

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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
Q0000	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 005392</p> <p>Survey Date: 01-22/24-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 01/30/13</p>			O0000			

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:  15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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	
Q0083	<p>416.43(d) PERFORMANCE IMPROVEMENT PROJECTS</p> <p>(1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.</p> <p>(2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results</p> <p>Based on document review and interview, the facility failed to document any corrective action for a performance improvement project.</p> <p>Findings:</p> <p>1. Review of a performance improvement project document entitled August 1, 2012, Administrative Re-Study Errors in Demographic Information, indicated no decrease in errors [demographic information]. The document further indicated this information will be shared with the physicians and the manager of the staff responsible to determine a corrective plan of action.</p> <p>2. Review of a document entitled Quality Assurance/Risk Management Minutes, August 21, 2012, indicated attendance by facility physicians and the facility's Director and Executive Director. There</p>	O0083	An addendum to the minutes was added detailing the corrective action that was carried out. (attached) The director was responsible. We will be following AAAHC guidelines for QA reporting. More detailed minutes will be documented in the future. This will prevent the problem from happening in the future	01/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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>was no documented corrective plan of action for the above-stated performance improvement project.</p> <p>3. In interview, on 01-24-13 at 2:05 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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			
Q0101	<p>416.44(a)(1) PHYSICAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on observation, the facility maintained 1 condition which may result in a hazard to patients, public, or employees</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 01-24-13 at 9:15 am in the presence of employee #A1, it was observed in the basement that there was 1 fire extinguisher standing upright on a cabinet unsecured by chain or holder.</li> <li>If the above extinguisher was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</li> </ol>	00101	<p>The fire extinguisher has been secured. We will implement a weekly visual check on all extinguishers. This will prevent this from happening in the future. This will be the responsibility of our maintenance staff who will report findings to the Director.</p>	01/24/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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			
Q0182	<p>416.48(a)(1) ADMINISTRATION - ADVERSE REACTIONS</p> <p>Adverse reactions must be reported to the physician responsible for the patient and must be documented in the record.</p> <p>Based on document review and interview, the facility failed to have a written policy and procedure of documenting adverse reactions and medication errors in the patient's medical record.</p> <p>Findings:</p> <p>1. Review of facility POLICY NO. 12.01, entitled PHARMACY SERVICES, revised 03/2012, section entitled Medication Error or Drug Reaction, did not indicate an adverse reaction and medication error was to be documented in the patient's medical record.</p> <p>2. In interview, on 01-24-13 at 2:40 pm, hospital staff confirmed the above and no further documentation was provided prior to exit.</p>	00182	<p>Surgical Care Center policy #12.01 was modified. See page 5 of 7. Staff was made aware of this at our staff meeting on January 31, 2013. Education of this will prevent this in the future. Director was responsible. The policy states that all medication errors and adverse reactions will be documented in the patient's medical record. If an error occurs an incident report will be presented to the Quality Assurance Committee for monitoring.</p>	01/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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			
Q0241	<p>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.</p> <p>Based on document review and interview the facility failed to ensure that staff followed policy and procedure and manufacturer's recommendations for cleaning instruments.</p> <p>Findings include:</p> <p>1. Review of policy/procedure #11.39, Instrument Cleaning, indicated the following: "Policy: Instruments used in the operating room shall be properly cleaned and appropriately transported." This policy/procedure was last reviewed/revised on 08-2012.</p> <p>2. Review of the manufacturer's recommendations for cleaning of the Beckert instrument indicated the following: "Cleaning - Use a mild soap solution and with a soft brush to clean the instrument and remove any stains. Use distilled or demineralized water to rinse instruments thoroughly."</p> <p>3. Review of the manufacturer's</p>	Q0241	<p>The staff reviewed manufacturer guidelines on all instruments. They worked closely with the Chairman of the Infection Control Committee. Policy #11.39 was rewritten and all appropriate staff were trained in appropriate instrument cleaning. Attached are policy #11.39, 11.391, 11.392. Policy #11.19 was changed to policy # 11.392. The policy states that instruments sited in deficiency will be cleaned with a mild soap solution and rinsed prior to autoclave risne cycle.The Director is responsible for this and will be moniitoring the procedure to be sure this is being done. This will be observed for the next month.</p>	02/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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>recommendations for cleaning of the Rhein Forceps indicated the following: "Instruments should be rinsed as soon as possible after use to remove blood, serum and saline. Use warm water and a commercially available instrument pre-soak or cleaning agent."</p> <p>4. Review of the manufacturer's recommendations for cleaning of the Katena Scissors indicated the following: "Manual Cleaning</p> <p>2. Do clean instruments with a mild soap solution and gently scrub stubborn stains with soft toothbrush."</p> <p>5. On 01-23-13 at 1430 hours, staff #41 confirmed that the Beckert instrument, the Rhein Forceps and the Katena Scissors are cleaned after surgery by wiping instruments with a wipe soaked in sterile water then placed in tray to be sterilized.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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
S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005392</p> <p>Survey Date: 1-22/24-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 01/30/13</p>	S0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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			
S0432	<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 document review and interview the facility failed to ensure that staff followed policy and procedure and manufacturer's recommendations for cleaning instruments.</p> <p>Findings include:</p> <p>1. Review of policy/procedure #11.39, Instrument Cleaning, indicated the following: "Policy: Instruments used in the operating room shall be properly cleaned and appropriately transported." This policy/procedure was last reviewed/revised on 08-2012.</p> <p>2. Review of the manufacturer's recommendations for cleaning of the Beckert instrument indicated the following:</p>	S0432	<p>The staff reviewed manufacturer guidelines on all instruments. They worked closely with the Chairman of the Infection Control Committee. Policy #11.39 was rewritten and all appropriate staff were trained in appropriate instrument cleaning. Attached are policy #11.39, 11.391, 11.392. Policy #11.19 was changed to policy # 11.392. The policy states that instruments sited in deficiency will be cleaned with a mild soap solution and rinsed prior to autoclave risne cycle. The Director is responsible for this and will be moniitoring the procedure to be sure this is being done. This will be observed for the next month</p>	02/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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>"Cleaning - Use a mild soap solution and with a soft brush to clean the instrument and remove any stains. Use distilled or demineralized water to rinse instruments thoroughly."</p> <p>3. Review of the manufacturer's recommendations for cleaning of the Rhein Forceps indicated the following: "Instruments should be rinsed as soon as possible after use to remove blood, serum and saline. Use warm water and a commercially available instrument pre-soak or cleaning agent."</p> <p>4. Review of the manufacturer's recommendations for cleaning of the Katena Scissors indicated the following: "Manual Cleaning 2. Do clean instruments with a mild soap solution and gently scrub stubborn stains with soft toothbrush."</p> <p>5. On 01-23-13 at 1430 hours, staff #41 confirmed that the Beckert instrument, the Rhein Forceps and the Katena Scissors are cleaned after surgery by wiping instruments with a wipe soaked in sterile water then placed in tray to be sterilized.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013	
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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			
S0826	<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 8 of 8 physician credential files reviewed (MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, MD#7 and MD#8).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of 8 physician credential files indicated files MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, MD#7 and MD#8 did not contain any documentation of safety training in areas where anesthetics are used.</li> <li>In interview, on 01-24-13 at 12:40 pm, employee #A1 confirmed the above and no documentation of the above training was provided prior to exit.</li> </ol>	S0826	<p>On 1/31/2012 A training inservice on anesthesia safety and procedures was presented by Dr. Wendy Rich to all OR staff. Documentation of this will be filed in each physician file. A copy of the written inservice will be shared with new OR personnel upon hire. The Director is responsible.</p>	01/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/24/2013
NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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	
S1020	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(D)</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>(D) Reporting of adverse reactions and medication errors to the practitioner responsible for the patient and the appropriate committee, and documented in the patient's record.</p> <p>Based on document review and interview, the facility failed to have a written policy and procedure of documenting adverse reactions and medication errors in the patient's medical record.</p> <p>Findings:</p> <p>1. Review of facility POLICY NO. 12.01, entitled PHARMACY SERVICES, revised 03/2012, section entitled Medication Error or Drug Reaction, did not indicate an adverse reaction and medication error was to be documented in the patient's medical record.</p> <p>2. In interview, on 01-24-13 at 2:40 pm, hospital staff confirmed the above and no further documentation was provided prior</p>	S1020	<p>Surgical Care Center policy #12.01 was modified. See page 5 of 7. Staff was made aware of this at our staff meeting on January 31, 2013. Education of this will prevent this in the future. Director was responsible. The policy states that all medication errors and adverse reactions will be documented in the patient's medical record. If an error occurs an incident report will be presented to the Quality Assurance Committee for monitoring.</p>	01/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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
	to exit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/24/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  SURGICAL CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY 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
S1146	<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, the facility maintained 1 condition which may result in a hazard to patients, public, or employees</p> <p>Findings:</p> <p>1. On 01-24-13 at 9:15 am in the presence of employee #A1, it was observed in the basement there was 1 fire extinguisher standing upright on a cabinet unsecured by chain or holder.</p> <p>2. If the above extinguisher was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p>	S1146	<p>The fire extinguisher has been secured. We will implement a weekly visual check on all extinguishers. This will prevent this from happening in the future. This will be the responsibility of our maintenance staff who will report findings to the Director.</p>	01/24/2013