

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
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NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005669</p> <p>Survey Date: 12-22/23-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Marcia Anness, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 01/28/15</p>	S000000		
S000162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>provide direct patient care.</p> <p>Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) for 3 (MD#2, MD#6, MD#7) of 7 medical staff credential files reviewed., in accordance with current standards of practice and facility policy.</p> <p>Findings:</p> <p>1. Review of a facility policy approved February 17, 2014, entitled LIFE SUPPORT COMPETENCY REQUIREMENTS, indicated:</p> <p style="padding-left: 40px;">B. Surgeons, podiatrists, dentists, and non-CAA anesthesiologists will be considered</p> <p style="padding-left: 80px;">CPR competent a result of:</p> <p style="padding-left: 40px;">1. Maintaining medical staff privileges at ISC-North</p> <p style="padding-left: 40px;">2. Maintaining medical staff privileges in at least one hospital within Marion county or a county adjacent to Marion county</p> <p>2. The above-stated policy did not indicate how maintaining the above-stated privileges showed competence in accordance with current standards of practice.</p>	S000162	<p>1. A process to maintain current CPR cards on file for all medical staff will be developed and implemented. The collection of the CPR cards will begin immediately. The collection of the physician's CPR cards will be an ongoing process and will now be a required element of the credentialing/re-credentialing process at the Surgery Center.</p> <p>2. Once the CPR cards are obtained for the current medical staff, the credentialing personnel will develop a spreadsheet that includes expiration dates to ensure the information maintained is current. At the credentialing and re-credentialing process the credentialing personnel will request a copy of the physicians CPR card. 3. It will be the responsibility of the credentialing personnel in conjunction with the Executive Director. See Attachment A</p>	03/13/2015

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S000444	<p>3. Review of 7 physician credential files indicated MD#2, an orthopedic surgeon, MD#6, a gynecologist, and MD#7, a gynecologist, had no documentation of competence in accordance with current standards of practice.</p> <p>4. In interview, on 12-23-14 at 11:45 am, employee #A2, Administrative Assistant, confirmed all the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on policy review, observation and staff interview, the infection control committee failed to ensure that medical staff followed the surgical attire policy for one staff member observed.</p>	S000444	<p>1. As a member of the medical staff at the Surgery Center, per the Medical Staff Bylaws, the applicant acknowledges that as a member of the Medical Staff they will comply with the responsibilities of the Medical</p>	01/30/2015

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S000640	<p>Findings:</p> <p>1. Review of policy and procedure, Dress Code Peri-operative Domain, with date of 02/08, indicated:</p> <p style="padding-left: 40px;">a. Under F, a. In restricted areas, earrings may be worn only if totally confined in a hair covering.</p> <p>2. At 1200 hours on 12/23/14, while observing a patient in OR room #4, it was noted that MD #1 had earrings present that were not confined within the surgical cap while a surgical procedure was in process.</p> <p>3. At 1140 hours on 12/23/14, staff member #10, the Executive Director, agreed that MD #1 did not have their earrings confined, as per facility policy.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on policy/procedure review, patient medical record review and staff interview, the facility failed to ensure the</p>	S000640	<p>Staff membership, the Medical Staff Bylaws, and all applicable state and federal laws and regulations. This includes the adherence to the Surgery Center's policy and procedures.</p> <p>2. The Medical Director reviewed the Surgery Center's policy, "Dress Code Peri-Operative Domain", with the physician involved in the incident. The physician was informed of their responsibility to follow the Surgery Center's policies and procedures to ensure patient safety. 3. The Medical Director in conjunction with the Executive Director will monitor the physician for compliance See Attachment B</p> <p>1. The preprinted order Forms #ASC014 (Physician Surgery Orders, #ASC019 (Pre-Anesthesia Care Orders)</p>	03/02/2015	

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S000888	<p>orders were timed on 30 of 30 medical records.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of policy and procedure, Medical Records - Documentation Requirements, effective 03/08, indicated: <ol style="list-style-type: none"> Under #7, Practitioner Orders, it stated that "All orders must be dated and timed". Review of patient medical records 1-30 indicated that preprinted order Forms #ASC014 (Physician Surgery Orders), #ASC046 (Post-Anesthesia Care Orders) and #ASC019 (Pre-Anesthesia Orders) were not timed by the physicians. At 1230 hours on 12/22/14, staff # 10, Executive Director, verified that medical records #1-30's pre-printed orders were not timed by the physicians. <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop,</p>		<p>and #ASC046 (Post-Anesthesia Care Orders) have been updated to include the Physician's Signature, Date, and Time the orders were written. 2. The new order forms will be distributed to the physicians' offices and will be instructed to use the new forms immediately. Any physician who provides orders received on a previous version of the order forms will be required to rewrite the orders on the updated forms. The change to the forms will be presented at the Medical Staff meeting on February 16, 2015. 3. It will be the responsibility of the Patient Rooms Team Leader, OR Team Leader, and Business Office Team Leader in conjunction with the Executive Director to monitor the physician order forms for compliance. See Attachment C</p>	

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	<p>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 policy and procedure review, patient medical record review and staff interview, the facility failed to ensure that there was an operative report written or dictated at the end of the procedure.</p> <p>Findings:</p> <p>1. Review of the policy and procedure, "Medical Records - Documentation Requirements", effective date 03/08, indicated:</p> <p>a. Under #12 it stated "A complete account of every operation must be dictated or written by the operating surgeon at the conclusion of an operation."</p> <p>2. Review of patient medical records indicated:</p> <p>a. Patient #2 had a surgical procedure on 07/11/14. The operative note was dictated on 07/15/14.</p> <p>b. Patient #12 had a surgical procedure</p>	S000888	<p>1. It was noted that the policy "Medical Records - Documentation Requirements" and policy "Medical Records - Physician Completion of Chart" had conflicting requirements for the completion of the Operative Note and the medical record. Both policies were revised to reflect the same requirement for completion. The changes made to the policies will be presented at the Medical Staff meeting and Board of Managers meeting for approval. The results of the survey will also be shared at the above meetings. 2. The process for completion of the medical record and the Operative Note was further delineated to provide the physicians with an understanding of the expectations for the completion of their patients' medical records and the notification time line for those physicians with delinquent charts (See policy: Medical Records - Physician Completion of Chart).</p>	02/16/2015

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S001168	<p>on 12/12/14. The medical record had no evidence of an operative note.</p> <p>c. Patient #21 had a surgical procedure on 10/24/14. The operative note was dictated on 10/27/14.</p> <p>d. Patient #25 had a surgical procedure on 10/14/14. The operative note was dictated on 11/07/14.</p> <p>3. At 1230 hours on 12/23/14, an interview with staff member #10, Executive Director, indicated that</p> <p>a. There was no operative note for patient #12.</p> <p>b. The operative notes for patient #s 2, 21 & 25 did not have operative notes written or dictated at the end of the procedure.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly</p>		<p>Monthly the Medical Records personnel will compile a list of the non-compliant physicians. These physicians will be required to complete all delinquent records prior to performing additional surgeries. 3. The Medical Records personnel and the Business Office Team Leader in conjunction with the Executive Director. See Attachment D</p>				

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	<p>serviced and maintained as follows:</p> <p>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the facility failed to conduct triennial analysis of preventive maintenance (PM) for 5 of 10 pieces of patient care equipment.</p> <p>Findings:</p> <p>1. Review of PM for 10 pieces of patient care equipment indicated a triennial analysis was not done for the overhead surgical swing lights, patient stretcher, sterilizer, surgical table and wheelchair.</p> <p>2. In interview, on 12-23-14 pm at 3:20 pm, employee #A4, Equipment Coordinator, indicated there was no documentation of triennial analysis for the above-stated pieces of equipment and no other documentation was provided prior to exit.</p>	S001168	<p>1. A policy for the preventive maintenance and triennial review of the equipment was developed to ensure all patient care equipment is safe and effective for patient use. The policy addresses all service contract directly with the OEM or Clinical Engineering. 2. The policy will be presented at the Medical Staff meeting and the Board of Managers meeting for approval on February 16, 2015. 3. It will be the responsibility of the OEM and Clinical Engineering in conjunction with the Executive Director to monitor the contracts and vendors for compliance. See Attachment E</p>	02/16/2015			