

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001015	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/23/2011
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NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER-SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN46227
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O0000	<p>This visit was for a recertification survey.</p> <p>Facility Number: 005396</p> <p>Survey Date: 11-21/23-11</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/05/11</p>	O0000		
Q0103	<p>[The ASC must provide a functional and sanitary environment for the provision of surgical services.] The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities. Based on observation and interview, the facility failed to provide a safe and healthful environment that minimized infection exposure and risk to patients and health care workers in 1 instance.</p> <p>Findings:</p>	Q0103	Center will write a policy "Tank Storage" to address the appropriate disinfection of the tanks before transfer to patient care areas. Responsible Person: Team Leader, Operating Room	12/13/2011

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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	<p>1. On 11-22-11 at 2:15 pm in the presence of employee #A3, it was observed in the biohazardous waste storage area that there were stored 4 small oxygen and 7 small carbon dioxide gas tanks.</p> <p>2. On that date and time, upon interview, employee #A2 indicated the tanks were periodically used in various patient care areas. The employee also indicated the tanks were wiped down with an appropriate disinfectant prior to being used. The employee was requested to provide a policy for wiping down the tanks and none was provided prior to exit.</p> <p>3. The location of the storage of the tanks created an infection exposure and risk to patients and health care workers issue since the tanks were stored in a dirty area and used in clean, patient care areas.</p>				

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O0162	<p>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ul style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on document review and interview, the facility failed to ensure that the medical record (MR) documented accurately the course of the patient's stay in the center for 1 of 30 MRs reviewed (Patient #10).</p> <p>Findings include:</p> <p>1. Review of patient #10's MR indicated the History and Physical was done on 10-07-11 and indicated the following; I had the pleasure of seeing patient #10 in the office today. Review of the Intra-Operative Record indicated the patient's surgical procedure started on 10-07-11 at 0703 hours.</p>	O0162	Medical and Executive Directors addressed the inaccurate documentation (Patient #10) in the medical record with the surgeon. An audit will be performed the first quarter of 2012 to monitor. Responsible Person: Clinical Director	12/02/2011	

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O0221	<p>2. On 11-23-11 at 1010 hours, staff #40 confirmed that patient #10 would have arrived to the facility at least 1 hour prior to the start of the surgical procedure.</p> <p>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.</p> <p>Based on document review and interview, the facility failed to provide the patient or patient's representative with verbal and written notice of those rights if the patient was incompetent, whether adjudged or not, and who could exercise the patient's rights.</p> <p>Findings:</p> <p>1. Review of the facility's patient rights statement, provided to the patient or patient's representative both verbally and in writing, indicated it did not include if a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient</p>	O0221	<p>Patient Right's brochure has been revised to address "if a patient is adjudged incompetent under applicable state health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under state law to act on the patient's behalf."Responsible Person:Clinical Director</p>	12/13/2011	

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	<p>incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>2. On 11-22-11 at 11:30 am, employee #A2 was requested to provide documentation that the facility's patient rights statement, provided to the patient or patient's representative both verbally and in writing, indicated it did not include if a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. At that time, upon interview, the employee indicated there was no documentation and none was provided prior to exit.</p>				

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O0222	<p>In addition, the ASC must - Post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.</p> <p>Based on document review and interview, the facility failed to post, if the patient was incompetent, whether adjudged or not, who could exercise the patient's rights.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's patient rights statement, posted by the facility, indicated it lacked if a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. On 11-22-11 at 11:30 am, employee #A2 was requested to provide 	O0222	Patient's Right posting has been changed to meet the standard. Responsible Person: Clinical Director	12/09/2011	

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O0225	<p>documentation that the facility's posted patient rights, included if a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. At that time, upon interview, the employee indicated this was not posted by the facility as part of its patient's rights.</p> <p>(i) The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC.</p> <p>(v) The grievance process must specify timeframes for review of the grievance and the provisions of a response.</p> <p>(vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished.</p> <p>(vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.</p>				

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	<p>Based on document review and interview, in 1 instance, the facility failed to follow its grievance process and failed to document how the grievance was addressed. The facility also failed to notify the complainant of the decision, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.</p> <p>Findings:</p> <p>1. On 11-21-11 at 9:30 am, employee #A1 was requested to provide documentation of the facility's grievance process.</p> <p>2. Review of the document provided by employee #A1, facility policy CLN: 3027, entitled REPORTING AND MANAGEMENT OF PATIENT CONCERNS/COMPLAINTS & GRIEVANCES, indicated in a section entitled Procedure, final resolution/apology will be communicated to complainant in writing as appropriate. There was no specification the final resolution/complaint should document how the grievance was addressed, as well as provide the patient with written notice of its decision. It also failed to indicate it should contain the name of an facility contact person, the steps taken to</p>	O0225	<p>All patient grievances will be notified in "writing" of the 1) decision 2) ASC contact person 3) investigation steps 4) results of process and 5) date grievance process was completed as per current policy. Will monitor the grievances for compliance first and second quarter 2012. Responsible Person: Team Leader, Patient Rooms</p>	12/13/2011	

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	<p>investigate the grievance, the results of the grievance process, and the date the grievance process was completed. No further complaint policy documentation was provided prior to exit.</p> <p>2. Review of a document entitled PATIENT GRIEVANCE/COMPLAINT TRACKING FORM, indicated the facility received a grievance from Patient #AD1 on 3-23-11.</p> <p>3. On 11-21-11 at 1:35 pm, employee #A1 was requested to provide documentation of all actions taken by the facility in response to the grievance submitted by Patient #AD1.</p> <p>4. Review of a letter dated 3-23-11, indicated the facility acknowledged receiving the grievance of Patient #AD1.</p> <p>5. Review of the documents provided by employee #A1 indicated there was no final resolution/apology communicated to the complainant in writing. It also failed to provide written communication of the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed. No further complaint policy documentation was provided prior to exit.</p>				

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O0230	<p>(2) If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.</p> <p>(3) If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>Based on document review, the facility failed to have a policy of those rights if the patient was incompetent, whether adjudged or not, and who could exercise the patient's rights.</p> <p>Findings:</p> <p>1. Review of the facility's patient rights statement indicated it lacked if a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>2. On 11-22-11 at 11:30 am, employee</p>	O0230	Center revised "Patient's Rights" policy to meet this standard. Responsible Person: Clinical Director	12/13/2011

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S0400	<p>#A2 was requested to provide documentation of a policy that indicated if a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. No documentation was provided prior to exit.</p> <p>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 and interview, the facility failed to provide a safe and healthful environment that minimized infection exposure and risk to patients and health care workers in 1 instance.</p> <p>Findings:</p> <p>1. On 11-22-11 at 2:15 pm in the presence of employee #A3, it was observed in the biohazardous waste</p>	S0400	Center will write a policy "Tank Storage" to address the appropriate disinfection process of the tanks before transfer to patient care areas. Responsible Person: Team Leader, Operating Room	12/13/2011	

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	<p>storage area that there were stored 4 small oxygen and 7 small carbon dioxide gas tanks.</p> <p>2. On that date and time, upon interview, employee #A2 indicated the tanks were periodically used in various patient care areas. The employee also indicated the tanks were wiped down with an appropriate disinfectant prior to being used. The employee was requested to provide a policy for wiping down the tanks and none was provided prior to exit.</p> <p>3. The location of the storage of the tanks created an infection exposure and risk to patients and health care workers issue since the tanks were stored in a dirty area and used in clean, patient care areas.</p>				

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S0414	<p>410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on document review, the facility failed to ensure that the infection control committee meets at least quarterly, with membership that includes, a representative from the medical staff.</p> <p>Findings include:</p> <p>1. Review of the Infection Control Committee Meeting minutes dated 01-06-11, 04-01-11, 07-07-11 and 09-27-11 lacked documentation that a representative from the Medical Staff</p>	S0414	The Center's Medical Director will attend Infection Control Meetings. Next meeting date: 1/5/2012. Responsible Person: Infection Control Officer	12/15/2011

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S0526	<p>attended the Infection Control Committee meetings.</p> <p>410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed. Based on interview and document review, the facility failed to ensure that all nursing personnel performing laboratory testing have competency assessed annually with documentation of assessment maintained in the employee file for urine pregnancy and INR procedures performed for 3 of 3 nursing personnel files reviewed (Staff # 1, 2 & 9).</p> <p>Findings include:</p> <p>1. On 11-21-11 at 1005 hours, staff #43 confirmed that nursing personnel who work the patient rooms perform the following laboratory tests: blood glucose, ISTAT, INR and urine pregnancy.</p> <p>2. Review of staff #1, 2 & 9's personnel files lacked documentation of annual competency for INR and Urine Pregnancy laboratory tests.</p>	S0526	All clinical staff will complete an annual competency on INR and urine pregnancy testing. These competencies will be added to the other annual mandatory competencies. The employee cannot work if the madatories are not up to date.Responsible Person:Team Leader, Patient Rooms	12/13/2011	

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S0630	<p>3. On 11-21-11 at 1230 hours, staff #43 confirmed that annual competencies for laboratory tests INR and Urine Pregnancy were not being done.</p> <p>410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(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.</p> <p>Based on document review and interview, the facility failed to ensure that the medical record (MR) documented accurately the course of the patient's stay in the center for 1 of 30 MRs reviewed (Patient #10).</p> <p>Findings include:</p> <p>1. Review of patient #10's MR indicated the History and Physical was done on 10-07-11 and indicated the following; I had the pleasure of seeing patient #10 in the office today. Review of the Intra-Operative Record indicated the patient's surgical procedure started on 10-07-11 at 0703 hours.</p> <p>2. On 11-23-11 at 1010 hours, staff #40</p>	S0630	Medical and Executive Directors addressed the inaccurate documentation in the medical record of Patient #10 with the surgeon. An audit will be performed the first quarter of 2012 to monitor. Responsible Person: Clinical Director	12/02/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001015	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/23/2011
NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER-SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN46227		
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S0780	<p>confirmed that patient #10 would have arrived to the facility at least 1 hour prior to the start of the surgical procedure.</p> <p>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 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 policy to have discharge instructions (orders) authenticated by the responsible practitioner for 2 of 27 medical records reviewed.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled DISCHARGE INSTRUCTIONS, COMMUNICATION OF, indicated discharge instructions [orders] shall be from the surgeon/physician performing the procedure.</p> <p>2. Review of 27 medical records</p>	S0780	Center's policy "Discharge Instructions, Communication Of," will be revised to meet standard.Audit will be performed first quarter of 2012 to monitor.Responsible Person:Team Leader, Patient Rooms	12/13/2011	

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S0888	<p>indicated records Pt #22 and Pt#25 did not have any documentation of the discharge orders being authenticated by the surgeon/physician performing the procedure.</p> <p>3. On 11-23-11 at 10:20 am and 10:35 am, employee #A2 was requested to provide documentation of the responsible practitioner authenticating the above orders. Upon interview, the employee indicated there was no authentication and none was provided prior to exit.</p> <p>410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review, the facility failed to ensure that the Operative Report was written or dictated immediately</p>	S0888	Audit will be performed first quarter 2012 to identify non-compliant surgeons and	12/15/2011

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	<p>following surgery by the surgeon and authenticated by the surgeon for 4 of 30 medical records (MR) reviewed (Patient #9, 11, 12 and 15).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of patient #9's MR indicated the patient had surgery on 10-11-11 and the Operative Report lacked documentation of being authenticated by the surgeon. 2. Review of patient #11's MR indicated the patient had surgery 09-29-11 and the Operative Report was dictated on 10-23-11. 3. Review of patient #12's MR indicated the patient had surgery 09-22-11 and the Operative Report was dictated on 10-11-11. 4. Review of patient #15's MR indicated the patient had surgery 08-10-11 and the Operative Report was dictated on 08-13-11. 		<p>appropriate actions needed. Responsible Person: Clinical Director</p>		