STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	This visit was for a re-certification survey. Facility Number: 005400 Survey Date: 1-17/19-12 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor QA: claughlin 01/23/11	O0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	15C0001019		01/19/2012

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Q0041	When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner. Based on document review and interview, the facility failed to include a monitor and standard for 1 service furnished by a contractor in its quality assessment performance improvement (QAPI) program. Findings: 1. Review of the facility ' s QAPI program indicated it did not include a monitor and standard for the contracted service of transplant tissues. 2. On 1-19-12 at 12:20 pm, upon interview, employee #A1 indicated there was no documentation of the above activities in its QAPI program and no documentation was provided prior to exit.	Q0041	Q041 Transplanted tissues from contracted services will be added to our QAPI program, reported and monitored on a quarterly basis at the QAPI meetings.The Director of Nursing for the Surgery Center will be responsible for overseeing this action.The QAPI program will be updated and presented to the Executive Board for approval at the March meeting.	02/17/2012

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Q0081	(a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors. (a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC. (c)(1) The ASC must set priorities for its performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care.			
	Based on document review and interview, the facility failed to include a monitor and standard for the activities of medication errors and reportable (adverse) events in its quality assessment and improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the activities of medication errors and reportable (adverse) events. 2. On 1-19-12 at 12:20 pm, upon	O0081	Q081 Medication errors and reportable events will be added to our QAPI program, reported and monitored on a quarterly basis at the QAPI meetings.The Director of Nursing for the Surgery Center will be responsible for overseeing this action.The QAPI program will be updated and presented to the Executive Board for approval at the March meeting.	02/17/2012

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	interview, employee #A1 indicated there was no documentation and no documentation was provided prior to exit.			

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Q0084	The governing body must ensure that the QAPI program- (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.			
	Based on document review and interview, the governing board failed to review quality assurance and performance improvement program (QAPI) reports for contracted transcription services, medication errors and reportable (serious) events. Findings: 1. Review of the facility's governing board meetings for year 2011, indicated the governing board did not review reports for contracted transcription services, medication errors and reportable (serious) events. 2. On 1-19-12 at 12:20 pm, upon interview, employee #A1 indicated there was no documentation of review of the above activities by the governing board and no documentation was provided prior to exit.	Q0084	Q084 Transcription services will be added to our QAPI reporting on a quarterly basis at the QAPI meetings. This will also be reported to the Executive Board quarterly.The Director of Nursing for the Surgery Center will be responsible for overseeing this action.Reporting will start at the quarterly QAPI meeting in March.	02/17/2012

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Q0101	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 document review and interview, the facility failed to document maintenance of 1 vacuum pump in accordance with the manufacturer's recommendations. Findings: 1. Review of the Squire-Cogswell/Aeros Instruments, Inc. manual for the facility's vacuum pump indicated the Maintenance Schedule AT EVERY 1000 HOURS [to] clean filters and strainers. 2. On 1-19-12 at 11:45 am, upon telephone interview, the biomedical engineer who performed the PM on the vacuum pump indicated he estimated the pump operated approximately 500 hours per quarter. 3. Based on the estimate of the above engineer, it is concluded the cleaning of the filters and strainers should have been done at least 2 times per year. 4. Review of documents entitled	O0101	Q101 Preventive maintenance on the vacuum pump will be changed to add the cleaning of the strainers and filters every 1000 hours of operation (approximately 2 times per year) as stated in user's manual.Terry Christman will be responsible for doing this PM and the Director of Nursing will be responsible for overseeing this action.An amended contract will be presented to the Executive Board for approval at the March quarterly meeting.	02/17/2012

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	QUARTERLY PREVENTIVE MAINTEANCE [sp], dated 9-8-11, 6-15-11, 11-26-10 and 7-1-10, indicated there was no cleaning of the filters and strainers.			

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Q0105	Emergency equipment available to the operating rooms must include at least the following: (1) Emergency call system. (2) Oxygen. (3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. (4) Cardiac defibrillator. (5) Cardiac monitoring equipment. (6) Tracheostomy set. (7) Laryngoscopes and endotracheal tubes. (8) Suction equipment. (9) Emergency medical equipment and supplies specified by the medical staff.			
	Based on document review and interview, the facility failed to have a provision for an emergency call system, oxygen and suction equipment. Findings: 1. Review of a facility policy indicating items contained on the Code Cart, indicated it did not include a provision for an emergency call system, oxygen and suction equipment. 2. Review of a document entitled QUARTERLY PREVENTIVE MAINTEANCE [sp] INSPECTION, dated 9-8-11, indicated the number and location of areas tested for the proper functioning of the nurse emergency call system. The document failed to include testing of those systems located in the	O0105	Q105 Location of the emergency call system, oxygen and suction equipment will be added to the Code Cart policy. The emergency call system located in the operating rooms will be added to the quarterly preventive maintenance list. Terry Christman will be responsible for doing this PM and the Director of Nursing for the Surgery Center will be responsible for overseeing this action.The amended contract and policy will be presented to the Executive Board for approval at the March quarterly meeting.	02/17/2012

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	operating rooms. 2. On 1-18-12 at 2:45 pm, upon interview, employee #A1 indicated there was no policy that included a provision for an emergency call system, oxygen and suction equipment. No other documentation was provided prior to exit.			

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Q0181	Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on document review the facility failed to ensure that drugs be administered as ordered for 2 of 30 medical records (MR) reviewed. (Patient #18 & 28) Findings include; 1. Review of policy/procedure 0780, Verbal and Written orders indicated the following; "Policy: Orders for patient treatment and medications, including the administration of medications, be carried out only when given by a qualified physician, surgeon, dentist, podiatrist or other person duly licensed or authorized to prescribe by the State of Indiana and who has been approved as a member of the medical staff of the Indiana Hand to Shoulder Surgery Center. All orders of medication and treatment shall be written into the medical record of the patient." This policy/procedure was last reviewed/revised on 12-2010. 2. Review of patient #18's MR indicates the patient was administered Zofran on 12-05-11 at 1005 hours and the MR lacked documentation of a Physicians Order to administer Zofran.	O0181	Q181 Further training will be held to review policy and requirements concerning medication orders and their documentation.All medical staff and nursing staff will review policy on medication orders. A separate QA will be put into place to monitor this activity and reported to the Executive Board at the quarterly meetings.The Director of Nursing of the Surgery Center will be responsible for setting up this QA project.The above project will be brought to the QAPI committee and Executive Board for approval at the March quarterly meeting.	02/17/2012

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	3. Review of patient #28's MR indicates the patient was administered Toradol 30 mg IV on 04-29-11 at 1300 hours and the MR lacked documentation of a Physicians Order to administer Toradol.			

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Q0221	The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands.			
	Based on document review, the facility failed to ensure a policy to provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure. Findings: 1. Review of the facility's policy and procedure manual indicated it did not include a policy to provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure. 2. On 1-19-12 at 10:15 am, employee #A1, upon interview, indicated there was no written policy, as requested. No documentation was provided prior to exit.	O0221	Q221 A policy will be put into place concerning providing patients with verbal and written notification of their right in advance of the day of surgery.A policy will be developed concerning the protocol of informing patients' of their rights.The Director of Nursing will be responsible for developing the above policy.The above policy will be presented to the Executive Board for approval at the March quarterly meeting.	02/17/2012

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Q0226	(ii) All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented. (iii) All allegations must be immediately reported to a person in authority in the ASC. (iv) Only substantiated allegations must be reported to the State authority or the local authority, or both.			
	Based on document review and interview, the facility failed to include in its rights provided to the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure and posted in the facility, that the grievance procedure was specific for grievances relating, but not limited to, mistreatment, neglect, verbal, mental or physical abuse, and that substantiated allegations must be reported to the appropriate State authority. Findings: 1. Review of a document entitled THE INDIANA HAND TO SHOULDER CENTER PATIENT RIGHTS AND RESPONSIBILITIES, provided to the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, and posted in the facility ' s patient reception room, did not include that the grievance procedure was specific for grievances relating, but not limited to, mistreatment, neglect, verbal, mental or	Q0226	Q226 An addition to the patient right and responsibilities will be made to include: the grievance procedure is specific for grievances relating to, mistreatment, neglect, verbal, mental or physical abuse, and that substantiated allegations must be reported to the appropriate State authority.The Director of Nursing will be responsible for amending the above rights.The amended policy and right will be presented to the Executive Board for approval at the March quarterly meeting	02/17/2012

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	physical abuse, and that substantiated allegations must be reported to the appropriate State authority. 2. On 1-19-12 at 10:15 am, upon interview, employee #A1 indicated the above patient rights document did not include that the grievance procedure was specific for grievances relating, but not limited to, mistreatment, neglect, verbal, mental or physical abuse, and that substantiated allegations must be reported to the appropriate State authority. No further documentation was provided prior to exit.			

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Q0232	[The patient has the right to -] Receive care in a safe setting Based on document review and interview, the facility failed to have a policy, give to the patient prior to the day of surgery and post, that the patient has a right to receive care in a safe setting, including free of contaminated materials and unwanted visitors. Findings: 1. Review of the facility's policies and procedures indicated they did not include a policy that the patient has a right to receive care in a safe setting, including free of contaminated materials and unwanted visitors. 2. Review of a document entitled THE INDIANA HAND TO SHOULDER CENTER PATIENT RIGHTS AND RESPONSIBILITIES, provided to the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, and posted in the facility's patient reception room, did not include that the patient has a right to receive care in a safe setting, including free of contaminated materials and unwanted visitors. 3. On 1-19-12 at 10:15 am, upon	O0232	Q232 An addition to the patient right and responsibilities will be made to include: the patient has a right to receive care in a safe setting, free of contaminated materials and unwanted visitors. The Director of Nursing will be responsible for amending the above rights.The amended policy and right will be presented to the Executive Board for approval at the March quarterly meeting.	02/17/2012

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	interview, employee #A1 indicated the above patient right was not a part of the facility's policies and procedures. The employee further indicated the above document did not include that the patient has a right to receive care in a safe setting, including free of contaminated materials and unwanted visitors. No further documentation was provided prior to exit.			

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Q0233	[The patient has the right to -] Be free from all forms of abuse or harassment Based on document review and interview, the facility failed to have a policy, give to the patient prior to the day of surgery and post, that the patient has a right to be free from all forms of staff neglect. Findings: 1. Review of the facility's policies and procedures indicated there was no policy indicating the patient has a right to be free from all forms of staff neglect. 2. Review of a document entitled THE INDIANA HAND TO SHOULDER CENTER PATIENT RIGHTS AND RESPONSIBILITIES, provided to the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, and posted in the facility's patient reception room, did not include that the patient has a right to be free from all forms of staff neglect. 3. On 1-19-12 at 10:15 am, upon interview, employee #A1 indicated the above patient right was not a part of the facility's policies and procedures. The employee further indicated the patient rights document (above) did not include	O0233	Q233 An addition to the patient right and responsibilities will be made to include: the patient has a right to be free from all forms of staff neglect. The Director of Nursing will be responsible for amending the above rights.The amended policy and right will be presented to the Executive Board for approval at the March quarterly meeting.	02/17/2012

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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8501 HARCOURT RD INDIANAPOLIS, IN 46260	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	that the patient has a right to be free from all forms of staff neglect. No further documentation was provided prior to exit.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2012

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SURGERY CENTER	8501 HARCOURT RD INDIANAPOLIS, IN 46260

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S0224	410 IAC 15-2.4-1(e)(2) 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: (2) Ensure that the services performed under a contract are provided in a safe and effective manner and are included in the center's quality assessment and improvement program.			
	Based on document review and interview, the governing board failed to review quality assurance and performance improvement program (QAPI) reports for contracted transcription services, medication errors and reportable events. Findings: 1. Review of the facility's governing board meetings for year 2011, indicated the governing board did not review reports for contracted transcription services, medication errors and reportable events. 2. On 1-19-12 at 12:20 pm, upon interview, employee #A1 indicated there was no documentation of review of the above activities by the governing board and no documentation was provided prior to exit.	S0224	**S224** Transcription services, medication errors and reportable events will be added to our QAPI reporting on a quarterly basis at the QAPI meetings.The Director of Nursing for the Surgery Center will be responsible for overseeing this action.Reporting will start at the quarterly QAPI meeting in March.	02/17/2012

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S0310	410 IAC 15-2.4-2(a)(1) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor.			
	Based on document review, the facility failed to include 1 service furnished by a contractor in its quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include a monitor and standard to evaluate the contracted service of transplanted tissues. 2. On 1-19-12 at 12:20 pm, employee #A1 was requested to provide documentation of inclusion of the above activity. No documentation was provided prior to exit.	S0310	**S310** Transplanted tissues from contracted services will be added to our QAPI program, reported and monitored on a quarterly basis at the QAPI meetings.The Director of Nursing for the Surgery Center will be responsible for overseeing this action.The QAPI program will be updated and presented to the Executive Board for approval at the March meeting.	02/17/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0320	410 IAC 15-2.4-2(a)(2) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (2) All functions, including, but not limited to, the following: (A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.			
	Based on document review and interview, the facility failed to include a monitor and standard for the activity of medication errors in its quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include a standard and monitor for the activity of medication errors. 2. On 1-19-12 at 12:20 pm, employee #A1 was requested to provide documentation of inclusion of the above activities. No documentation was provided prior to exit.	S0320	**S320** Medication errors will be added to our QAPI program, reported and monitored on a quarterly basis at the QAPI meetings.The Director of Nursing for the Surgery Center will be responsible for overseeing this action.The QAPI program will be updated and presented to the Executive Board for approval at the March meeting.	02/17/2012

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S0332	410 IAC 15-2.4-2.2(a)(1) Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the center: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained. (CC) Objects not present prior to surgery that are intentionally left in when the risk of			

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	removal exceeds the risk of retention, such as microneedles or broken screws. (v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. (B) The following product or device events: (i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product. (ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators. (iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism. (C) The following patient protection events: (i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries that were the			

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	reason for admission to the center. (D) The following care management events: (i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability. (ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products. (iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy. (iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center. (v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates. (vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is progression from Stage 2 or Stage 3 if the			

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	Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar. (vii) Patient death or serious disability resulting from joint movement therapy performed in the center. (viii) Artificial insemination with the wrong donor sperm or wrong egg. (E) The following environmental events: (i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion. (ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient: (AA) contains the wrong gas; or (BB) is contaminated by toxic substances. (iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center. (iv) Patient death or serious disability associated with a fall while being cared for in the center. (v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center. (F) The following criminal events: (i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider. (ii) Abduction of a patient of any age. (iii) Sexual assault on a patient within or on the grounds of the center. (iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.			
	Based on document review and interview,	S0332	**S332** Reportable events will be	02/17/2012

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	the facility failed to include a monitor and standard for the activity of reportable events in its quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility ' s QAPI program indicated it did not include a standard and monitor for the function of reportable events. 2. On 1-19-12 at 12:20 pm, employee #A1 was requested to provide documentation of inclusion of the above activities. No documentation was provided prior to exit.		added to our QAPI program, reported and monitored on a quarterly basis at the QAPI meetings.The Director of Nursing for the Surgery Center will be responsible for overseeing this action.The QAPI program will be updated and presented to the Executive Board for approval at the March meeting.	

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S0454	410 IAC 15-2.5-1(g)(2) Sterilization services must be directed by a qualified person or persons and must provide for the following: (2) Written policies and procedures must be available and followed by personnel responsible for sterilizing equipment and supplies, including, but not limited to, the following: (A) Minimum time and temperature for processing various size bundles and packs. (B) Instructions for loading, operating, cleaning, and maintaining sterilizers. (C) Instructions for cleaning packaging, storing, labeling, and dispensing of sterile supplies. (D) Procedure for maintaining and recording the particular sterilizing cycle. (E) Sterilization of heat labile reusable equipment.			
	Based on observation and interview the facility failed to ensure that written policies and procedures were available for operating the Steris System 1E sterilizing equipment for 1 facility. Findings include; 1. On 01-18-12 at 1250 hours during the	S0454	**S454** A policy will be put into place concerning the operation of the Steris System 1E.The Director of Nursing will be responsible for developing a policy for the operation of the Steris System 1E and it will be presented to the Surgery Center staff upon adoption.The above policy will be presented to the Infection Prevention and Control	02/17/2012

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	facility tour of the substerile area of the Surgery Area, 1 Steris System 1E was observed in the presence of staff #40. 2. On 01-19-12 at 1005 hours staff #40 confirmed that the facility did not have policy/procedures on how to operate the Steris System 1E.		and the Executive Board for approval at the March quarterly meeting.	

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S0630	410 IAC 15-2.5-3(d) (d) The medical record must contain sufficient information to: (1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.			
	Based on document review the facility failed to ensure that the medical record (MR) contain sufficient information to justify the treatment for 2 of 30 MRs reviewed. (Patient #18 & 28) Findings include; 1. Review of policy/procedure 0780, Verbal and Written orders indicated the following; "Policy: Orders for patient treatment and medications, including the administration of medications, be carried out only when given by a qualified physician, surgeon, dentist, podiatrist or other person duly licensed or authorized to prescribe by the State of Indiana and who has been approved as a member of the medical staff of the Indiana Hand to Shoulder Surgery Center. All orders of medication and treatment shall be written into the medical record of the patient." This policy/procedure was last	S0630	S0630Further training will be held to review policy and requirements concerning medication orders and their documentation.All medical staff and nursing staff will review policy on medication orders. A separate QA will be put into place to monitor this activity and reported to the Executive Board at the quarterly meetings.The Director of Nursing of the Surgery Center will be responsible for setting up this QA project.The above project will be brought to the QAPI committee and Executive Board for approval at the March quarterly meeting	02/17/2012

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	reviewed/revised on 12-2010. 2. Review of patient #18's MR indicates the patient was administered Zofran on 12-05-11 at 1005 hours and the MR lacked documentation of a Physicians Order to administer Zofran. 3. Review of patient #28's MR indicates the patient was administered Toradol 30 mg IV on 04-29-11 at 1300 hours and the MR lacked documentation of a Physicians Order to administer Toradol.			

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S0672	410 IAC 15-2.5-3(f)(13) All patient records must document and contain, at a minimum, the following: (13) A copy of the transfer form, if the patient is referred to a hospital or other facility.			
	Based on document review and interview the facility failed to ensure that all patient medical records (MR) contain a copy of the transfer form, if the patient is referred to a hospital or other facility for 4 of 5 transfer MRs reviewed. (Patient #26, 27, 28 and 30) Findings include; 1. Review of policy/procedure #0648, Medical Record Content, indicated the following; "Policy - It is the policy of The Indiana Hand to Shoulder Surgery Center that the medical record shall contain sufficient information to identify the patient, support the diagnosis, to justify the treatment and accurately document the course of the patient's stay in the Center and the results." This policy/procedure was last reviewed/revised on 04-2011. 2. Review of patient #26's MR indicated the patient had surgery on 09-09-11. The Nurses Notes dated 09-09-11 at 1220	S0672	**S672** Further training will be held to review policy and requirements concerning transfer protocol and necessary documentation.All medical staff and nursing staff will review policy on transfer orders. All transferred patients' medical records will be presented to the contracted medical record reviewer quarterly.The Director of Nursing of the Surgery Center will be responsible for overseeing this action.The above project will be brought to the QAPI committee and Executive Board for approval at the March quarterly meeting.	02/17/2012

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	hours indicated the patient was transferred via ambulance to a hospital. The patient's MR lacked documentation of a transfer form. 3. Review of patient #27's MR indicated the patient had surgery on 07-11-11. The Nurses Notes dated 07-11-11 at 1330 hours indicated the patient was transferred via ambulance to a hospital. The patient's MR lacked documentation of a transfer form. 4. Review of patient #28's MR indicated the patient had surgery on 04-29-11. The Nurses Notes dated 04-29-11 at 1355 hours indicated the patient was transferred via ambulance to a hospital. The patient's MR lacked documentation of a transfer form. 5. Review of patient #30's MR indicated the patient had surgery on 01-26-11. The Nurses Notes dated 01-26-11 at 1356 hours indicated the patient was transferred via ambulance to a hospital. The patient's MR lacked documentation of a transfer form. 6. On 01-19-12 at 1405 hours staff #40 confirmed that the MRs did not have copies of the transfer form.			

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S0862	410 IAC 15-2.5-4(d)(2)(C) Requirement for surgical services include: (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: (C) A provision for the following equipment and supplies to be available to the surgical and recovery areas: (i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff.			
	Based on document review and interview, the facility failed to have a provision for an emergency call system, oxygen and suction equipment. Findings: 1. Review of a facility policy indicating items contained on the Code Cart, indicated it did not include a provision for an emergency call system, oxygen and suction equipment.	S0862	**S862** Location of the emergency call system, oxygen and suction equipment will be added to the Code Cart policy. The emergency call system located in the operating rooms will be added to the quarterly preventive maintenance list. Terry Christman will be responsible for doing this PM and the Director of Nursing for the Surgery Center will be responsible for overseeing this action.The amended contract and policy will be presented to the Executive Board for approval at the March quarterly meeting.	02/17/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001019	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/19/2012
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8501 HARCOURT RD INDIANAPOLIS, IN 46260	

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	2. Review of a document entitled QUARTERLY PREVENTIVE MAINTEANCE [sp] INSPECTION, dated 9-8-11, indicated the number and location of areas tested for the proper functioning of the nurse emergency call system. The document failed to include testing of those systems located in the operating rooms. 2. On 1-18-12 at 2:45 pm, upon interview, employee #A1 indicated there was no policy that included a provision for an emergency call system, oxygen and suction equipment. No other documentation was provided prior to exit.			

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S0888	410 IAC 15-2.5-4(d)(2)(F) Requirement for surgical services include: (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: (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 document review the facility failed to ensure that Operative Reports were dictated immediately following surgery for 10 of 30 medical records (MR) reviewed. (Patient # 9, 12, 13, 14, 15, 16, 19, 21, 25 and 26) Findings include; 1. Review of the following MRs indicated the following; Patient #9 had surgery on 10-11-11 and the Operative Report was dictated on 10-12-11. Patient #12 had surgery on 12-16-11 and the Operative Report was dictated on 12-18-11. Patient #13 had surgery on 12-13-11 and	S0888	**S888** Further training will be held to review policy and rules for medical staff concerning operative dictation.All medical staff and nursing staff will review policy and medical staff rules concerning dictation. A separate QAPI will be developed to monitor the timeliness of operative dictations.The Director of Nursing of the Surgery Center will be responsible for overseeing the development of this QA.The above project will be brought to the QAPI committee and Executive Board for approval at the March quarterly meeting.	02/17/2012

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	the Operative Report was dictated on 12-16-11. Patient #14 had surgery on 09-14-11 and the Operative Report was dictated on 10-27-11. Patient #15 had surgery on 09-21-11 and the Operative Report was dictated on 09-24-11. Patient #16 had surgery on 12-08-11 and the Operative Report was dictated on 12-09-11. Patient #19 had surgery on 12-02-11 and the Operative Report was dictated on 12-03-11. Patient #21 had surgery on 11-08-11 and the Operative Report was dictated on 11-11-11. Patient #25 had surgery on 10-04-11 and the Operative Report was dictated on 10-07-11. Patient #26 had surgery on 09-09-11 and the Operative Report was dictated on 09-10-11.			

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S0908	410 IAC 15-2.5-5(a)(3) (a) Patient care services must require the following: (3) That a registered nurse serves as head nurse supervising patient care services personnel.			
	Based on document review and interview, the facility failed to ensure a policy designating a registered nurse serving as head nurse supervising patient care services personnel if the Director of Nursing was not available. Findings: 1. On 1-17-12 at 9:45 am, employee #A1 was requested to provide documentation of who was in charge in the absence of the Director of Nursing (Administrator). 2. Employee #A1 provided a document entitled Indiana Hand to Shoulder Center Organizational Chart. Review of this document indicated the areas of PACU (post anesthetic care unit) , OR (operating rooms) and Surgery Scheduling reported to the Director of Nursing. It did not indicate there was a registered nurse serving as head nurse supervising patient care services personnel if the Director of Nursing was not available. 3. On 1-18-12 at 3:05 pm, upon	S0908	**S908** A policy will be adopted to indicate who is responsible for the supervision of patient care in the absence of the Director of Nursing.The Director of Nursing will be responsible for overseeing this action.The above policy will be presented to the Executive Board for approval at the March quarterly meeting	02/17/2012

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	interview, employee #A1 indicated there was no written policy designating a registered nurse serving as head nurse supervising patient care services personnel if the Director of Nursing was not available and no documentation was provided prior to exit.			

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S1146	410 IAC 15-2.5-7(b)(2) (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: (2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.			
	Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance. Findings: 1. On 1-17-12 at 1:50 pm in the presence of employees #A2 and #A3, it was observed in the Boiler Room there was a flexible hose connected to a hot water line, adjacent to the water heater, and there was no visible backflow preventor in the line.	S1146	**S1146** A backflow preventor will be added to the flexible hose connected to the hot water line adjacent to the water heater in the boiler room.Dennis Pfiester will be notified to complete the above change as soon as possible.The Director of Nursing will be responsible for overseeing the completion of the task by February 25, 2012.Completion of this will be presented to the Executive Board at the March quarterly meeting.	02/17/2012

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S1152	410 IAC 15-2.5-7(b)(3)(B) (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: (3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plan and equipment by qualified personnel as follows: (B) All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.			
	Based on document review and interview, the facility failed to document maintenance of 1 vacuum pump in accordance with the manufacturer's recommendations. Findings: 1. Review of the Squire-Cogswell/Aeros Instruments, Inc. manual for the facility's vacuum pump indicated the Maintenance Schedule AT EVERY 1000 HOURS [to] clean filters and strainers. 2. On 1-19-12 at 11:45 am, upon	S1152	**S1152** Preventive maintenance on the vacuum pump will be changed to add the cleaning of the strainers and filters every 1000 hours of operation (approximately 2 times per year) as stated in user's manual.Terry Christman will be responsible for doing this PM and the Director of Nursing will be responsible for overseeing this action.An amended contract will be presented to the Executive Board for approval at the March quarterly meeting.	02/17/2012

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	telephone interview, the biomedical engineer who performed the PM on the vacuum pump indicated he estimated the pump operated approximately 500 hours per quarter. 3. Based on the estimate of the above engineer, it is concluded the cleaning of the filters and strainers should have been done at least 2 times per year. 4. Review of documents entitled QUARTERLY PREVENTIVE MAINTEANCE [sp], dated 9-8-11, 6-15-11, 11-26-10 and 7-1-10, indicated there was no cleaning of the filters and strainers.			