., the condition appeared exactly the same. 2. In the medication room on 6/23/2014 at 1 p.m., the 		<p>basis. The completed cleaning schedules will be turned in weekly and spot checked by the employee's immediate supervisor. Deficiencies noted will result in employee counseling and retraining. This process will be ongoing as a means of continued quality assurance. 2. The refrigerator in question will be replaced. 3. Rocuronium was discarded at time of survey. The new refrigerator will remedy the issue with leaking ice pack. The leaking ice packs have been disposed of. Responsible Party: Clinical Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
	<p>medication refrigerator was soiled with brownish debris on the top and bottom shelves. Also, a cold pack had leaked a greenish, wet substance onto one single dose box of the medication Recuronium, compromising package integrity and making it difficult to read instructions.</p> <p>3. Community Surgery Center North policy titled "Cleaning , last reviewed 5/2014, stated "The Center will provide and maintain a functional and sanitary environment for surgical services to avoid sources and transmission of infections and communicable diseases. All areas of the facility will be clean and sanitary C.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH				STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256			
(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			
S000746	<p>Unless otherwise specified, each duty is done on a daily basis."</p> <p>4. Staff member # 3 (Support Services Supervisor over housekeeping) on 6/24/2014 at 3 p.m. stated that the floors are supposed to be mopped daily.</p> <p>5. Staff members #2 (RN Clinical Director) and #3 (Support Services Supervisor) at 6/24/2014 at 3 p.m. agreed with the above findings.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(E)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(E) A statement of duties and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
S000826	<p>privileges for each category of the medical staff.</p> <p>Based on review of documents and interview, the facility's medical staff failed to follow medical staff rules and regulations for granting temporary privileges for 1 (MD#4) of 7 credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the medical staff rules and regulations, entitled MEDICAL STAFF: TEMPORARY, CONSULTATIVE AND EMERGENCY PRIVILEGES, approved 8-14-12, indicated temporary privileges may be granted by the Medical Director and Executive Director, or their respective designee. Review of 7 medical staff credential files indicated file MD#4 had been granted temporary privileges on 5-1-14 by the Medical Director but not the Executive Director. In interview, on 6-24-14 at 11:30 am, employee #A2 confirmed the above and no other documentation was provided prior to exit. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL</p>	S000746	Moving forward, all requests for temporary privileges for medical staff will be approved by both the Medical Director and the Executive Director as evidenced by both signatures on the attached document. Responsible Party: Executive Director	07/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
410	<p>IAC 15-2.5-4(c)(1)(E)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(E) Safety training required of personnel.</p> <p>Based on document review and interview, the facility failed to ensure a policy and failed to provide documentation of safety training in areas where anesthetics are used for 8 (MD#2, MD#3, MD#4, MD#5, MD#6, and MD#7, and AH#1 and AH#2) of 9 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. On 6-23-14 at 9:45 am, employee #A2 was requested to provide documentation of having provided Operating Room Safety Training of credentialed medical staff members.</p> <p>2. Review of a document entitled EMPLOYMENT - MANDATORY INSERVICES, revised 05/14, indicated the policy and procedure was for employees and did not indicated it included credentialed medical staff members.</p> <p>3. Review of 9 medical staff credential</p>	S000826	<p>1. Safety training will be demonstrated at at the medical staff member's initial appointment by viewing an OR safety video in-service. All current medical staff will be notified of requirement to view safety training by July 31, 2014. Each medical staff member will have until 8/31/2014 to complete training. Credentialing and re-appointments will be delayed in the event that the safety training is not completed. 2. The attached policy and procedure has been updated to reflect this requirement. Responsible Party: Executive Director</p>	07/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
S000920	<p>files indicated files MD#2, MD#3, MD#4, MD#5, MD#6, and MD#7, and AH#1 and AH#2, did not contain any documentation of safety training in areas where anesthetics are used.</p> <p>4. In interview, on 6-24-14 at 2:30 pm, employee #A2 confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following: This STANDARD is NOT MET as evidenced by:</p> <p style="padding-left: 40px;">Based on document review and interview, the facility failed to ensure implementation of facility policy regarding patient discharge for 3 of 30 patient medical records, patients # 13, #16, and #25.</p> <p>Findings include:</p>	S000920	<p>Beginning with the second quarterly nursing documentation audits, a verification of a discharge order on each patient's medical record will be reviewed. The surgeon and the RN caring for patient post-operatively will share responsibility to ensure that a discharge order is present on the patient's medical record prior to the patient being discharged. The necessity of a discharge order will be re-emphasized to nursing and medical staff with staff updates. Responsible Party: Clincial Director</p>	07/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
	<ol style="list-style-type: none"> 1. Review of 30 medical records, 6/23&24/2014, indicated that patients #13, #16, and #25 lacked a discharge order. 2. Community Surgery Center North (CSCN) policy "Discharge Criteria of Patients to Home", last reviewed February of 2014, states: "All patients discharged from Community Surgery Center must have an order from the attending physician or anesthesiologist prior to leaving the Center." Section C. "The discharge process will include the following steps: 1. An order for discharge will be obtained from the attending physician." 3. In an interview on 6/24/2014 at 2:30 p.m., staff 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
S001170	<p>member #2 (RN- Clinical Director) confirmed these findings.</p> <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 document review and interview, the facility failed to document defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator.</p> <p>Findings:</p>	S001170	The daily/weekly checklist for the defibrillator has been updated to be identical to the daily/weekly checklist provided by the manufacturer. In so doing, the documentation of the steps taken will support following manufacturer guidelines. The	07/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH			STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256		
(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	
S001182	<p>1. Review of the Zoll defibrillator user handbook indicated the facility was to perform weekly checks per the Operator's Checklist for R Series that included, but were not limited to, inspect paddles - paddles clean, not pitted, release from housing easily, and inspect disposable supplies - alcohol wipes, razors.</p> <p>2. Review of a document entitled ISC NORTH ZOLL DEFIBRILLATOR WEEKLY CHECKLIST, dated 6-23-14, location PACU, Unit Serial # AF10HC117CY, indicated it did not include the above-stated weekly checks.</p> <p>3. In interview, on 6-24-14 at 3:35 pm, employee #A2 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about</p>		policy and procedure has also been updated with the updated checklist. Responsible Party: Executive Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTH	STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256
--	---

(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
	<p>hazards and safety practices to be reviewed by the committee.</p> <p>Based on document review and interview, the facility failed to follow its policy for conducting safety inspections in 2 instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a document entitled SAFETY MANAGEMENT PLAN, approved 5-13-14, indicated safety inspections will be conducted at least twice per year. 2. On 6-23-14 at 9:45 am, employee #A2 was requested to provide documentation of the facility's process to evaluate and collect information about hazards and safety practices. 3. In interview, on 6-24-14 at 4:15 pm, employee #A2 indicated there was no documentation as requested and no other documentation was provided prior to exit. 	S001182	<p>Safety inspections will be conducted two times each year by a member of the safety committee. For the 2014 year the audits will be performed in the 3rd and 4th quarter. Moving forward, the inspections will occur in January and July each year. The inspections will be reported to and documented in the safety committee meeting minutes. In addition, the safety management plan has been updated and will be presented and approved at the next safety committee meeting 8/13/14. Responsible Party: Clinical Director</p>	08/13/2014