STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MERIDIAN SURGERY CENTER	13225 N MERIDIAN STREET CARMEL, IN 46032

(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
Q 0000 Bldg. 00	The visit was for a re-certification survey Facility Number: 007125 Survey Date: 5-9/11-16 QA: cjl 05/24/16	Q 0000		
Q 0041 Bldg. 00	416.41(a) CONTRACT SERVICES 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 center failed to ensure that all services performed under contract were evaluated by the Quality Assurance and Performance Improvement (QAPI) program for 2 of 21 contracted services (medical transcription and radiation exposure monitoring). Findings include: 1. The policy/procedure Quality Assurance & Performance Improvement (QAPI) Program (approved 10-14) indicated that all contracted services would be monitored and reviewed through the QA&I program.	O 0041	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q041 – **416.41(a)** – CONTRACT SERVICES Lamaster Radiation Services, Landauer Occupational Radiation Monitoring, and Transcription Connection, Inc. have been added to the QAPI Program. The Director reviewed and evaluated these three services on June 24, 2016 (Attachment A, B, and C). These evaluations, as well as a current Contracted Vendor List, will be presented to the Governing Body during the next Medical Staff Meeting/ Governing Board Meeting	07/28/2016

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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	2. Review of QAPI committee documentation dated 1-26-15, 5-06-15, 7-29-15, 10-28-15, 1-27-16 and 4-27-16 failed to indicate that 2 contracted services (medical transcription by CS20 and radiation badge exposure monitoring by CS21) had been evaluated or reviewed by the QAPI program. 3. On 5-10-16 at 1540 hours, the director, staff A1, confirmed that the QAPI documentation failed to indicate the 2 contracted services had been evaluated in 2015 or 2016.		on July 28, 2016. The Governing Body will then be updated throughout the year regarding the status of these services. The Director is responsible for making sure this evaluation process is done on an on-going basis and documented annually. This will be studied by the QAPI committee until compliance on an ongoing basis has been satisfied.	
Q 0043 Bldg. 00	416.41(c) DISASTER PREPAREDNESS PLAN (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with State and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan. Based upon document review and interview, the center failed to coordinate its emergency and disaster preparedness program with community and State preparedness agencies for one (1) facility.	Q 0043	Q043 – **416.41(c)** – DISASTER PREPAREDNESS PLAN Director attended multiple IFASC Disaster Preparedness Webinars/	07/01/2016

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	Findings include: 1. The policy/procedure Emergency Operations (revised 10-14) indicated the following: "As an outpatient surgery facility the Center is neither equipped nor staffed to assist in the treatment of patients as a result of a disaster. It is therefore the policy of the Center to not participate in the event of an external disaster and to so notify and inform appropriate community/governmental parties." 2. On 5-9-16 at 1030 hours, the director, staff A1, was requested to provide documentation of center participation and/or coordination with community, State and/or local emergency and disaster preparedness agencies and no documentation was provided prior to exit. 3. During an interview on 5-10-16 at 1620 hours, the director, staff A1, confirmed that no center disaster drill activity in 2015 or 2016 has been coordinated with a State or local (District 5) disaster drill event and confirmed that no center personnel have been or currently are attending the quarterly District 5 disaster management meetings.		Exercises in May and June of 2016, as evidence by Certificates of Training (Attachments N, O, P, Q, R). Director also completed the 2016 IFASC Emergency Preparedness Ambulatory Surgery Center Survey (Attachment S). This survey is reported via IFASC to the Indiana State Healthcare Preparedness Program in coordination with the Federal ASPR program. Director has registered for the 2016 IHEPS (Indiana Healthcare Emergency Preparedness Symposium) on October 6, 2016 in Indianapolis. Director also reached out to Business Operations Manager of Indiana District Five Hospital Preparedness Planning Committee to obtain information about attending quarterly meetings.	

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Q 0100 Bldg. 00	416.44 ENVIRONMENT The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. Based on Life Safety Code (LSC) survey, North Meridian Surgery Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 20, New Ambulatory Health Care Occupancies. The facility, located on the first floor of a three story building, was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors. Based on LSC survey and deficiencies found (see CMS 2567L), it was determined that the facility failed to ensure documentation to ensure 100% of fire dampers in the facility were inspected and provided necessary maintenance at least every four years (see K 067), failed to provide emergency	O 0100	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 31, 2016), however, the deficienciesweren't available for review until June 10, 2016. Q100 – **416.44** – ENVIRONMENT As presented in our POC for our May 31, 2016 LSC submitted on June 24, 2016: Our current Fire Protection Company does not offer fire damper inspection. We have received a quote (Attachment D) for fire damper inspection and maintenance. Due to the price of this quote, our Chief Engineer will be asking other companies to bid on this service request. The fire dampers will be inspected prior to August 31, 2016, which would be 90 days from the surveyor's exit conference. The Director is responsible for assuring that this inspection is completed and properly documented. The Director will also be responsible for future compliance of fire damper testing within at least every four years.	08/31/2016

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	lighting in 3 of 3 operating rooms where general anesthesia or life support equipment is used (see K 105) and failed to ensure other tenants and occupancies were separated by fire barriers with at least a one hour fire resistance rating (see K 114). The cumulative effect of these systemic problems resulted in the center's inability to ensure that all locations from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.		Our Chief Engineer was unavailable to respond to the surveyor's questions regarding emergency lighting during part of the facility tour. Each of our 3 Operating Rooms are equipped with battery-powered emergency lighting units within each bank of lights (Attachment E & F). During the tour, the Director didn't realize that the test button was beneath the plastic cover (Attachment G & H). Our battery-powered emergency lighting units were tested by our Chief Engineer on June 20, 2016. Going forward, our Chief Engineer will inspect, maintain, and document findings for these emergency lighting units on a monthly basis. The Director is responsible for assuring that monthly inspections/ maintenance occurs and is properly documented. We discussed the deficiency of the non-rated, glass doors of the main entrance with the door manufacturer and building architects. They pointed out that the installation of a "Water Curtain" in the patient/ family waiting room was approved by the State Fire Marshall's Office prior to construction, as evidence by the attached documents (Attachment I, J, K). With regards to the gaps and positive latch deficiencies, we have received details from the glass manufacturer (Attachment L, M) and will be moving forward with the proposed additions. Edge	

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			weathering will be installed to close the gaps around the glass doors and a positive latch device will be added to meet code requirements. This installation will be completed within 90 days for the surveyor's exit conference before August 31, 2016. The Director is responsible for assuring that this installation is properly completed. These deficiencies will be studied by the QAPI committee until compliance on an ongoing basis has been satisfied.	
Q 0101 Bldg. 00	416.44(a)(1) PHYSICIAL 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 document review, observation and interview, it was determined that the facility failed to ensure documentation to assure 100% of fire dampers in the facility were inspected and provided necessary maintenance at least every four years, failed to provide emergency lighting in 3 of 3 operating rooms where general anesthesia or life support equipment is used and failed to ensure other tenants and occupancies were separated by fire barriers with at least a	Q 0101	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 31, 2016), however, the deficiencies weren't available for review until June 10, 2016. Q101 – **416.44(a)(1)** – PHYSICAL ENVIRONMENT As presented in our POC for our May 31, 2016 LSC submitted on June 24, 2016: Our current Fire Protection Company does not offer fire damper inspection. We have received a quote (Attachment D) for fire damper	08/31/2016

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	one hour fire resistance rating. Findings include: 1. Record review with the Chief Engineer and the Director from 9:20 a.m. to 12:00 p.m. on 05/31/16 indicated fire damper inspection and maintenance documentation within the most recent four year period was not available for review. 2. Observation with the Chief Engineer and the Director during a tour of the facility from 12:00 p.m. to 1:45 p.m. on 05/31/16 noted one fire damper was installed in HVAC ductwork above the suspended ceiling above the patient discharge exit door by the Consultation Room. 3. In interview at the time of record review and observation, the Chief Engineer stated fire dampers are installed throughout the facility and acknowledged fire damper inspection and maintenance documentation within the most recent four year period was not available for review. 4. Record review with the Chief Engineer and the Director from 9:20 a.m. to 12:00 p.m. on 05/31/16 indicated documentation of operating room battery		inspection and maintenance. Due to the price of this quote, our Chief Engineer will be asking other companies to bid on this service request. The fire dampers will be inspected prior to August 31, 2016, which would be 90 days from the surveyor's exit conference. The Director is responsible for assuring that this inspection is completed and properly documented. The Director will also be responsible for future compliance of fire damper testing within at least every four years. Our Chief Engineer was unavailable to respond to the surveyor's questions regarding emergency lighting during part of the facility tour. Each of our 3 Operating Rooms are equipped with battery-powered emergency lighting units within each bank of lights (Attachment E & F). During the tour, the Director didn't realize that the test button was beneath the plastic cover (Attachment G & H). Our battery-powered emergency lighting units were tested by our Chief Engineer on June 20, 2016. Going forward, our Chief Engineer will inspect, maintain, and document findings for these emergency lighting units on a monthly basis. The Director is responsible for assuring that monthly inspections/ maintenance occurs and is properly documented. We discussed the deficiency of the non-rated, glass doors of the main entrance with	

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	operated lighting systems monthly and annually functional testing in the most recent twelve month period was not available for review. 5. In interview at the time of record review, the Director stated the facility has three operating rooms where general anesthesia is used and battery operated lighting systems are not installed in each of the three operating rooms. 6. Observation with the Director at 12:00 p.m. on 05/23/16 noted battery operated emergency lighting systems were not installed in each of three operating rooms where general anesthesia is used. 7. In interview at the time of the observations, the Director stated patients in each of the three operating rooms can be completely sedated and rendered immobile using general anesthesia, an emergency generator is utilized to provide emergency lighting for the facility but acknowledged battery operated emergency lighting systems were not installed in the three operating rooms to provide continuous illumination. 8. Observation with the Chief Engineer and the Director during a tour of the facility from 12:00 p.m. to 1:45 p.m. on		the door manufacturer and building architects. They pointed out that the installation of a "Water Curtain" in the patient/ family waiting room was approved by the State Fire Marshall's Office prior to construction, as evidence by the attached documents (Attachment I, J, K). With regards to the gaps and positive latch deficiencies, we have received details from the glass manufacturer (Attachment L, M) and will be moving forward with the proposed additions. Edge weathering will be installed to close the gaps around the glass doors and a positive latch device will be added to meet code requirements. This installation will be completed within 90 days for the surveyor's exit conference before August 31, 2016. The Director is responsible for assuring that this installation is properly completed. These deficiencies will be studied by the QAPI committee until compliance on an ongoing basis has been satisfied.	

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	05/31/16 noted the following in the tenant separation smoke barrier wall at the main entrance to the patient waiting room from the main lobby of the building: a. the set of main entrance doors were nonrated glass doors which each measured four feet wide by eight feet high. b. each door in the main entrance door set was provided with a locking device which was 'dogged down' to allow patient and visitor access during normal operating hours. The locking devices would not enable positive latching of the door set if left in the unlocked position. c. a one inch gap was noted in between the meeting edges of the door set on the handle side and on each side of door set on the hinge side. Neither the glass doors nor the gaps maintained the fire resistance rating of the smoke barrier wall. 9. In interview at the time of the observations, the Chief Engineer and the Director stated the fire resistance rating of the glass door set might be available but acknowledged the aforementioned door set in the tenant separation wall was not fire rated, was not equipped with a positive latching device and gaps in the door set did not maintain the fire resistance rating of the smoke barrier			

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	wall.			
Q 0181 Bldg. 00	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on document review and interview, the facility failed to ensure the implementation of its policy related to patient pain level documentation and follow up documentation to the administration of pain medications for 4 of 18 patients, Pts. #1, 3, 17 and 18; and failed to ensure the implementation of its policy related to following physician orders for 1 of 2 patients of physician #54, Pt. #10. Findings Include: 1. Review of the policy Pain Evaluation, policy number 5.242, last approved 10/1/14, indicated on page two under Procedure: The patient will undergo reassessment of pain at least once per shift and after every pain control mechanism employed by patient care providers...Any patient care provider, from any department, that has implemented a pain control mechanism	O 0181	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q181 – **416.48(a)** – ADMINISTRATION OF DRUGS Policy 5.242 "Pain Evaluation" and Policy 6.02 "Standing Orders" will be reviewed with staff at the next Staff Meeting scheduled July 8, 2016. We will be discussing the importance of following our policies and procedures, but specifically those policies and procedures regarding pain evaluation and following standing orders. Our Medical Director has updated the Outpatient Anesthesia PACU Orders with timeframes for administration. We will also be discussing the use of the Recovery Room Record for proper documentation of pain assessment and reassessment. Going forward, it	07/28/2016

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	will reassess the patient within one-half (1/2) hour to determine amount of pain control or relief achieved. 2. Review of patient medical records indicated: A. On 3/10/16, Pt. #1 had: a. An order on the "Outpatient Anesthesia PACU (post anesthesia care unit) Orders" form for Oxycodone 5 mg 1 - 3 tabs P.O. (orally) with no indication of a time frame between tablets, or a limit as to the number of tablets that can be given for a total amount of Oxycodone. b. Oxycodone 10 mg given orally at 1645 hours, with no notation of a pain level. c. No follow up pain assessment done until 1730 hours. d. A second 10 mg dosage of Oxycodone given at 2030 hours at the time of discharge. B. On 12/22/15, Pt. #3 had: a. An order on the "Outpatient Anesthesia PACU Orders" form for Oxycodone 5 mg 1 - 2 tabs P.O. with no indication of a time frame between tablets, or a limit as to the number of tablets that can be given for a total amount of Oxycodone. b. Oxycodone 10 mg given at 1530 hours with documentation of: feels some pain L (left) lower abd (abdomen), with no pain level noted.		is the responsibility of the Director to maintain compliance with NMSC's Policies and implementing corrective action for noncompliance. PACU Staff's compliance of documenting Pain Evaluations will be added to our QAPI Program as our next QAPI Study until compliance on an ongoing basis has been satisfied.	

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	c. No follow up pain assessment documented. C. On 4/8/16, Pt. #17 had: a. Morphine 2 mg given IV (intravenous) at 0820 hours, 0825 hours, 0833 hours, 0847 hours and 0852 hours. b. Documentation at 0820 hours: c/o (complaining of) operative pain; at 0835 hours: c/o neck pain; and at 0850 hours: c/o pain (no pain levels noted to indicate whether pain continued at a same level, or at some point decreased in intensity). D. On 4/8/16, Pt. #18 had: a. Oxycodone 5 mg given at 1410 hours with no follow up pain reassessment noted prior to discharge at 1516 hours. 3. Review of the policy Standing Orders, policy number 6.01, last approved 10/1/14, indicated under "Function", Standing orders, when properly utilized, serve as a convenient means for the physician/surgeon to completely and accurately communicate and document his/her orders for patient care and treatment to nursing personnel. Practice and Procedures...2. All standing orders shall contain the following information:...Specific detailed instruction that do not require interpretation. 4. Review of patient medical records			

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	indicated that patient #10 had: A. Orders on the "Outpatient Anesthesia PACU Orders" form for Morphine 1 - 2 mg every 2 - 5 minutes up to 20 mg and Valium 1 - 2 mg IV every 15 minutes up to 10 mg. B. Documentation that Morphine 3 mg was given IV at 1315 on 12/1/15. C. Documentation that Valium 2.5 mg was given IV at 1347 hours on 12/1/15. 5. At 4:15 PM on 5/10/16 and 2:30 PM on 5/11/16, interview with the center director, staff member #54, confirmed that: A. Physician post op orders on the "Outpatient Anesthesia PACU Orders" form do not give nursing staff clear direction for a limit in the amount/dosage of Oxycodone or a time frame, such as every 4 to 6 hours, thus the physicians are not giving "detailed instruction that do not require interpretation", as per standing orders policy requirements. B. Patient #10 had 3 mg Morphine and 2.5 mg Valium documented in the medical as having been administered, but with orders only for 1 to 2 mg Morphine and 2 mg of Valium.			
Q 0182	416.48(a)(1)			

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Bldg. 00	ADMINISTRATION - ADVERSE REACTIONS Adverse reactions must be reported to the physician responsible for the patient and must be documented in the record. Based on interview, the center failed to ensure policies & procedures that addressed reporting adverse medication reactions to the responsible practitioner and document in the medical record for 1 facility. Findings include: 1. On 5-9-16 at 1030 hours, the director, staff A1, was requested to provide a policy/procedure for adverse medication responses and no documentation was received prior to exit. 2. During an interview on 5-11-16 at 1230 hours, the director, staff A1, confirmed that the center lacked a policy/procedure requirement for reporting all adverse medication responses to the responsible physician and documenting in the MR.	Q 0182	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q182 – **416.48(a)(1)** – ADMINISTRATION – ADVERSE REACTIONS Policy 8.01 – "Pharmacy Services" was updated and will be presented to the Governing Body for approval during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. Previous verbiage "Any medication errors or drug reactions shall be reported immediately to the physician ordering the drugs. The RN shall also identify this matter on the chart with her full name or full initials. An Incident Report shall be completed and given to the Director" was updated to "All medication errors or adverse reactions to medications will be documented in the patient's record, reported to the physician, and an incident report will be completed." This information will also be discussed with staff at the next Staff Meeting scheduled July 8, 2016. This information will also be reviewed with Medical Staff at the next medical Staff	07/28/2016

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			Meeting/ Governing Board Meeting on July 28, 2016 as part of the QAPI Program. Going forward, it is the responsibility of the Director to maintain compliance with NMSC's Policies and implement corrective action for noncompliance.. This will be added into our Medical Record review, as well as the QAPI Program for evidence of compliance quarterly for the next 12 months.	
Q 0204 Bldg. 00	416.49(b)(2) RADIOLOGIC SERVICES (2) If radiologic services are utilized, the governing body must appoint an individual qualified in accordance with State law and ASC policies who is responsible for assuring all radiologic services are provided in accordance with the requirements of this section. Based upon document review and interview, the center failed to ensure that its radiology services were supervised by a qualified professional appointed to the medical staff in accordance with State law. Findings include: 1. Indiana Administrative Code 410 IAC 15-2.5-8(c)(1) indicated the following: Radiology services must be supervised by a radiologist or radiation oncologist. 2. On 5-10-16 at 1630 hours, the	O 0204	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q204 – **416.49(b)(2)** – RADIOGRAPHIC SERVICES The Director will be requesting approval from the Governing Body to appoint Kevin Macadaeg, MD to oversee NMSC's Radiologic Services during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. Dr. Macadaeg has maintained privileges at NMSC	07/28/2016

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	director, staff A1, was requested to provide documentation indicating that the center radiologic services were supervised by a qualified individual appointed to the medical staff by the governing board and none was received prior to exit. 3. During an interview on 5-11-16 at 1240 hours, the director, staff A1, confirmed that a medical physicist has been performing an annual review of the radiologic services provided at the center and confirmed that the radiologic services lacked documentation of supervision by a qualified medical staff professional.		since 1996. He has been Board Certified in Anesthesia/ Pain Management since 1993. With his qualifications and experience, the Director feels that Dr. Macadaeg has appropriate qualifications to provide oversight for NMSC's Radiologic Services. Dr. Macadaeg will have a strong team to support him, including NMSC's Radiation Safety Liaison and Lamaster Radiation Consulting. The Director is responsible for assuring compliance.	
Q 0225 Bldg. 00	416.50(d)(4),(5), & (6) SUBMISSION AND INVESTIGATION OF GRIEVANCES 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. The following criteria must be met: (1) The grievance process must specify timeframes for review of the grievance and the provisions of a response. (2) The ASC, in responding to the grievance, must investigate all grievances made by a patient, the patient's representative, or the patient's surrogate regarding treatment or			

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	care that is (or fails to be) furnished. (3) The ASC must document how the grievance was addressed, as well as provide the patient, the patient's representative, or the patient's surrogate 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 result of the grievance process and the date the grievance process was completed. Based on document review and interview, the grievance policy/procedures failed to establish when a complaint made to the center will be regarded as a grievance, failed to indicate the timeframes for conducting the grievance investigation, determination, and providing a written response to the patient or patient's representative, and failed to ensure the notice of the decision included the name of a center contact person, the steps taken to investigate, the results, and the date the grievance process was completed. Findings include: 1. The policy/procedure titled Policy And Procedure For Patient Grievance Or Complaint (approved 10-14) indicated the following: "The complainant may express the concern to nursing staff, business staff or manager - verbally, by phone, or in writing within 30 days of the event precipitating the complaint... A	O 0225	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q225 – **416.50(d)(4),(5) &(6)** – SUBMISSION AND INVESTIGATION OF GRIEVANCES Policy 1.18 – "Grievance Reporting" (Attachment T) was updated and will be presented to the Governing Body for approval during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. This information will also be discussed with staff at the next Staff Meeting scheduled July 8, 2016. The Director is responsible for maintaining compliance with NMSC's Policies and compliance with investigating and reporting according to the situation.	07/28/2016

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	complaint or concern from a patient will be handled as discussed in the policy titled Grievance Reporting. See Risk Management Policy for timeframes for review and provisions of a response." 2. Review of the policy/procedures titled Grievance Reporting (approved 10-14) and Risk Management Program (approved 10-14) failed to indicate when a complaint will be considered a grievance, the timeframes for investigation and review of a grievance, or the provisions of a written response including the name of a contact person at the center, the steps taken to investigate the grievance, the results, and the date the grievance process was completed. 3. During an interview on 5-10-15 at 1020 hours, the director, staff A1 confirmed that the policy/procedures failed to indicate when a complaint will be regarded as a grievance including the timeframes for investigation and review and failed to indicate the required elements for the written notice of determination.			
Q 0226 Bldg. 00	416.50(d)(1), (2), & (3) GRIEVANCES - MISTREATMENT, ABUSE .... The following criteria must be met: (1) All alleged violations/grievances relating,			

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	but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented. (2) All allegations must be immediately reported to a person in authority in the ASC. Only substantiated allegations must be reported to the State authority or the local authority, or both. Based on document review and interview, the center failed to ensure that all allegations of abuse, neglect, or mistreatment which are determined to have occurred at the center will be reported to the State and/or a local authority. Findings include: 1. The policy/procedure Risk Management Program (approved 10-14) indicated the following: "All grievances... regarding, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse must be fully documented. All allegations must be immediately reported to a person on authority in the ASC. All grievances will be investigated promptly, reviewed by the QAPI (quality improvement and performance improvement) committee, [and] reported to the Board of Directors at the next scheduled meeting. Upon review and consideration action will be instigated." The policy statement failed	Q 0226	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q226 – **416.50(d)(1),(2) &(3)** – SUBMISSION AND INVESTIGATION OF GRIEVANCES Policy 1.18 – "Grievance Reporting" (Attachment T) was updated and will be presented to the Governing Body for approval during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. This information will also be discussed with staff at the next Staff Meeting scheduled July 8, 2016. The Director is responsible for maintaining compliance with NMSC's Policies and compliance with investigating and reporting according to the situation.	07/28/2016

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	to indicate all substantiated allegations must be reported to the State and/or authorities. 2. The policy/procedure Endangered Adult Reporting Policy (approved 10-14) failed to indicate a reporting requirement for substantiated allegations of patient abuse, neglect, or mistreatment that were determined to have occurred at the center. 3. During an interview on 5-10-16 at 1250 hours, the director, staff A1, confirmed that the policy/procedures lacked the indicated provisions and no other documentation was available.			
Q 0241 Bldg. 00	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. Based on document review, observation, and interview, the facility failed to ensure the cleanliness of the facility in accordance with current standards of practice for surgical facilities in relation to: the knowledge and education of contracted housekeeping staff, dust found on three ceiling air vents and in the soiled utility room, and failure to follow facility policy by surgery personnel for	Q 0241	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q241 – **416.51(a)** – SANITARY ENVIRONMENT The dust accumulation on the ceiling air exchange face plates in the women's changing room,	07/08/2016

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	end of day cleaning. Findings Include: 1. Review of the policy Housekeeping Services, policy number 11.01, last approved 10/1/14, indicated in the section Practices and Procedures: A. Contract service company shall be provided with appropriate procedural guides for cleaning all areas of the Center...H. (on page 5) Soiled Utility...7. Wipe down walls, ceiling & doors w/disinfectant...Monthly....Bathrooms (page 8)...12. Wipe down walls, ceiling & doors w/disinfectant...Monthly. 2. At 4:30 PM on 5/9/16, interview with housekeeper #52 confirmed that: A. It was unknown what was the kill/dwell time for the Virex disinfectant being utilized in the OR (operating room) suites. B. It was unknown how often the OR suite floors were to be stripped and buffed, it was assumed only when asked to do this by the center. C. It was unknown how often the walls and ceilings of the OR suites were to be disinfected/wiped down and when these had been done the last time. Staff member #52 stated "they don't ask us to do walls". D. This housekeeper stated that they had trained housekeeping staff member		patient bathroom, and the patient/ staff bathroom, as well as the angled cabinet tops in the soiled utility room was immediately removed or "dusted" on May 11, 2016 after the surveyor's exit conference. Due to some members of Housekeeping Leadership being on vacation this week, a meeting is scheduled for July 6th between the Director, Browning Investments, and GSF Housekeeping Company to discuss a plan of correction and future compliance. The Director will: · Review ISDH's findings/ deficiencies · Reeducate GSF Staff on proper procedures, included in NMSC's Policy 11.01 – "Housekeeping Services" (i.e. Chemical kill/ dwell time, clarification of proper procedure for walls, ceilings, floors, and the use of microfiber mop heads) · Reemphasize expectations for NMSC's physical environment · Reiterate that proper documentation (i.e. orientation documentation) for each GSF Employee is required to be kept onsite · Conduct random audits to verify that GSF Staff are compliant in following NMSC's Policy Policy 10.07 "Cleaning of Operating Rooms" will be reviewed with staff at the next Staff Meeting scheduled July 8, 2016. The Director will reeducate	

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	N11 at this facility. 3. Review of the "Terminal Cleaning Checklist" for housekeeping staff indicated in the section "Cleaning Task Description Daily" that on 5/9/16 and 5/10/16 that #1. was checked off, this reads: "1. Damp dust ceilings, AC (air conditioner) returns/vents...2. Walls, doors, wall panels, suction wall mounts...". The checklist was initialed by housekeeper N11 in the area "Task completed initials of person cleaning" with OR Room 1 and OR Room 2 checked off as having these tasks completed. 4. At 8:35 AM on 5/10/16, it was observed in the women's changing room that one of the ceiling air exchange face plates had an excessive accumulation of dust present on the louvers. 5. At 8:40 AM on 5/10/16, staff member #50, the center director, confirmed the accumulation of dust on the ceiling vent in the women's dressing room and confirmed that even with a monthly requirement to clean the ceilings/vents, the amount of dust present was more than a month's worth of accumulation. 6. At 1:15 PM on 5/10/16, it was observed that there was an excessive		OR Personnel about proper procedures for cleaning at the beginning of the day prior to the first procedure. It is the Director's responsibility to ensure compliance to CMS Condition 416.51(a) Sanitary Environment and ISDH Regulation 410 IAC 15-2.5-7 Physical Plant and implementing corrective action for noncompliance. This will be studied by the QAPI committee until compliance on an ongoing basis has been satisfied.	

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	accumulation of dust on the ceiling air exchange face plate in the patient bathroom beside pre/post op bay #1. 7. At 1:25 PM on 5/10/16, staff member #50, the center director, confirmed the accumulation of dust on the ceiling vent in the bathroom beside bay #1 and that even with a monthly requirement to clean the ceilings/vents, the amount of dust present was more than a month's worth of accumulation. 8. At 2:30 PM on 5/10/16, it was observed that there was an excessive accumulation of dust on the ceiling air exchange face plate in the patient/staff bathroom in the back hallway beside the consultation room. Staff member #50 was informed of the dusty vent. 9. At 10:25 AM on 5/11/16, while on tour of the facility in the company of staff member #50, it was observed in the soiled utility room that there was an accumulation of dust on the angled cabinet tops. 10. Review of the policy Housekeeping Services, policy number 11.01, last approved on 10/1/14, indicated under Practices and Procedures: A. Contract service company shall be provided with			

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	appropriate procedural guides for cleaning all areas of the Center...B. Director shall confirm with contract service that employees are instructed in proper procedures. 11. Review of the training manual provided by the contracted housekeeping company indicated: A. There was no documentation of training of staff member #52 to perform cleaning services within this facility. (Several cleaning staff documents were present in the binder, but there were none for #52.) B. Staff member #52 had reported they trained housekeeper N11. The file for N11 had no documentation of training by staff member #52. C. In the file for N11, the training statement: "I...have been trained on the GSF (Group Services France) USA, Inc. cleaning methodologies as described in the manual. I understand the importance of following these guidelines. If I have any questions I will contact my Supervisor". This was signed 12/10/15 and witnessed by a GSF main office "supervisor". D. The training manual instructs housekeepers to "rinse out a microfiber mop head from the bucket of disinfectant solution" (step #2 of Damp Mopping) and then to (step #8), "Place the soiled			

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	microfiber in the bucket and start again from step 2". 12. Review of the policy Daily Routine Of Operating Rooms, policy number 5.11, last approved 10/1/14, indicated on page two of the attachment "Closing Chores 5.111" that in the OR: "...Tables cleaned and cleared off" is a requirement daily. 13. Review of the policy Cleaning of Operating Rooms, policy number 10.07, last approved 10/1/14, indicated under Practices and Procedures: B. At the beginning of each day or prior to the first procedure, horizontal surfaces, OR/procedure room lights, OR/procedure room furniture will be damp-dusted sing a clean lint free cloth dampened with a facility-approved, Environmental Protection Agency (EPA)-registered disinfectant. 14. At 4:30 PM on 5/9/16, while on tour of OR suite #1 in the company of staff member #52, a housekeeper, it was observed that the OR back table had unopened surgical packs that were covered with a sheet and that the surgical table had linens placed on it both in preparation of the first surgical case for the next day.			

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	15. At 4:30 PM on 5/9/16, interview with staff member #52 confirmed that OR suite #1 was scheduled to be "high dusted" on this day. 16. Interview with staff member #50, the center director and infection control practitioner, at 11:40 AM on 5/10/16 and 11:45 AM and 12:25 PM on 5/11/16, confirmed that: A. There was no documented orientation to the center for housekeeper #52. B. The supervisor who signed off on the training of housekeeper N11 was a staff member of GSF who only works in their offices and has never been to the center or trained in the cleaning policies and processes of the center. C. Microfiber mop heads should not be double dipped in the cleaning solution, per standards of practice. D. There is a discrepancy in the facility policy requiring walls and ceilings to be washed monthly, the contracted cleaning company checklist stating they are cleaned daily, and housekeeping staff indicating they have never been asked to clean walls and ceilings, but checking off daily that this task was performed. E. There was no documentation indicating the contracted housekeeping company had been trained in the facility/center cleaning policies and			

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	expectations. F. The housekeeping staff needed re education in facility policies and expectations for cleaning the center. G. Per facility policy, the surgery staff are to be sure the surfaces and tables of the OR suites are cleared off for housekeeping terminal cleaning and for next day damp dusting/wiping prior to the first case of the day.			
Q 0242 Bldg. 00	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. Based on document review and interview the infection control committee failed to maintain an ongoing program for the monitoring of communicable disesases by failing to ensure the communicable disease history for Varicella, Rubella, and Rubeola for 4 of 8 employees, N4, N5, N6 and N8. Findings Include: 1. Review of the policy Employment Physical Examination, policy number 3.022, last approved on 10/1/14,	O 0242	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q242 – **416.51(b)** – INFECTION CONTROL PROGRAM Staff member N4, N5, N6 had appropriate titers drawn on 06/29/16. Staff member N8 had appropriate titers drawn on 06/30/16. When processed and received, these results will be	06/30/2016

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH MERIDIAN SURGERY CENTER	13225 N MERIDIAN STREET CARMEL, IN 46032

(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
	indicated under Practice: The pre-employment history and physical examination shall include the following:...Hepatitis B or a declination form signed - Rubella titer/Chicken Pox Form. 2 Review of employee files indicated: A. Staff member N4 had a self reported history of disease for Varicella that was not authenticated by a practitioner. B. Staff member N5 had no documentation of immunization for, immunity to, or practitioner statement of having had, Rubella and Rubeola. C. Staff member N6 lacked documentation of immunization for, immunity to, or practitioner statement of having had, Rubella. D. Staff member N8 had a self reported history of disease for Varicella that was not authenticated by a practitioner. 3. At 2:30 PM on 5/9/16, staff member #50, the center director, confirmed that N4 and N8 had only self reported history of disease for Varicella, N5 had no documentation for Rubella and Rubeola, and N6 lacked documentation related to Rubella.		added to each employee's file and any vaccination required will be administered according to policy. Going forward, the Director is now aware of employee immunization requirements and is responsible to verify that these requirements are met after new employees.	
Q 0245	416.51(b)(3) INFECTION CONTROL PROGRAM			

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	15C0001046		05/11/2016

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Bldg. 00	The program is - Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement. Based on interview the infection control practitioner/committee failed to create a policy related to the State Reportable Disease requirements. Findings Include: 1. At 4:15 PM on 5/10/16, interview with staff member #50, the center director and infection control practitioner, confirmed that the facility does not have a policy related to the State required reportable diseases.	O 0245	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q245 – **416.51(b)(3)** – INFECTION CONTROL PROGRAM Policy 10.25 – "Communicable Disease Reporting" (Attachment U) was created and will be submitted to the Governing Body for approval during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. This information will also be discussed with staff at the next Staff Meeting scheduled July 8, 2016. It is the Director's responsibility for assuring compliance.	07/28/2016
Q 0266 Bldg. 00	416.52(c)(2) DISCHARGE - ORDER [The ASC must -] Ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy. Based on document review and	Q 0266	The completion date for this	07/28/2016

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	interview, the facility failed to implement its policy related to the need for a transfer order by physician for 1 of 3 transfer patients, Pt. #4. Findings Include: 1. Review of the policy Patient Transfer to Another Healthcare Facility, policy number 5.19, last approved on 10/1/14, indicated under Practices and Procedures: Procedure: When the attending physician determines that a patient should be transferred to another facility, he/she shall confirm the decision in writing. In this event, the Director...is to be notified...and will in turn initiate the transfer process as follows: 1. Verify physician's orders...6. Attending physician will complete the Physicians Orders and Diagnosis on the form. 2. Review of patient medical records, for those who were transferred, indicated that Pt. #4 lacked a physician order for transfer for the transfer to a higher level of care on 10/16/15. 3. At 10:05 AM on 5/10/16, interview with staff member #50, the facility director, confirmed that there was no physician order for transfer that could be found in the medical record for patient #4, and that per facility policy, there should have been one.		deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. Q266 – **416.52(c)(2)** – DISCHARGE ORDER Policy 5.231 - "Discharge Criteria" will be reviewed with Medical Staff at the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016 and with staff at the next Staff Meeting scheduled July 8, 2016. The Director is responsible for compliance assuring that every patient has a discharge order written. This will be studied by the QAPI committee until compliance on an ongoing basis has been satisfied.	

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S 0000 Bldg. 00	The visit was for a licensure survey. Facility Number: 007125 Survey Date: 5-9/11-16 QA: cjl 05/24/16	S 0000		
S 0148 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c) (4) (c) The governing body shall do the following: (4) Require that the chief executive officer designate in writing an administrative officer to serve during his or her absence. Based on document review and interview, the facility failed to designate in writing the responsible person to be in charge when the chief executive officer (CEO) was absent or unavailable. Findings include: 1. The first amendment to the governing board bylaws (approved 10-14) indicated the following: "The Administrator/CEO of the Center and the Director of the Center may be the same person provided	S 0148	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S148 – **410 IAC 15-2.4-1(c)(4) –** GOVERNING GODY; POWERS AND DUTIES Policy 1.035 – "Chain of Command" (Attachment V) was created and will be submitted to	07/28/2016

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	that the individual is a registered nurse and meets the qualifications for either the CEO and/or the Director of the Center... If the Administrator/CEO is absent, an appropriate individual within the organization shall be designated as the individual in charge during the Administrator/CEO's absence." 2. The job description for the position of director indicated the following: "Designate Physician or Director to be responsible for Center operations for any period of absence from the Center." 3. On 5-9-16 at 1030 hours, the director, staff A1, was requested to provide a policy/procedure indicating who would be in charge in the event the director was absent of unavailable and no documentation was received prior to exit. 4. On 5-11-16 at 1100 hours, the director, staff A1, confirmed the governing board bylaws failed to designate who would be in charge when the director was not present and no other documentation was available.		the Governing Body for approval during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. This information will also be discussed with staff at the next Staff Meeting scheduled July 8, 2016. The Director is responsible for educating staff and physicians about this policy, as well as compliance of the chain of command.	
S 0156 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E) Require that the chief executive officer develop and implement policies			

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	and programs for the following: (E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on document review and interview, the chief executive officer failed to ensure that performance evaluations were completed per facility policy for 1 of 2 CSTs (certified surgical techs), staff member N6, and 2 of 2 radiology techs, N7 and N8. Findings Include: 1. Review of the policy Performance Evaluation, policy number 3.026, last approved 10/1/14, indicated in the "Policy" section: All employees of the Center will receive performance evaluations and formal performance reviews on an annual basis following the anniversary date of hire. 2. Review of employee files indicated: A. Staff member N6, a CST hired 6/28/13, had a most recent performance evaluation dated 9/14 in the file. B. Staff member N7, a radiology tech hired 7/16/08, had a most recent	S 0156	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S156 – **410 IAC 15-2.4-1(c)(5)(E)** – GOVERNING GODY; POWERS AND DUTIES Staff members N6, N7, and N8 received a performance evaluation per Policy 3.026 – "Performance Evaluation" on June 29, 2016. These evaluations will be added to each employee's file. Going forward, the Director is responsible to maintain compliance with NMSC Policies and provide future evaluations for employees in the appropriate timeframe.	06/29/2016

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	performance evaluation dated 9/14 in the file. C. Staff member N8, a radiology tech hired 1/1/02, had a most recent performance evaluation dated 9/14 in the file. 3. At 2:30 PM on 5/9/16, interview with staff member #50, the center director, confirmed that performance evaluations for staff members N6, N7, and N8 were delinquent and were not completed annually, as required per facility policy.			
S 0226 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3) 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: (3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided. Based on document review and interview, the center failed to maintain a list of all contracted services, including the scope and nature of services provided, for 3 of 21 contracted services (medical physicist, medical transcription, and radiation exposure monitoring).	S 0226	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S226 – **410 IAC 15-2.4-1(e)(3)** – GOVERNING GODY; POWERS	07/28/2016

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	Findings include: 1. Review of a list of 18 contracted services provided on 5-9-16 at 1300 hours by the director, staff A1, failed to indicate the name of a medical physicist, a medical transcription service, or a radiation badge monitoring service. 2. Review of center documentation indicated the following: a medical physicist (CS19) provided periodic medical physicist services, medical transcription was provided by CS20, and radiation badge exposure monitoring was provided by CS21 at the center. 3. On 5-11-16 at 1245 hours, the director, staff A1, confirmed that the list of contracted services had not been maintained.		AND DUTIES Lamaster Radiation Services, Landauer Occupational Radiation Monitoring, and Transcription Connection, Inc. have been added to the QAPI Program. The Director reviewed and evaluated these three services on June 24, 2016 (Attachment A, B, and C). These evaluations, as well as a current Contracted Vendor List, will be presented to the Governing Body during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. The Governing Body will then be updated throughout the year regarding the status of these services. The Director is responsible for making sure this evaluation process is done on an on-going basis and documented annually. This will be studied by the QAPI committee until compliance on an ongoing basis has been satisfied.	
S 0310 Bldg. 00	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 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			

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	furnished by a contractor. Based on document review and interview, the center failed to ensure that all services performed under contract were evaluated by the Quality Assurance and Performance Improvement (QAPI) program for 2 of 21 contracted services (medical transcription and radiation exposure monitoring). Findings include: 1. The policy/procedure Quality Assurance & Performance Improvement (QAPI) Program (approved 10-14) indicated that all contracted services would be monitored and reviewed through the QA&I program. 2. Review of QAPI committee documentation dated 1-26-15, 5-06-15, 7-29-15, 10-28-15, 1-27-16 and 4-27-16 failed to indicate that 2 contracted services (medical transcription by CS20 and radiation badge exposure monitoring by CS21) had been evaluated or reviewed by the QAPI program. 3. On 5-10-16 at 1540 hours, the director, staff A1, confirmed that the QAPI documentation failed to indicate the 2 contracted services had been evaluated in 2015 or 2016.	S 0310	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016.S310 – **410 IAC 15-2.4-2(a)(1)** – QUALITY ASSESSMENT AND IMPROVEMENT Lamaster Radiation Services, Landauer Occupational Radiation Monitoring, and Transcription Connection, Inc. have been added to the QAPI Program. The Director reviewed and evaluated these three services on June 24, 2016 (Attachment A, B, and C). These evaluations, as well as a current Contracted Vendor List, will be presented to the Governing Body during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. The Governing Body will then be updated throughout the year regarding the status of these services. The Director is responsible for making sure this evaluation process is done on an on-going basis and documented annually. This will be studied by the QAPI committee until compliance on an ongoing basis has been satisfied.	07/28/2016

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S 0442 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii) The infection control committee responsibilities must include, but are not limited to: (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: (viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies. Based on document review and interview, the infection control committee failed to ensure the communicable disease history for Varicella, Rubella, and Rubeola for 4 of 8 employees, N4, N5, N6 and N8. Findings Include: 1. Review of the policy Employment Physical Examination, policy number 3.022, last approved on 10/1/14, indicated under Practice: The pre-employment history and physical examination shall include the following:...Hepatitis B or a declination form signed - Rubella titer/Chicken Pox Form.	S 0442	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S442 – **410 IAC 15-2.5-1(f)(2)(E)(viii)** – INFECTION CONTROL PROGRAM Staff member N4, N5, N6 had appropriate titers drawn on 06/29/16. Staff member N8 had appropriate titers drawn on 06/30/16. When processed and received, these results will be added to each employee's file and any vaccination required will be administered according to policy. Going forward, the Director is now aware of employee immunization requirements and is responsible	06/30/2016

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	2 Review of employee files indicated: A. Staff member N4 had a self reported history of disease for Varicella that was not authenticated by a practitioner. B. Staff member N5 had no documentation of immunization for, immunity to, or practitioner statement of having had, Rubella and Rubeola. C. Staff member N6 lacked documentation of immunization for, immunity to, or practitioner statement of having had, Rubella. D. Staff member N8 had a self reported history of disease for Varicella that was not authenticated by a practitioner. 3. At 2:30 PM on 5/9/16, staff member #50, the center director, confirmed that N4 and N8 had only self reported history of disease for Varicella, N5 had no documentation for Rubella and Rubeola, and N6 lacked documentation related to Rubella.		to verify that these requirements are met after new employees.	
S 0742 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(C) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (C) A provision for maintaining records of all meetings of the medical			

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	staff and its committees. Based on document review and interview, the center failed to maintain documentation of quarterly medical staff meetings. Findings include: 1. The Medical Staff Bylaws (approved 10-14) indicated the following: "Regular meetings of the medical staff shall be held quarterly... Minutes of all meetings shall be taken and prepared by the Administrator and shall include a record of attendance and the vote taken on each matter... Copies of such minutes... shall be forwarded to the governing body... A permanent file of the minutes of all medical staff meetings shall be maintained by the Administrator." 2. On 5-9-16 at 1030 hours, the director, staff A1, was requested to provide documentation of medical staff meetings and none was provided prior to exit. 3. Review of quarterly meeting documentation titled Professional Staff & Board of Director's Meeting Minutes dated 1-26-15, 5-06-15, 7-29-15, 10-28-15, 1-27-16 and 4-27-16 failed to indicate a section, chapter heading, or meeting times that distinguished the medical staff meeting activity from the	S 0742	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S742 – **410 IAC 15-2.5-4(b)(3)(C)** – MEDICAL STAFF; ANESTHESIA AND SURGICAL An update to Policy 2.01 – "Medical Staff By-Laws" will be proposed to the Medical Staff and Governing Board for approval at our next Meeting/ Governing Board Meeting on July 28, 2016 to reflect our current activity of a Committee as a Whole. On a quarterly basis, Medical Staff (which includes Committee Members of the Credentials Committee, Quality Assurance Performance Improvement, and Infection Control Committee) meet jointly with the Governing Board as a Committee as a Whole. Further verbiage will be proposed that follow up actions, feedback, or recommendations discussed by the Medical Staff will be immediately available for the Governing Body to consider or discuss. The Medical Staff and Governing Board of North Meridian Surgery Center feel this is the most effective way to communicate by having all parties involved in one meeting together. It is the Director's responsibility to adequately document the quarterly meetings in an	07/28/2016

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	governing board meeting activity. 4. On 5-9-16 at 1545 hours, the director, staff A1, confirmed the Center failed to maintain documentation of its medical staff meetings and no other documentation was available.		organized manner with clear, separated minutes for each committee.	
S 0920 Bldg. 00	410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b) (b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following: Based on document review and interview the facility failed to ensure the implementation of its policy related to patient pain level documentation and follow up documentation to the administration of pain medications for 4 of 18 patients, Pts. #1, 3, 17 and 18; and failed to ensure the implementation of its policy related to following physician orders for 1 of 2 patients of physician #54, Pt. #10. Findings Include: 1. Review of the policy Pain Evaluation, policy number 5.242, last approved 10/1/14, indicated on page two under Procedure: The patient will undergo reassessment of pain at least once per shift and after every pain control	S 0920	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S920 – **410 IAC 15-2.5-5(b) –** PATIENT CARE SERVICES Policy 5.242 "Pain Evaluation" and Policy 6.02 "Standing Orders" will be reviewed with staff at the next Staff Meeting scheduled July 8, 2016. We will be discussing the importance of following our policies and procedures, but specifically those policies and procedures regarding pain evaluation and following standing orders. Our Medical Director has updated the Outpatient Anesthesia PACU Orders with timeframes for administration.	07/28/2016

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	mechanism employed by patient care providers...Any patient care provider, from any deportment, that has implemented a pain control mechanism will reassess the patient within one-half (1/2) hour to determine amount of pain control or relief achieved. 2. Review of patient medical records indicated: A. On 3/10/16, Pt. #1 had: a. An order on the "Outpatient Anesthesia PACU (post anesthesia care unit) Orders" form for Oxycodone 5 mg 1 - 3 tabs P.O. (orally) with no indication of a time frame between tablets, or a limit as to the number of tablets that can be given for a total amount of Oxycodone. b. Oxycodone 10 mg given orally at 1645 hours, with no notation of a pain level. c. No follow up pain assessment done until 1730 hours. d. A second 10 mg dosage of Oxycodone given at 2030 hours at the time of discharge. B. On 12/22/15, Pt. #3 had: a. An order on the "Outpatient Anesthesia PACU Orders" form for Oxycodone 5 mg 1 - 2 tabs P.O. with no indication of a time frame between tablets, or a limit as to the number of tablets that can be given for a total amount of Oxycodone.		We will also be discussing the use of the Recovery Room Record for proper documentation of pain assessment and reassessment. Going forward, it is the responsibility of the Director to maintain compliance with NMSC's Policies and implementing corrective action for noncompliance. PACU Staff's compliance of documenting Pain Evaluations will be added to our QAPI Program as our next QAPI Study until compliance on an ongoing basis has been satisfied.	

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	b. Oxycodone 10 mg given at 1530 hours with documentation of: feels some pain L (left) lower abd (abdomen), with no pain level noted. c. No follow up pain assessment documented. C. On 4/8/16, Pt. #17 had: a. Morphine 2 mg given IV (intravenous) at 0820 hours, 0825 hours, 0833 hours, 0847 hours and 0852 hours. b. Documentation at 0820 hours: c/o (complaining of) operative pain; at 0835 hours: c/o neck pain; and at 0850 hours: c/o pain (no pain levels noted to indicate whether pain continued at a same level, or at some point decreased in intensity). D. On 4/8/16, Pt. #18 had: a. Oxycodone 5 mg given at 1410 hours with no follow up pain reassessment noted prior to discharge at 1516 hours. 3. Review of the policy Standing Orders, policy number 6.01, last approved 10/1/14, indicated under "Function", Standing orders, when properly utilized, serve as a convenient means for the physician/surgeon to completely and accurately communicate and document his/her orders for patient care and treatment to nursing personnel. Practice and Procedures...2. All standing orders shall contain the following information:...Specific detailed			

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	instruction that do not require interpretation. 4. Review of patient medical records indicated that patient #10 had: A. Orders on the "Outpatient Anesthesia PACU Orders" form for Morphine 1 - 2 mg every 2 - 5 minutes up to 20 mg and Valium 1 - 2 mg IV every 15 minutes up to 10 mg. B. Documentation that Morphine 3 mg was given IV at 1315 on 12/1/15. C. Documentation that Valium 2.5 mg was given IV at 1347 hours on 12/1/15. 5. At 4:15 PM on 5/10/16 and 2:30 PM on 5/11/16, interview with the center director, staff member #54, confirmed that: A. Physician post op orders on the "Outpatient Anesthesia PACU Orders" form do not give nursing staff clear direction for a limit in the amount/dosage of Oxycodone or a time frame, such as every 4 to 6 hours, thus the physicians are not giving "detailed instruction that do not require interpretation", as per standing orders policy requirements. B. Patient #10 had 3 mg Morphine and 2.5 mg Valium documented in the medical as having been administered, but with orders only for 1 to 2 mg Morphine and 2 mg of Valium.			

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S 1020 Bldg. 00	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(D) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (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. Based on document review and interview, the center failed to ensure that all adverse medication reactions and medication errors would be reported to the responsible practitioner and documented in the medical record (MR). Findings include: 1. On 5-9-16 at 1030 hours, the director, staff A1, was requested to provide a policy/procedure for medication errors and adverse medication responses and no documentation was received prior to exit. 2. During an interview on 5-11-16 at 1230 hours, the director, staff A1,	S 1020	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S1020 – **410 IAC 15-2.5-6(3)(D) –** PHARMACEUTICAL SERVICES Policy 8.01 – "Pharmacy Services" was updated and will be presented to the Governing Body for approval during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. Previous verbiage "Any medication errors or drug reactions shall be reported	07/28/2016

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	confirmed that the center lacked a policy/procedure requirement for reporting all medication errors and adverse medication responses to the responsible physician and documenting in the MR.		immediately to the physician ordering the drugs. The RN shall also identify this matter on the chart with her full name or full initials. An Incident Report shall be completed and given to the Director" was updated to "All medication errors or adverse reactions to medications will be documented in the patient's record, reported to the physician, and an incident report will be completed." This information will also be discussed with staff at the next Staff Meeting scheduled July 8, 2016. This information will also be reviewed with Medical Staff at the next medical Staff Meeting/ Governing Board Meeting on July 28, 2016 as part of the QAPI Program. Going forward, it is the responsibility of the Director to maintain compliance with NMSC's Policies and implement corrective action for noncompliance.. This will be added into our Medical Record review, as well as the QAPI Program for evidence of compliance quarterly for the next 12 months.	
S 1174 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(A) (b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the			

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	safety and well-being of patients are assured as follows: (5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: (A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice. Based on document review, observation and interview, the facility failed to ensure the cleanliness of the facility in accordance with current standards of practice for surgical facilities in relation to dust found on three ceiling air vents and in the soiled utility room. Findings Include: 1. Review of the policy Housekeeping Services, policy number 11.01, last approved 10/1/14, indicated in the section Practices and Procedures: A. Contract service company shall be provided with appropriate procedural guides for cleaning all areas of the Center...H. (on page 5) Soiled Utility...7. Wipe down walls, ceiling & doors	S 1174	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S1174 – **410 IAC 15-2.5-7(b)(5)(A) –** PHYSICAL PLANT, EQUIPMENT MAINTENANCE The dust accumulation on the ceiling air exchange face plates in the women's changing room, patient bathroom, and the patient/ staff bathroom, as well as the angled cabinet tops in the soiled utility room was immediately removed or "dusted" on May 11, 2016 after the surveyor's exit conference. Due to some members of Housekeeping Leadership being on vacation this	07/08/2016

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	w/disinfectant...Monthly....Bathrooms (page 8)...12. Wipe down walls, ceiling & doors w/disinfectant...Monthly. 2. At 8:35 AM on 5/10/16, it was observed in the women's changing room that one of the ceiling air exchange face plates had an excessive accumulation of dust present on the louvers. 3. At 8:40 AM on 5/10/16, staff member #50, the center director, confirmed the accumulation of dust on the ceiling vent in the women's dressing room and confirmed that even with a monthly requirement to clean the ceilings/vents, the amount of dust present was more than a month's worth of accumulation. 4. At 1:15 PM on 5/10/16, it was observed that there was an excessive accumulation of dust on the ceiling air exchange face plate in the patient bathroom beside pre/post op bay #1. 5. At 1:25 PM on 5/10/16, staff member #50, the center director, confirmed the accumulation of dust on the ceiling vent in the bathroom beside bay #1 and that even with a monthly requirement to clean the ceilings/vents, the amount of dust present was more than a month's worth of accumulation.		week, a meeting is scheduled for July 6th between the Director, Browning Investments, and GSF Housekeeping Company to discuss a plan of correction and future compliance. The Director will: · Review ISDH's findings/ deficiencies · Reeducate GSF Staff on proper procedures, included in NMSC's Policy 11.01 – "Housekeeping Services" (i.e. Chemical kill/ dwell time, clarification of proper procedure for walls, ceilings, floors, and the use of microfiber mop heads) · Reemphasize expectations for NMSC's physical environment · Reiterate that proper documentation (i.e. orientation documentation) for each GSF Employee is required to be kept onsite · Conduct random audits to verify that GSF Staff are compliant in following NMSC's Policy Policy 10.07 "Cleaning of Operating Rooms" will be reviewed with staff at the next Staff Meeting scheduled July 8, 2016. The Director will reeducate OR Personnel about proper procedures for cleaning at the beginning of the day prior to the first procedure. It is the Director's responsibility to ensure compliance to CMS Condition 416.51(a) Sanitary Environment and ISDH Regulation 410 IAC 15-2.5-7 Physical Plant and	

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	6. At 2:30 PM on 5/10/16, it was observed that there was an excessive accumulation of dust on the ceiling air exchange face plate in the patient/staff bathroom in the back hallway beside the consultation room. Staff member #50 was informed of the dusty vent. 7. At 10:25 AM on 5/11/16, while on tour of the facility in the company of staff member #50, it was observed in the soiled utility room that there was an accumulation of dust on the angled cabinet tops. 8. Interview with staff member #50 at 11:45 AM on 5/10/16 confirmed that the housekeeping staff needed re education in facility policies and expectations for cleaning the center.		implementing corrective action for noncompliance. This will be studied by the QAPI committee until compliance on an ongoing basis has been satisfied.	
S 1180 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(1) (c) A safety management program must include, but not be limited to, the following: (1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.			

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	Based on document review and interview, the center failed to establish a safety management program that included a review of safety functions by a committee appointed by the chief executive officer and included representatives from administration and patient care services. Findings include: 1. On 5-9-16 at 1030 hours, the director, staff A1, was requested to provide documentation of a safety management program including committee minutes and none was provided prior to exit. 2. Review of the section heading Risk Management / Safety Report observed in the Professional Staff & Board of Director's Meeting Minutes dated 1-26-15, 5-06-15, 7-29-15, 10-28-15, 1-27-16 and 4-27-16 failed to indicate documentation of safety committee activity including the active participation of required committee members. 3. On 5-11-16 at 1310 hours, staff A1 confirmed that the center lacked documentation of an active safety management program that reviewed safety functions during periodic safety committee meetings attended by representatives from administration and	S 1180	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S1180 – **410 IAC 15-2.5-7(c)(1)** – PHYSICAL PLANT, EQUIPMENT MAINTENANCE Policy 14.001 – "Safety Program" (Attachment W) was created and will be presented to the Governing Body for approval during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. This information will also be discussed with staff at the next Staff Meeting scheduled July 8, 2016. The Director is responsible to maintain compliance with NMSC's Policies and implement corrective action for noncompliance.	07/28/2016

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	patient care.			
S 1182 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2) (c) A safety management program must include, but not be limited to, the following: (2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee. Based on interview, the safety program failed to develop and maintain an organized process to collect and evaluate information about safety issues, hazards, and practices at the center. Findings include: 1. On 5-9-16 at 1030 hours, the director, staff A1, was requested to provide documentation of a safety management program including a description of committee responsibilities, functions, and evidence of activity and none was provided prior to exit. 2. On 5-11-16 at 1310 hours, staff A1 confirmed that the center lacked documentation of a safety management	S 1182	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S1182 – **410 IAC 15-2.5-7(c)(2)** – PHYSICAL PLANT, EQUIPMENT MAINTENANCE Policy 14.001 – "Safety Program" (Attachment W) was created and will be presented to the Governing Body for approval during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. This information will also be discussed with staff at the next Staff Meeting scheduled July 8, 2016. The Director is responsible to maintain compliance with NMSC's Policies and implement corrective action	07/28/2016

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	program including a process for collecting and evaluating information about issues, hazards and safety practices to be reviewed by the committee.		for noncompliance.	
S 1198 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6) (c) A safety management program must include, but not be limited to, the following: (6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies. Based upon document review and interview, the safety management program failed to coordinate its emergency and disaster preparedness program with community, state and/or federal emergency and disaster preparedness agencies. Findings include: 1. The policy/procedure Emergency Operations (revised 10-14) indicated the following: "As an outpatient surgery facility the Center is neither equipped nor staffed to assist in the treatment of patients as a result of a disaster. It is	S 1198	S1198 – **410 IAC 15-2.5-7(c)(6)** – PHYSICAL PLANT, EQUIPMENT MAINTENANCE Director attended multiple IFASC Disaster Preparedness Webinars/ Exercises in May and June of 2016, as evidence by Certificates of Training (Attachments N, O, P, Q, R). Director also completed the 2016 IFASC Emergency Preparedness Ambulatory Surgery Center Survey (Attachment S). This survey is reported via IFASC to the Indiana State Healthcare Preparedness Program in coordination with the Federal ASPR program. Director has registered for the 2016 IHEPS	07/01/2016

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	therefore the policy of the Center to not participate in the event of an external disaster and to so notify and inform appropriate community/governmental parties." 2. On 5-9-16 at 1030 hours, the director, staff A1, was requested to provide documentation of center participation with community, state and/or federal emergency and disaster preparedness agencies and no documentation was provided prior to exit. 3. During an interview on 5-10-16 at 1620 hours, the director, staff A1, confirmed that no center disaster drill activity in 2015 or 2016 has been coordinated with a State or local (District 5) disaster drill event and confirmed that no center personnel have been or currently are attending the quarterly District 5 disaster management meetings.		(Indiana Healthcare Emergency Preparedness Symposium) on October 6, 2016 in Indianapolis. Director also reached out to Business Operations Manager of Indiana District Five Hospital Preparedness Planning Committee to obtain information about attending quarterly meetings.	
S 1210 Bldg. 00	410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1) (c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following: (1) Radiology services must be			

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NAME OF PROVIDER OR SUPPLIER NORTH MERIDIAN SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 13225 N MERIDIAN STREET CARMEL, IN 46032	

(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
	supervised by a radiologist or radiation oncologist. Based upon document review and interview, the center failed to ensure that its radiology services were supervised by a radiologist or radiation oncologist for 1 facility. Findings include: 1. On 5-10-16 at 1630 hours, the director, staff A1, was requested to provide documentation indicating that the center radiologic services were supervised by a qualified individual appointed to the medical staff by the governing board and none was received prior to exit. 2. During an interview on 5-11-16 at 1240 hours, the director, staff A1, confirmed that a medical physicist has been performing an annual review of the radiologic services provided at the center and confirmed that the radiologic services lacked documentation of supervision by a radiologist or radiation oncologist.	S 1210	The completion date for this deficiency is dated past the 30 days from the date of the survey (May 9-11, 2016), however, the deficiencies weren't available for review until June 21, 2016. S1210 – **410 IAC 15-2.5-8(c)(1)** – RADIOLOGY SERVICES The Director will be requesting approval from the Governing Body to appoint Kevin Macadaeg, MD to oversee NMSC's Radiologic Services during the next Medical Staff Meeting/ Governing Board Meeting on July 28, 2016. Dr. Macadaeg has maintained privileges at NMSC since 1996. He has been Board Certified in Anesthesia/ Pain Management since 1993. With his qualifications and experience, the Director feels that Dr. Macadaeg has appropriate qualifications to provide oversight for NMSC's Radiologic Services. Dr. Macadaeg will have a strong team to support him, including NMSC's Radiation Safety Liaison and Lamaster Radiation Consulting. The Director is responsible for assuring compliance.	07/28/2016