

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001034	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER NORTHWEST	STREET ADDRESS, CITY, STATE, ZIP CODE 8651 TOWNSHIP LINE ROAD INDIANAPOLIS, IN 46260
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S 0000 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005974</p> <p>Survey Date: 7-22/25-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>QA: cloughlin 08/13/13</p>	S 0000	Not required	
S 0110 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made,</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.

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S 0134	<p>actions taken, and follow-up. Based on document review and interview, the facility's governing board failed to review 1 contracted service during calendar year 2012 as part of the facility's quality assurance/performance improvement (QAPI) program.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a document entitled AGREEMENT FOR SERVICES, dated April 1, 1998,, between Foot & Ankle Surgery Center and Mid America Clinical Laboratories indicated the contract for laboratory service is to include the provision of blood products in the event they are needed. 2. Review of the governing board meeting minutes for calendar year 2012 indicated the governing board failed to review QAPI activities for the contracted service of blood products. 4. In interview, on 7-24-13 at 3:45 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND</p>	S 0110	The contracted service of blood products was added to QAPI quarterly review. First review was conducted 8/15/2013.This update was approved by the QAPI committee on 8/15/2013.Person responsible: Executive Director	08/15/2013	

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Bldg. 00	<p>DUTIES 410 IAC 15-2.4-1 (b)(9)</p> <p>The governing body shall do the following:</p> <p>(9) Ensure surgical procedures performed are limited to procedures authorized by the governing body and not requiring a stay longer than twenty-four (24) hours.</p> <p>Based on document review and interview, the governing board approved of privileges for 1 podiatrist which were not on the approved list of podiatry procedures.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of 7 medical staff credential files indicated file MD#2 was approved for the podiatry procedures of skin grafts, flat foot repair and syndactyly. Review of the August 7, 2012 board of managers meeting minutes indicated the above procedures were not on the approved list of procedures. In interview, on 7-24-13 at 9:35 am, employee #A1 confirmed the above and no further documentation was provided prior to exit. 	S 0134	The attached list of procedures will be submitted for Board of Manager approval at the August 28, 2013 meeting. This list will be used for credentialing purposes. Responsible person: Executive Director	08/28/2013
S 0162 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p>			

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S 0176	<p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(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 appropriately define a category of physician who would be considered a direct care giver.</p> <p>1. Review of a facility policy entitled LIFE SUPPORT COMPETENCY REQUIREMENTS, effective 01/01/2012 and revised 3/14/2013, indicated from a medical staff standpoint, only anesthesiologists and intensivists will be considered direct care patient givers.</p> <p>3. In interview, on 7-22-13 at 1:30 pm, employee #A1 confirmed the above-stated policy and that the facility had no intensivists, and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND</p>	S 0162	<p>The policy "Life Support Competency Requirements" has been updated to reflect the fact that the Center does not have intensivists. The term "intensivists" has been removed from the policy. This policy will be submitted for approval at the August 28, 2013 Board of Managers meeting. Person responsible: Executive Director</p>	08/15/2013			

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Bldg. 00	<p>DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on document review and interview, the facility failed to document personnel competency for 3 of 5 employee personnel files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a document entitled AGREEMENT FOR SERVICES, dated April 1, 1998,, between Foot & Ankle Surgery Center and Mid America Clinical Laboratories indicated the contract for laboratory service is to include the provision of blood products in the event they are needed. 2. Review of 5 employee files indicated employees P#1, P#2, and P#3, had no documentation of competency assessment of blood administration. 3. In interview, on 7-23-13 at 2:15 pm, employee #A1 confirmed the above and no documentation was provided prior to 	S 0176	<p>Blood administration competency has been added to the policy "Continuing Education/In-Service Training/Competencies". This policy will be submitted for approval at the August 28, 2013 Board of Managers Meeting. The blood administration lap pack has been added to the "Employee Yearly Inservice/Competency" sheet. Responsible person: Executive Director</p>	08/15/2013	

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S 0228 Bldg. 00	<p>exit.</p> <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 (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 for 6 of 6 podiatrists'</p>	S 0228	At the time of survey, the "Standing Waiver for 410 IAC 15-2.3-1(e)(4)" was presented by surveyor. Plan of correction will be to create an agreement between physician(s) and podiatrists. August 8, 2013-Conference call with legal department to discuss regulation and next steps. Regulation will be	09/28/2013

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S 0310 Bldg. 00	<p>medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 6 podiatrists' medical staff credential files indicated files MD#1, MD#2, MD#3, MD#4, MD#5, and MD#6 did not have documentation of 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.</p> <p>2. In interview, on 7-22-13 at 1:30 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to include a</p>	S 0310	<p>discussed and decided upon at the August 28, 2013 Board of Managers meeting. Agreements will be in place by September 28, 2013. Responsible person: Executive Director</p> <p>The contracted service of blood products was added to QAPI</p>	08/15/2013	

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S 0400 Bldg. 00	<p>monitor and standard for 1 service furnished by a contractor in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a document entitled AGREEMENT FOR SERVICES, dated April 1, 1998,, between Foot & Ankle Surgery Center and Mid America Clinical Laboratories indicated the contract for laboratory service is to include the provision of blood products in the event they are needed. 1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the contracted service of the provision of blood. 2. In interview, on 7-24-13 at 3:45 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit. <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</p>		quarterly review. First review was conducted 8/15/2013. This update was approved by the QAPI committee on 8/15/2013. Person responsible: Executive Director	

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S 0780 Bldg. 00	<p>minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors in 1 instance.</p> <p>Findings:</p> <p>1. On 7-23-13 at 10:45 am, in the presence of employee #A3, it was observed in a housekeeping storage area 3 large packages of paper towel rolls and 5 packages of hand towels were stored, unprotected, on an open shelf. Thus, the items, used by patients, health care workers and visitors, were subject to cross contamination.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible</p>	S 0400	Any unprotected paper products stored in the housekeeping storage area will be contained in disposable plastic bags. Housekeeping company will be educated on this new process. Responsible person: Executive Director	08/21/2013

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	<p>practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on document review and interview, the facility failed to follow its protocol for performing and electrocardiogram (EKG) on a patient prior to surgery in 1 instance.</p> <p>Findings:</p> <p>1. Review of a facility document entitled ANESTHESIA PRE-OP STANDING ORDERS, indicated an EKG on all patients with one or more of the following:</p> <p>a. >60 years of age b. Past Medical History of Hypertension c. Past Medical History of Diabetes d. Cardiac disease e. Lung Disease f. Obesity</p> <p>2. Review of the medical record of patient MR#27, who had a procedure performed 5-16-13, indicated in the section entitled SIGNIFICANT HEALTH PROBLEMS, the patient had Heart Disease, and Lung Disease. The document was signed by MD#vgbh.; and dated 5-16-13.</p> <p>3. Review of all other documents in the</p>	S 0780	The policy "Admission Criteria to the Community Surgery Center Northwest" was updated to reflect the protocol that EKG's will be accepted if performed within one year of date of surgery. This policy will be presented at the August 28, 2013 Board of Managers meeting for approval. Responsible person: Executive Director	08/15/2013

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S 0826 Bldg. 00	<p>medical record of patient MR#27 indicated there was no documented order or documentation of an EKG having been performed on 5-16-13.</p> <p>4. In interview, on 7-25-13 at 11:20 am, employee #A1 confirmed the above and no further documentation was provided by exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 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 provide documentation of safety training in areas where anesthetics are used for 7 of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 7 medical staff credential files indicated files MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, and MD#7 did not</p>	S 0826	The policy "Continuing Education/In-Service Training/Competencies" has been updated to reflect that medical staff and anesthesia, by virtue of their training, continuing education requirements and maintenance of board certification, are considered safety trained. This policy will be submitted to the Board of Managers for approval on August 28, 2013. Responsible person: Executive Director	08/15/2013

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S 0854 Bldg. 00	<p>contain any documentation of safety training in areas where anesthetics are used.</p> <p>2. In interview, on 7-23-13 at 3:20 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)</p> <p>Requirements 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>Based on document review and interview, the facility failed to have a policy of tissue review, including macro and micro requirements in 1 instance.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled SPECIMEN CARE, revised 5/24/2012, indicated all tissue and specimens will be sent to pathology with the exception of</p>	S 0854	The policy "Specimen Care" has been updated to reflect the physician removing the specimen will make the determination for macro and/or micro requirements. This policy will be submitted to the Board of Managers for approval on August 28, 2013. Responsible person: Executive Director	08/15/2013

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S 1196 Bldg. 00	<p>the following:</p> <ol style="list-style-type: none"> Bone segments removed as part of corrective or reconstructive orthopedic/podiatric procedures Orthopedic hardware Skin scar Toenails <p>2. In interview, on 7-24-13 at 9:50 am, employee #A1 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)(5)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(5) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with center policy and state and local regulations. Based on document review and interview, the facility failed to maintain documentation of regular inspection and approval of the facility by a state or local fire control agency.</p> <p>Findings:</p>	S 1196	Fire marshall was contacted to schedule an inspection on August 12, 2013. Fire marshall inspection will be scheduled by August 25, 2013. Fire marshall inspection will occur by September 25, 2013. Fire marshall inspections will occur on a yearly basis. Responsible person: Executive Director	09/25/2013			

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	<p>1. Review of documents indicated there was no State or local fire agency inspection for year 2012 and also there was no documentation of request for a State or local fire agency inspection for year 2012.</p> <p>2. In interview, on 7-24-13 at 2:30 pm, employee #A2 confirmed the above and indicated there was no state or local fire inspection since March, 2011. No other documentation was provided prior to exit.</p>			