

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/06/2014
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NAME OF PROVIDER OR SUPPLIER SURGICAL CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8103 CLEARVISTA PKWY INDIANAPOLIS, IN 46256
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005392</p> <p>Survey Date: 8-4/6-14</p> <p>Surveyor: Jack I. Cohen, MHA Medical Surveyor</p> <p>QA: cloughlin 08/14/14</p>	S000000		
S000116	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</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>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on document review and interview, the governing board failed to grant privileges to a medical staff member, according to the medical staff bylaws, for 1 of 1 allied health practitioners credential file.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the medical staff rules, as part of the facility policies, POLICY NO. 3.05, entitled CREDENTIALING ALLIED HEALTH PROFESSIONALS, approved 8-27-13 by the medical staff and the governing board, each, indicated application for privileges for AHP [allied health practitioner] shall be made on the attached form. Review of the above-stated attached form, entitled ALLIED HEALTH PROFESSIONAL REAPPOINTMENT FORM, indicated there was no portion of the form in which the reapplicant could request surgery center privileges to be requested. Further review of the above-stated policy indicated the AHP and physician employer shall be informed of the privileges granted. 	S000116	The allied health individual was re-credentialed at the Medical Staff Meeting on 8/26/2014. The form used for re-credentialing of allied health staff has been revised to include delineation of privileges, this will prevent the problem from happening again. The Director of Nursing will monitor this.	08/26/2014

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S000226	<p>4. Review of the credential file of allied health professional AHP#1 indicated the governing board approved the re-application in March, 2013.</p> <p>5. Since the above-stated form had no portion to indicate what the requested privileges were, and since no other documentation was presented which indicated what privileges were granted by the governing board, it is concluded the governing board failed to grant privileges to a medical staff member, according to the medical staff bylaws</p> <p>6. In interview, on 08-4-14 at 1:45 pm, employee #A2 confirmed all the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</p> <p>The governing body is responsible for services delivered in</p>			

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	<p>the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review and interview, the facility failed to maintain a list of all contracted services.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 8-4-14 at 10:00 am, employee #A2 was requested to provide documentation of a list of all contracted services, including the scope and nature of the services provided. Review of a document entitled EQUIPMENT MAINTENANCE CONTRACTS indicated it did not have all facility contracted services as part of the list. These services were biohazardous waste, housekeeping, laboratory, laundry/linen, medical records, pharmacy, and tissue transplant. Further review of the above-stated document indicated the name of the contract service provider but did not indicate the service provided. This included VEI and IOL Master. 	S000226	<p>A new list of contracts was created which includes the scope and nature of the services provided. This list will be updated as new equipment contracts are received. This will be reviewed annually and approved at the August Medical Staff Meeting. The Director of Nursing will be responsible for maintaining this list.</p>	08/26/2014

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S000400	<p>4. Further review of the above-stated document indicated the type of the contract service provider but did not indicate the service provider. This included GAS, Sprinkler, HAVAC, Nurse Call Light, Ck Power outlets, Emergency Light Testing, GENERATOR, and Load Bank.</p> <p>5. In interview, on 8-6-14 at 1:55 pm, employee #A1 confirmed 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(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and interview, the facility failed to provide a safe and healthful environment that minimized infection exposure and risk to patients, health care workers and visitors in 1 instance.</p>	S000400	All non-bio-hazardous items were immediately removed from the Bio-hazardous room. A policy on storage of dirty, clean and sterile items has been created. A staff training was conducted on what items are "clean" vs items that are "dirty". A category has been added to our weekly check-log	08/07/2014

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S000862	<p>Findings:</p> <p>1. On 8-5-14 at 12:05 pm, in the presence of employee #A2, the following items were observed in a biohazard waste storage room:</p> <p>9 unused sharps containers, 1 suction container, 1 ophthalmoscope, 1 electric warming device, 1 cabinet and 1 metal case, each containing patient care instruments and 1 open box containing biohazardous waste material.</p> <p>2. In interview on the above date and time, employee #A2 indicated the unused sharps containers, suction container, ophthalmoscope, electric warming device, cabinet and metal case, each containing patient care instruments, were used in patient care areas.</p> <p>3. The above-stated items could become contaminated by biohazardous waste and posed an infection control issue.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND</p>		<p>requiring monitoring of our clean/sterile and dirty storage. The Director of Nursing will review these logs monthly and randomly assess policy compliance.</p>		

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	<p>SURGICAL 410 IAC 15-2.5-4(d)(2)(C)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(C) A provision for the following equipment and supplies to be available to the surgical and recovery areas:</p> <p>(i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff.</p> <p>Based on document review and observation, the facility failed to follow its provision of medications in the emergency cart in 5 instances.</p> <p>Findings:</p> <p>1. On 8-5-14 at 11:40 am, in the presence of employee #A4, an inventory of the items in the facility's emergency cart, compared to a document entitled EMERGENCY CART DRUG LIST,</p>	S000862	The emergency drug cart list was revised. Each item/drug listed in the emergency cart will have minimum inventory of 1 (one). Our policy has been modified to reflect better compliance. The facility's pharmacist will review and sign our Medication Station Review form monthly. The Director of Nursing will review these logs quarterly. The policy and count were corrected immediately.	08/07/2014

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S001006	<p>indicated the following items did not at least equal the STOCK QUANTITY:</p> <table border="0"> <tr> <td>DRUG NAME</td> <td></td> <td># Items</td> </tr> <tr> <td>STOCK</td> <td></td> <td></td> </tr> <tr> <td>QUANTITY</td> <td>in cart</td> <td></td> </tr> <tr> <td>Dextrose 50% 25grams (0.5g/ml)</td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td>1</td> </tr> <tr> <td>Esmolol Hydrochloride (Brevibloc) 100mg/10ml</td> <td></td> <td>4</td> </tr> <tr> <td>3</td> <td></td> <td></td> </tr> <tr> <td>KCL 20meq 40meq (2 meq/ml)</td> <td></td> <td></td> </tr> <tr> <td>2</td> <td></td> <td>1</td> </tr> <tr> <td>Mannitol 25% 12.5mg (50cc vial)</td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td>2</td> </tr> <tr> <td>Procaiamide 500mg2ml (1gm/2ml)</td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td>1</td> </tr> </table> <p>2. In interview, on the above date and time, employee #A4 confirmed the above inventory results.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(2)</p> <p>Pharmaceutical services must have the following:</p> <p>(2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed.</p>	DRUG NAME		# Items	STOCK			QUANTITY	in cart		Dextrose 50% 25grams (0.5g/ml)			2		1	Esmolol Hydrochloride (Brevibloc) 100mg/10ml		4	3			KCL 20meq 40meq (2 meq/ml)			2		1	Mannitol 25% 12.5mg (50cc vial)			4		2	Procaiamide 500mg2ml (1gm/2ml)			4		1			
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	<p>Based on document review and interview, the facility failed to follow its policy/procedure for accounting for scheduled substances.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of facility POLICY NO. 12:01, entitled PHARMACY SERVICES, approved 8-27-13, indicated each time narcotics are administered to a patient an entry is made on the form [Narcotic Record Form]. On 8-5-14 at 11:40 am, in the presence of employee #A4, review of a form to account for the narcotic Midazolam 1mg/cc, indicated the starting day count was 27 vials. A physical inventory conducted by employee #A4 indicated there were 20 vials in a double-locked drug cabinet. In interview, on 8-5-14 at 11:40 am, employee #A4 was requested to account for the other 7 vials. The employee indicated at the beginning of the day, employee #A4 had given 7 vials to an anesthesiologist to use during the workday. The employee also indicated a list of those given to the anesthesiologist was kept on a separate piece of paper and placed on a desk in the nursing station area. 	S001006	Our narcotic count verification sheet has been revised. This form will indicate lot number and expiration date of each drug as well as what is dispensed/used/returned/wasted by the physician each day. This will then be reconciled at the end of each day. This will be recorded and signed off on by two nurses or one nurse and one physician. The Director of Nursing will be responsible for monitoring this procedure.	08/26/2014

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S001010	<p>4. At the above date and time, employee #A4 was requested to provide the separate piece of paper with the list of medications given to the anesthesiologist and no piece of paper was provided then nor prior to exit.</p> <p>5. Based on the above process, the facility failed to follow its policy/procedure for accounting for scheduled substances.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on document review and observation the facility failed to follow its policy to securely store drugs in 1 instance.</p> <p>Findings:</p>	S001010	Labetalol, Flumazenil and Ephedrine were removed from the anesthesia basket permanently. These medications were placed in a locked anesthesia supply cart in each operating room. These medications were added to the	08/07/2014

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	<p>1. Review of a facility policy entitled PHARMACY SERVICES, POLICY NO. 12.01, approved 8-27-13, indicated drugs shall be stored in a locked cabinet.</p> <p>2. On 8-5-14 at 12:25 pm, in the presence of employee #A2, it was observed in Operating Room #2, the following medications were in a tray on a table, neither in a locked cabinet nor secured in any other manner.</p> <p style="padding-left: 40px;">Labetalol Hydrochloride injectable, 10 mg /20 ml - 1 vial Flumazenil 0.5 mg/5 ml - 1 vial Ephedrine sulfate 50 mg/ml - 1 ml vial</p> <p>3. On the above date and time, it was also observed there was no facility staff in the room or within eyesight of the room.</p>		OR Anesthesia Cart Drug List. Quarterly reviews of the anesthesia policy compliance will be completed by the Director of Nursing.				