

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001086	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/22/2013
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NAME OF PROVIDER OR SUPPLIER  BELTWAY SURGERY CENTERS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 151 PENNSYLVANIA PKWY INDIANAPOLIS, IN 46280
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002277</p> <p>Survey Date: 2-18/22-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 03/06/13</p>	S000000		

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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S000110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the facility's governing board failed to review 13 contracted services and 1 other activity during calendar year 2011 as part of the facility's QAPI program.</p> <p>Findings:</p> <p>1. Review of the governing board meeting minutes for calendar year 2012 indicated the governing board did not review QAPI activities for contracted services of ambulance, bioengineering, biohazardous waste, housekeeping, laboratory, laundry/linen, maintenance, medical records, pharmacy, radiology, security, tissue transplant and transcription.</p> <p>2. Review of the governing board meeting minutes for calendar year 2012 indicated the governing board did not</p>	S000110	<p>Tag S 0110 1. The "Contracted Services Activity Report" will be taken to the Beltway Surgery Center's Board of Managers meeting on Wednesday, April 17 by the Administrative Director, Vi Farrell, for review and discussion. Thereafter, the "Contracted Services Activity Report" will be taken to Board each quarterly, going forward, for review and discussion. April 17, 2013 is beyond the 30 days from the date of the survey, but Board meetings are held the month after the quarter ends - 1st Quarter Board meeting is in April. 2. Patient discharge information will be added to the QAPI Report that is given to the Board of Managers each quarter, effective Wednesday, April 17, 2013. Currently, all patient transfers to inpatient hospital are reviewed and discussed at each of the Board meetings. Responsible Person: Vi Farrell, Administrative</p>	04/17/2013	

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	<p>review QAPI activities for discharges.</p> <p>3. In interview, on 2-21-13 at 9:30 am, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p>		Director	

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S000148	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c) (4)</p> <p>(c) The governing body shall do the following:</p> <p>(4) Require that the chief executive officer designate in writing an administrative officer to serve during his or her absence.</p> <p>Based on document review and interview, the facility's Administrative Director failed to assure designation in writing who was to serve in her absence.</p> <p>Findings:</p> <p>1. Review of the facility's policies and procedures indicated there were none to designate in writing who was to serve in the absence of the Administrative Director.</p> <p>2. In interview on 2-18-13 at 11:30 am, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p>	S000148	<p>Tag S 0148 Regarding this citation, the Administrative Director will direct a manager to cover the administrative responsibilities when she is at work, but is away from her office to visit another Center, or to attend an internal meeting at another facility. This will be effective immediately. The General Administration Policy - ADM 3.08 "Delegation of Authority" will reflect this change. Responsible Person; Vi Farrell, Administrative Director</p>	03/11/2013	

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S000153	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review and interview, the facility failed to follow its policy to provide orientation of contracted employees to the facility for 4 of 4 (P#1, P#2, P#3, and P#4) personnel files reviewed.</p> <p>Findings:</p> <p>1. Review of facility Policy Number: ADM 3.05, approved May, 2011, entitled ORIENTATION TO THE AMBULATORY SURGERY CENTER - EMPLOYEES, indicated this policy applies to ... all persons contracted to work for the ASC [ambulatory surgery center] for more than thirty (30) calendar days.</p> <p>2. Review of 4 contracted radiology personnel files indicated files P#1,P#2, P#3 and P#4 were contracted to the ASC for more than thirty (30) days and their</p>	S000153	<p>Tag S 0153A "Radiology Orientation to the OR" Checklist has been developed and completed by all current radiology techs that go to the OR to utilize the C-Arm. A copy of the checklist has been placed in each of the radiology tech's personnel file, effective March 6, 2013. Going forward, a Radiology Orientation to the OR Checklist will be completed on all new radiology tech employees. Responsible Person: Vi Farrell, Administrative Director</p>	03/06/2013			

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	<p>files contained no documentation of a general orientation to the facility.</p> <p>3. In interview on 2-21-13 at 4:00 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p>			

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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 provide direct patient care.</p> <p>Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice for 4 (MD#4, MD#5, MD#6 and MD#8) of 9 medical staff credential files reviewed..</p> <p>Findings:</p> <p>1. Review of facility Policy Number: MS 2.02, entitled CARDIOPULMONARY RESUSCITATION (CPR) COMPETENCE FOR PHYSICIANS, ALLIED HEALTH PROFESSIONALS, AND SUPERVISED ALLIED HEALTH PROFESSIONALS, last approved April, 2010, indicated cardiopulmonary resuscitation (CPR), Basic life Support (BLS) and Advanced Cardiac Life Support (ACLS) competence is only</p>	S000162	<p>Tag S 0162:Responsible: The administrative director of the Beltway Surgery Centers, LLC (BSC).The Tag S_0162 needed to be readdressed due to the incongruence in the definition of "physicians" roles relative to the assurance of cardiopulmonary resuscitation (CPR) in accordance with current standards of physician practice. The tag has been reviewed, and in response, the Medical Staff Policy MS 2.02 has been rewritten to clarify definitions of surgeons and anesthesiologists in regard to CPR competence. The revised policy addresses the following: Policy Statements:A. Surgeons at the ASC are "licensed health professionals" who are not considered direct care providers of patient care; therefore, they do not require documentaton of CPR comptence.B. Cardiopulmonary</p>	07/29/2013

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	<p>required for those physicians who must demonstrate CPR competence to comply with Policy MS 2.13 Procedural Sedation.</p> <p>2. Further review of the above policy indicated there was no other criteria used to determine what was current standard of practice.</p> <p>3. Review of 9 medical staff credential files indicated the CPR competency of MD#6 had expired in May, 2011 and there was no CPR competency in accordance with current standards of practice for MD#4, MD#5 and MD#8.</p> <p>4. In interview, on 10-24-12 at 12:15 pm, at 1:20 pm, employee #A1 confirmed there was no other criteria for standard of practice and also confirmed the above results of the review of the above medical staff credential files. No further documentation was provided prior to exit.</p>		<p>resuscitation (CPR) competence is only required of surgeons who request privileges for Procedural Sedation. See MS 2.13 Procedural Sedation. C. Anesthesiologists are providers of direct patient care. Their CPR competency is assured through their eligibility for board certification, board certification, continuing education, BLS and ACLS training. D. All residents hold and maintain current ACLS and/or PALS certification as a residency requirement. E. A current cardiopulmonary resuscitation certification in ACLS, ATLS, BLS, HST, NRP, or PALS is required for all Allied Health Professionals and Supervised Allied Health Professionals in accordance with their job training requirements and consistent with their job documentation, qualifications knowledge, skills and abilities as direct care providers of patient care. Procedure: The Ambulatory Surgery Center Administrative Office shall maintain documentation of CPR competency for physicians who are required to maintain CPR competence and for all Allied Health Professionals and Supervised Allied Health Professionals. See the attached policy. Thank you for the opportunity to readdress Tag S_0162. Vi Farrell Director Clinical Operations</p>				

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S000332	<p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the center:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention.</p>			

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

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	<p>resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p>			

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	<p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on</p>			

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	<p>the grounds of the center. (iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for the activity of all reportable events in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of a QAPI report document entitled BELTWAY SURGERY CENTER, L.L.C., commonly referred to as a dashboard, did not indicate some of the State-reportable events, including but not limited to:</p> <p>a. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center.</p> <p>b. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, catheters, drains and other specialized tubes, infusion pumps and ventilators.</p> <p>c. Patient death or serious disability associated with a medication error, for example, errors involving the wrong drug,dose, patient, time, rate, preparation</p>	S000332	<p>Tag S 0332 Effective Wednesday, April 17, 2013, a report of the State-reportable events will be included in the QAPI report given to the Board of Managers to indicate if the BSC has, or has not, experienced any of the designated 28 reportable events. Reportable events, and/or "never events" have always been taken to the Board for review and discussion. Going forward, the Board will be informed that we have had NO reportable events, if this is the status at the time of the meeting. The BSC Board meeting is scheduled in April, July, October and January of each year. The reportable event report will also be included in the agenda for the monthly QAPI meetings. Responsible Person: Vi Farrell, Administrative Director</p>	04/17/2013			

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	<p>or route of administration.</p> <p>2. In interview, on 2-21-13 at 9:30 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p>			

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S000400	<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 interview, document review, observation and interview the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients in 4 instances.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On 02-20-13 at 1135 hours, staff #46 confirmed that he/she uses 70% alcohol to wipe down the wrapping tables in the clean work room.</li> <li>2. On 02-21-13 at 1510 hours, staff #45 confirmed that the facility has not approved 70% alcohol to be used as a disinfectant.</li> <li>3. Review of the manufacturer's recommendations for Pure Endochoice enzymatic cleaner indicated the following: "Use 1/2 ounce per 1 gallon of water."</li> <li>4. On 02-19-13 at 1435 hours, staff #47 confirmed that he/she uses 4 ounces of</li> </ol>	S000400	<p>Tag: S 0400 1. &amp; 2. Staff #46, as well as all the staff members in instrument processing, have been re-educated to use the PDI Sani-Cloth Plus Germicidal Disposable Cloth to clean the wrapping tables in the instrument room instead of using the 70% alcohol. 3. &amp; 4. &amp; 5. The staff were inserviced on #3, #4, and #5 deficiencies on the day they were discovered, which was on Tuesday, February 19, 2013 per Beverly Sanders, BSC Spring Mill OR Clinical Manager. In addition, labels were placed on the sink and ultrasonic cleaner to indicate water line levels and the amount of Pure Endochoice enzymatic cleaner that is required. The supervisor of instrument processing and the OR manager will monitor activity and compliance as they are making rounds.6. Policy - Pharmacy Section PHARM 11.11 "Medication Use Process" has been revised to include the following verbiage: C. Administration #4. (m.) When injecting into an IV port, use an alcohol swab to cleanse the port prior to inserting a needle into the</p>	03/11/2013			

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	<p>Pure Endochoice enzymatic cleaner in the ultrasonic cleaner.</p> <p>5. On 02-20-13 at 1005 hours, staff #43 confirmed that the ultrasonic cleaner requires 11 gallons of water.</p> <p>6. On 02-20-13 at 1200 to 1215 hours in Operating Room #4, a staff person was observed 3 times administering IV medications via IV tubing port without wiping the port with an alcohol wipe.</p> <p>7. On 2-20-13 at 2:20 pm, in the presence of employee #A2, it was observed in the 3rd floor janitorial room of the Beltway building, the following items were stored on open shelving that had no covering, thus no protection for cross contamination:                      147 packages handtowels, with open ends                      120 rolls toilet paper with no wrapping                      3 rolls of handtowels with no wrapping</p>		<p>port. The importance of cleansing an IV port was discussed at two staff meetings on Wednesday, February 27 and in unit report throughout the week. Observation and monitoring will take place when the manager is making rounds. 7. Employee #A2, has requested that housekeeping rearrange the stocking of supplies in the 3rd floor janitorial room of the Beltway building to ensure the supplies are contained in boxes, and/or covered with a plastic or impermeable drape. This has been completed and was verified on Monday, March 11, 2013. Responsible Person(s): Vi Farrell, Administrative Director Beverly Sanders, BSC Spring Mill OR Clinical Manager</p>	

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S000414	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on document review and interview, the facility failed to follow established medical staff bylaws for 1 infection control committee.</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Bylaws indicated the following: "A. Infection Control and Tissue Committee</p>	S000414	Tag S 0414 The Beltway Surgery Centers, LLC Medical Staff Bylaws have been revised to reflect the following verbiage:ARTICLE XStanding CommitteesA. Infection Control and Tissue Committee1. The Infection Control and Tissue Committee shall consist of, but is not limited to, at least one member of the Medical Staff, the Infection Control Coordinator, and a representative from the nursing staff. Membership may also	03/19/2013

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	<p>1. The Infection Control and Tissue Committee shall consist of at least three members of the Active Medical Staff and may also include one or more physicians with special expertise in infection control and anatomical pathology who are not on the Medical Staff, all of whom shall be chosen by the Medical Advisory Board." The Medical Staff Bylaws were last reviewed/revised on 01-08-12.</p> <p>2. Review of the Infection Control Committee meeting minutes dated 12-15-11, 03-27-12, 05-16-12, 08-22-12, 09-26-12 and 12-31-12 indicated that only 1 physician attended the Infection Control Committee meeting.</p> <p>3. On 02-21-13 at 1105 hours, staff #45 confirmed that the Infection Control Committee does not have 3 physicians to attend the meetings.</p>		<p>include one or more physicians with special expertise in infection control and anatomical pathology who are not on the Medical Staff, all of whom shall be chosen by the Medical Advisory Board. The Medical Staff Bylaws will be presented at the Medical Staff meeting on Tuesday, March 19, 2013 for review and approval, and at the Board of Managers Meeting on Wednesday, April 17, 2013 for approval. They will be sent to the Board of Managers prior to the April 17 meeting for review. Responsible Person: Vi Farrell, Administrative Director</p>		

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S000444	<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 document review, observation and interview, the facility failed to follow surgical attire standards in 2 observations.</p> <p>Findings include;</p> <p>1. Review of the 2012 Association of Perioperative Registered Nurses (AORN) Standards indicated the following on page 62: "IV.a.2. Reusable head coverings should be laundered in a health care-accredited laundry facility after each daily use."</p> <p>2. On 02-21-13 at 1205 hours in Operating Room (OR) #4 a staff person was observed wearing a personal cap.</p> <p>3. On 02-21-13 at 1300 hours in OR #1, a staff person was observed wearing a</p>	S000444	<p>Tag S 0444: Effective March 25, 2013, staff will no longer be able to wear the cloth hats unless they are covered by the blue disposable bouffant cap. Managers will monitor and enforce ruling. Responsible Person(s): Vi Farrell, Administrative Director Bev Sanders, OR Clinical Manager Lori Jordan, OR Clinical Manager</p>	03/25/2013

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	<p>personal cap.</p> <p>4. On 02-21-13 at 1410 hours, staff #41 confirmed that the facility follows AORN Standards and staff personal caps are not laundered in a health care accredited facility.</p>			

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S000606	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(b)(1)</p> <p>(b) The organization of the medical record service must be appropriate to the scope and complexity of the services provided as follows:</p> <p>(1) The services must be directed by a registered record administrator (RRA) or an accredited record technician (ART). If a full-time and/or part-time RRA or ART is not employed, then a consultant RRA or ART must be provided to assist the qualified person in charge. Documentation of the findings and recommendations of the consultant must be maintained.</p> <p>Based on document review and interview, the facility failed to follow its contract for consultant medical record services by not documenting the consultant findings according to the contract for the consultant services.</p> <p>Findings:</p> <p>1. Review of a document entitled Letter of Agreement for Revenue Cycle Services (Includes Medical Record Agreement), between Clarian Health Partners Revenue Cycle Division and Beltway North Surgery Center, LLC, dated April 1, 2006, indicated in Section 1.36, a maximum of 30 retrospective monthly chart reviews</p>	S000606	<p>Tag S 0606 There was a gap in receipt of medical record reviews by Clarian Health Partners during the months of January, February, and March 2012. Clarian Health was no longer able to provide the medical reviews for the Beltway Surgery Centers, LLC (BSC). Due to the gap and knowledge that Clarian could not provide the reviews for the BSC for the 1st Quarter 2012, the BSC hired Med-Rec Systems for the 2nd Quarter (April, May and June) 2013 to complete the reviews. BSC did not go back and complete the reviews for the 1st Quarter 2012; we moved on to address the 2nd Quarter and all future quarters. Med-Rec Systems has been retained to</p>	03/11/2013

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	<p>for JCAHO and ISDH compliance.</p> <p>2. Review of medical record consultant reviews indicated there were no monthly chart reviews for the months of January, February and March, 2012.</p> <p>3. In interview, on 2-22-13 at 10:55 am, employee #A2 confirmed the above monthly reviews did not occur and no other documentation was provided prior to exit.</p>		<p>complete the medical record reviews on a quarterly basis, which they have done since the 2nd Quarter 2012. This schedule will be maintained going forward. Responsible: Vi Farrell, Administrative Director</p>		

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S000732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based on document review and interview, the medical staff did not review the medical staff rules at least once every three (3) years.</p> <p>Findings:</p> <p>1. Review of the medical staff bylaws and rules and regulations indicated they were last approved by the medical staff on 7-5-06.</p> <p>2. In interview on 2-18-13 at 3:15 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p>	S000732	<p>Tag S 0732The Medical Staff Bylaws will be presented at the Medical Staff meeting scheduled on Tuesday, March 19, 2013 at 4:30 p.m. for review and approval. Done, effective March 19, 2013. In the future, the reveiw schedule shall be maintained by Vi Farrell, Administrative Director or designee.</p>	03/19/2013			

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S000826	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(E) Safety training required of personnel. Based on document review and interview, the facility failed to have a policy to require safety training of personnel for areas where anesthesia procedures were performed and failed to perform training of physician/personnel in areas where anesthesia procedures were performed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policies and procedures, approved 1-18-12, indicated there was no policy to require safety training of personnel for areas where anesthesia procedures were performed.</li> <li>2. In interview, on 2-21-13 at 11:40 am, employee #A2 confirmed the above and no further documentation was provided prior to exit.</li> <li>3. Review of physician credential files indicated there was no documentation of</li> </ol>	S000826	<p>Tag S 0826 Safety training of personnel for areas where anesthesia procedures are performed will be added to Policy - Anesthesia Services AS 9.09 "Educational Responsibilities of the Anesthesia Section." To be completed by April 30, 2013. V. Policy Statements A. 3. A representative from the anesthesia section, along with a Center staff nurse representative, will participate in providing safety training of personnel for areas where anesthesia procedures are performed. In addition, a safety checklist will be developed to be used in the educational process. The checklist will be developed by April 12, 2013. As of April 1, we have a listing of items for the checklist, but we are in the process of formatting and formalizing the checklist to ensure we include all appropriate elements for safety. Due to the large number of physicians on staff, as well as the OR staff, the</p>	05/31/2013	

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	<p>safety training of physicians for areas where anesthesia procedures were performed.</p> <p>4. In interview, on 2-21-13 at 11:40 am, employee #A2 confirmed there was no documentation of safety training of physicians for areas where anesthesia procedures were performed and no further documentation was provided prior to exit.</p>		<p>actual training may take longer than the deficiency correction period allowed. Phase II of this POC will be completed by April 30, 2013, which will include 50% of the physicians. Phase III of this POC will be completed by May 31, which will include the remainder of the physicians that we weren't able to reach in Phase II. Person Responsible: Vi Farrell, Administrative Director</p>		

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S000856	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(A)</p> <p>Requirements 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>(A) A mechanism must be maintained which specifies the delineated surgical privileges of each practitioner.</p> <p>Based on document review and interview, the facility failed to have a policy approved by the medical staff which indicated a mechanism to maintain the delineated surgical privileges of each practitioner.</p> <p>Findings:</p> <p>1. Review of facility documents indicated there was no policy approved by the medical staff which indicated a mechanism to maintain the delineated surgical privileges of each practitioner.</p> <p>2. In interview on 2-21-13 at 2:10 pm, employee #A2 confirmed the above and no further documentation was provided prior to exit.</p>	S000856	S 0856The BSC does have a policy delineating surgical privileges of each practitioner. I apologize, I do not recall this conversation. Policy - Section: Governing BodyCredentialing - CR 2.02 "Delineation of Clinical Privileges."Approved: January 18, 2012. Responsible Person: Vi Farrell, Administrative Director	03/11/2013			

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S001026	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)(i)</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>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(i) Drug cabinets must be accessible only to authorized personnel.</p> <p>Based on document review, interview and observation, the facility failed to follow its policy for authorized access to medications in 1 instance.</p> <p>Findings:</p> <p>1. Review of facility Policy: PHARM 11.11, entitled MEDICATION USE PROCESS, reviewed October, 2011, indicated a licensed independent practitioner or appropriate health care personnel could remove medications from a cabinet [i.e. a storage area].</p> <p>2. On 2-20-13 at 1:50 pm, in the presence of employees #A2 and #A8, it was</p>	S001026	<p>Tag S 1026In regard to the medication storage area in the basement at the BSC, keys have been retrieved from persons who were not authorized in the policy to have access to the room. During safety rounds, this will be monitored to ensure compliance. Responsible Person: Vi Farrell, Administrative Director</p>	02/25/2013	

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	<p>observed in the basement of the Beltway building, 2 individuals were able to gain access to a locked drug storage room. The door contained 2 locks: one requiring a key, used by one individual, and the other requiring and code number, used by the other individual.</p> <p>3. In interview, at the above date and time, employee #A2 indicated the 2 individuals were not a licensed independent practitioner or appropriate health care personnel who could have access to a medication storage area.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001086		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/22/2013	
NAME OF PROVIDER OR SUPPLIER  BELTWAY SURGERY CENTERS LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 151 PENNSYLVANIA PKWY INDIANAPOLIS, IN 46280			
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S001116	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(a)(4)(A)</p> <p>(4) In new construction, renovations, and additions, the center site and facilities, or nonlicensed facilities acquired for the purpose of providing center services shall meet the following:</p> <p>(A) The 2001 edition of the national "Guidelines for Design and Construction of Hospitals and Health Care Facilities" (Guidelines). Based on document review, observation and interview, the facility failed to have a gasketed or clipped lay-in ceiling in a semi-restricted area in 1 instance.</p> <p>Findings:</p> <p>1. Review of the 2001 edition of the national " Guidelines for Design and Construction of Hospital and Health Care Facilities " indicates in section 9.5.H2: Finishes shall conform to the following guidelines:</p> <p>a. Ceiling finishes shall be appropriate for the areas they are to be located in and shall be as follows: Ceiling finishes in semi-restricted areas ..., if a lay-in ceiling is provided, shall be gasketed or clipped down to prevent the passage of particles from the cavity above the ceiling plane into the semi-restricted</p>	S001116	<p>Tag S 1116The ceiling in the semi-restricted supply storage area at BSC Spring Mill will be renovated on Saturday, March 16, to meet code. On Sunday, March 17, the room will be terminally cleaned and supplies returned. It will be available for use on Monday, March 18. Responsible Person(s): Vi Farrell, Administrative DirectorRobert Stanley, Supply Chain Supervisor - ASCKyle Hardie, ArchitectM S K T D &amp; Associates, Inc.9 3 0 North Meridian StreetIndianapolis, Indiana 46204</p>	03/18/2013			

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	environment.  2. On 2-20-13 at 11:15 am, in the presence of employees #A4, #A6 and #A7, it was observed in the semi-restricted clean supply room of the Springmill offsite building, there were lay-in ceiling tiles. In interview, on that same day and time, employee #A7 indicated the tiles were not gasketed or clipped.			

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S001146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</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>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, the facility maintained a condition which may result in a hazard to patients, public, or employees</p> <p>Findings:</p> <p>1. On 2-20-10 at 1:30 pm in the presence of employees #A2 and #A8, it was observed in the medical gas storage area, there was 1 small nitrogen tank stored upright on the floor.</p> <p>2. If the above tank was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property.</p>	S001146	<p>Tag S 1146The small nitrogen tank has been removed from the medical gas storage area, and it will not be replaced per Adam Johnson, Facilities Tech. This will be monitored during safety rounds. Person(s) Responsible: Adam Johnson, Facilities Tech Vi Farrell, Administrative Assistant.</p>	02/25/2013

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S001170	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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 serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to document defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator.</p> <p>Findings:</p> <p>1. Review of the LIFEPAK 20 Defibrillator/Monitor Operating Instructions indicated the facility was to perform daily checks per the Operator's Checklist provided by the manufacturer that included, but were not limited to, inspect physical condition for foreign</p>	S001170	Tag S 1170 Within the code cart on Unit OR 2, there were two checklists. One was a checklist made up by facility representatives that was used daily, and one was the manufacturer's checklist located in the LIFEPAK 20 Defibrillator/Monitor Operating Instructions Manual. The surveyor noted we should use the checklist provided by the manufacturer to ensure we include all aspects of the checklist. The managers have adopted the manufacturer's checklist which is located in the Operating Instructions Manual. Staff that check the code carts	03/04/2013			

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	<p>substances, damages or cracks, Inspect power source for broken, loose, or worn power cable, and confirm therapy cable connected to defibrillator and perform cable check.</p> <p>2. Review of a document entitled Code Cart Checklist for Unit OR2, dated 2-18, 2-19 and 2-20 for year 2013, indicated it did not include the above daily checks.</p> <p>3. In interview, on 2-21-13 at 3:55 pm, employee #A2 confirmed the above was and no further documentation was provided prior to exit.</p>		<p>have been re-educated to use the Operating Manuals Checklist. Responsible Person(s): Clinical Managers for BSC and BSC Spring Mill</p>		