STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001034	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY SURGERY CENTER NORTHWEST	8651 TOWNSHIP LINE ROAD INDIANAPOLIS, IN 46260

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Q 0000 Bldg. 00	This visit was for a re-certification survey. Facility Number: 005975 Survey Date: 6-29/7-1-2015 QA: cjl 07/16/15	Q 0000		
Q 0083 Bldg. 00	416.43(d) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations. (2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results Based on document review and interview, it could not be determined the facility took effective action and follow-up to address an opportunity for improvement found through a performance improvement project in 1 instance. Findings:	O 0083	For all future QI studies the AAAHC template will be followed for each study. A minimum of 2studies will be conducted each year. At the completion of the study results will be analyzed to see if goal was met. If goal was not met, data will be reevaluated in order to pursue additional actions for follow up (extend study, implement new techniques to reach goal, reevaluate goal if it	08/31/2015

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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	1. Review of a document entitled Quality Assessment Performance Improvement Study, conducted February 2014 - April 2014, indicated the purpose was to improve first case on time starts for surgical operations, with a goal based on industry benchmarks of 80% first case on time start as best practice. 2. Further review of the study indicated: Data was collected for the first 45 days of the study, the result being 2% first case on time starts. At the end of this time, the facility took various actions to improve the outcome. At the end of 90 days, review of the study indicated data will continue to be collected to monitor any improvement in the on start time of the first case of the day. Policies and procedures will continue to be updated and implemented to insure 80% compliance with start time. No further data was collected to indicate if the actions taken resulted in improvement of the outcome. Thus, the study was incomplete because it could not be determined the		was determined to be unattainable, etc.) Responsible Parties: Executive Director and clinical director	

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	facility took effective action and follow-up to address an opportunity for improvement 3. In interview, on 7-1-2015 at 9:45 am, employee #A3, Clinical Director, confirmed all the above and indicated the facility stopped gathering data after 90 days because it didn't seem there was any problem with the issue. On that day and time, the employee was requested to provide documentation showing the goal had been met and the employee indicated there was no other documentation to support the conclusion of reaching the goal.			
Q 0105 Bldg. 00	416.44(c) EMERGENCY EQUIPMENT The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC' s operating room. The equipment must meet the following requirements: (1) Be immediately available for use during emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel. Based on document review and interview, the facility failed to document	O 0105	The daily operator's checklist has been reviewed with allstaff who has opportunity to check the	07/31/2015

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	defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator. Findings: 1. Review of the OPERATOR'S CHECKLIST FOR R SERIES ZOLL DEFIBRILLATOR indicated it was recommended the facility was to perform daily checks per that checklist provided by the manufacturer that included, but was not limited to, Batteries- fully charged spare battery available, Disposable supplies - defib gel or gel patches, hands-free therapy electrodes in sealed packages - 3 sets, ECG electrodes, recorder paper, alcohol wipes, and razors. 2. Review of a facility document entitled OPERATOR'S CHECKLIST FOR R SERIES ZOLL DEFIBRILLATOR, dated Jan 5, 6, 7, 8, and 9, for year 2014, indicated it did not include the above daily checks. 3. In interview on 7-1-2015 at 12:50 pm, employee #A1, Executive Director, confirmed the above and no further documentation was provided prior to exit.		defibrillator daily (RNs). All items on checklist must be attended to/checked on a daily basis and indicated on the checklist. A monthly audit of the checklist will becompleted for the duration of 2015 to ensure that it is completed in its entirety. Any omissions will be addressed with the individual who checked the defibrillator on that day and coaching will occur. Responsible party: clinical director	
Q 0122	416.45(b) REAPPRAISALS			

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Bldg. 00	Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. Based on document review and interview, the governing board failed to ensure 5 of 7 medical staff members (MD#1, MD#2, MD#3, MD#4, and MD#5), were periodically appraised of the quality of care they provided at the facility. Findings: 1. Review of 7 medical staff credential files indicated files MD#1, MD#2, MD#3, MD#4, and MD#5, all podiatrists, did not have any documentation of appraisal of the quality of care they provided at the facility, as part of their reappointment, each, in August, 2013. 2. In interview, on 6-29-2015 at 12:45 pm, employee #A1, Executive Director, confirmed all the above and no other documentation was provided prior to exit.	Q 0122	1.A new form has been developed that includes achecklist for recredentialing candidates. This form provides for reviewof outcome-oriented performance evaluations of applicants. In additionthe following categories have been added: appropriateness of diagnosis andtreatments rendered related to a standard of care and anticipated or expectedresults, performance evaluation based on clinical performance indicated in partby the results or outcome of surgical intervention, and scope and frequency ofprocedures. Responsible parties: executive director, medical director, credentialing coordinator	07/31/2015
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.			

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	Based on document review and interview, the facility failed to ensure a licensed health care professional, who had been designated responsible for the ASC's pharmaceutical services, abided by the contract in 1 of 2 instances. Findings: 1. Review of a contract between NORTHWEST SURGERY CENTER, LLC and VISIONARY ENTERPRISES, INC, dated November 21, 2012, indicated [there will be] two on-site inspections of pharmaceutical supplies and equipment annually by a Consultant Pharmacist. 2. Review of facility documents indicated for calendar year 2014, there was only 1 inspection report, on 6-12-2014. 3. In interview, on 7-1-2015 at 11:45 am, employee #A1, Executive Director, confirmed the above-stated documentation and no other documentation was provided prior to exit.	Q 0181	Pharmacy consultant has been contacted and requested to come 2x each year. 1 visit has occurred in2015 so far and one additional visit will be scheduled before 12/31/2015. Responsible parties: clinical director and executive director	08/31/2015
Q 0184 Bldg. 00	416.48(a)(3) VERBAL ORDERS Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician.			

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	Based on document review and staff interview, the medical staff failed to ensure a written order was provided by the prescribing practitioner for drugs and biologicals for 2 of 20 (Patient 1 and 4) closed patient medical records reviewed. Findings: 1. Policy titled, "Pharmacy Services", revised/reapproved 1/14/15, was reviewed on 6/29/15 at approximately 1600 hours, and indicated on pg. 2 of 4, under Procedure section, points G. Physician Orders and J. Drug Administration to the Patient, "In addition to Standing Orders; physicians may prescribe drugs for patients during the patient's stay in the Center using the Physician's Order Form portion of the patient's chart. The specific drug and dosage are entered on the form and signed by the physician. The Registered Nurse will prepare and issue the drugs as prescribed...All drugs will be administered to the patients only upon the order of the Physician in charge of the patient." 2. Review of medical records on 6/29/15 at approximately 1258 hours, confirmed per Recovery Room Record, patient: A. 1: a. received Toradol 30 mg, IV	Q 0184	The QA committee will begin audits on drugs given with corresponding order. A random sampling of 10 charts each month will be selected and each drug administration will be reviewed toensure that the ordered drug is also the drug/dosage/route administered. Results will be provided to the QA committee and any misses will be addressed with the individuals involved. Responsible parties: Executive director, clinical director, QA committee	08/31/2015

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	(intravenously) at 0726 hours on 2/12/15. b. lacked a physician order for Toradol 30 mg, IV. B. 4: a. received Tylenol with Codeine Elixir 10 ml, PO (by mouth) at 1140 hours on 1/28/15. b. lacked a physician order for Tylenol with Codeine Elixir 10 ml, PO 3. Staff 1 (Clinical Director) was interviewed on 6/29/15 at approximately 1310 hours, and confirmed the above-mentioned patient medical records lacked physician orders as required by facility policy and procedure for medications administered.			
Q 0221 Bldg. 00	416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. Based on document review and interview, the facility failed to include, in	O 0221	Patient rights have always been distributed both in written form	08/31/2015

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	its policy, that it would provide the patient, or the patient's representative, or the patient's surrogate with verbal notice of the patient's rights in 1 instance and failed to include, in its written patient rights given to the patient, that if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law in 1 instance. Findings: 1. Review of the facility's policy on patient rights indicated there was no documentation the facility would provide the patient, or the patient's representative, or the patient's surrogate with verbal notice of the patient's rights. 2. Review of medical record ADM#1, indicated it did not include documentation of the facility having provided the patient, or the patient's representative, or the patient's surrogate with verbal notice of the patient's rights. 3. Review of documents of patient rights, given to the patient, indicated there was no documentation that if a State court has not adjudged a patient incompetent, any legal representative		and given to the patient and asked if they have any questions. This will be documented in the patient's medical record that patient received written and verbal patient rights and signed and dated by patient. This will be audited beginning September 1 on 10 patient charts each month through December 31 If it is found to be present on all charts the audits will cease at that time but the information will continue to be documented in the patient's medical record indicating that they received their rights in both written and verbal format Responsible parties: executive director, clinical director, and registration staff	

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	designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. 4. In interview, on 7-1-2015 at 12:45 pm, employee #A1, Executive Director, confirmed all the above and no other documentation was provided prior to exit.			
Q 0230 Bldg. 00	416.50(e)(2)& (3) EXERCISE OF RIGHTS BY OTHERS (2) If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf. (3) If a State court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. Based on document review and interview, the facility failed to include, in its patient rights policy, that if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's	O 0230	If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law will be addressed in our patient right policy. The policy will include the statement above. If a	08/31/2015

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	rights to the extent allowed by State law in 1 instance. Findings: 1. Review of documentation of the facility's policy on patient rights, revised 8/7/2013, indicated there was no documentation that if a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. 2. In interview, on 7-1-2015 at 12:45 pm, employee #A1, Executive Director, confirmed the above and no other documentation was provided prior to exit.		patient presents with this situation we will follow our policy to allow any legal representative designated by the patient to exercise the patient's rights. Responsible party: executive director	
Q 0245 Bldg. 00	416.51(b)(3) INFECTION CONTROL PROGRAM 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.			

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	Based on document review and staff interview, the facility failed to provide a plan of action for preventing, identifying, and managing infections and communicable diseases related to tuberculosis risk assessment. Findings: 1. Email communication from corporate representative was reviewed on 6/29/15 at approximately 1500 hours, and indicated a document related to tuberculosis risk assessment could not be provided. 2. Policy titled "Tuberculosis (TB) Infection Control Program", revised/reapproved 1/14/15, was reviewed on 6/29/15 at approximately 1515 hours, and indicated on pg. 3 of 5, under section IV. Risk Assessment, points A. B. and C., "Shall be done by the Executive Director. A. The 'Risk Assessment' is determined by an ongoing analysis of: 1. The epidemiology of our TB population. 2. PPD (purified protein derivative) test conversion data; B. Risk categories will be determined based on the risk assessment; C. Epidemiology of our TB population shall include (refer to Figure 2)." Figure 2 was not provided to surveyor.	O 0245	Annual TB risk assessment will be completed by Executive director in conjunction with the quality management support in the Network. The risk assessment template that is already completed for the network will be utilized at the surgery center. Responsible party: executive director	08/31/2015

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	3. Staff 9 (Executive Director) was interviewed on 6/30/15 at approximately 1530 hours, and confirmed they lacked documentation of a TB risk assessment as required by facility policy and procedure.			
S 0000 Bldg. 00	This visit was for a State licensure survey. Facility Number: 005975 Survey Date: 6-29/7-1-2015 QA: cjl 07/16/15	S 0000		
S 0124 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(4) The governing body shall do the following: (4) Ensure that the medical staff is accountable and responsible to the governing body for the quality of care provided to patients. Based on document review and interview, the governing board failed to ensure 5 of 7 medical staff members	S 0124	1.A new form has been developed that includes achecklist for recredentialing candidates. This form provides	07/31/2015

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	(MD#1, MD#2, MD#3, MD#4, and MD#5) were periodically appraised of the quality of care they provided at the facility. Findings: 1. Review of 7 medical staff credential files indicated files MD#1, MD#2, MD#3, MD#4, and MD#5, all podiatrists, did not have any documentation of appraisal of the quality of care they provided at the facility, as part of their reappointment, each, in August, 2013. 2. In interview, on 6-29-2015 at 12:45 pm, employee #A1, Executive Director, confirmed all the above and no other documentation was provided prior to exit.		for reviewof outcome-oriented performance evaluations of applicants. In additionthe following categories have been added: appropriateness of diagnosis andtreatments rendered related to a standard of care and anticipated or expectedresults, performance evaluation based on clinical performance indicated in partby the results or outcome of surgical intervention, and scope and frequency ofprocedures. responsible parties: executive director, medical director, credentialing coordinator	
S 0176 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M) Require that the chief executive officer develop and implement policies and programs for the following: (M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special			

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	procedures. Based on document review, staff record review, and staff interview, the chief executive officer failed to implement policies related to demonstrating and documenting personnel competency in fulfilling assigned responsibilities for 1 of 1 (Staff 4, Infection Control Officer) infection control staff record reviewed. Findings: 1. Job Description, titled "Infection Control Officer" revised/reapproved 1/14/15, was reviewed on 6/29/15 at approximately 1300 hours, and indicated on pg. 1 of 2, under section II. Functions and Duties/Responsibilities, point E., "Maintains APIC (Association for Professionals in Infection Control and Epidemiology) membership. 2. Policy titled, "Infection Control Policy", revised/reapproved 1/14/15, was reviewed on 6/29/15 at approximately 1315 hours, and indicated on pg. 1 of 2, under Infection Control Officer section, point 2., "Membership in the Association for Professionals in Infection Control and Epidemiology (APIC) will be maintained to stay abreast of critical issues and conditions." 3. Review of staff records on 6/29/15 at	S 0176	In the infection prevention plan the verbiage will bechanged and approved to indicate "Membership in the Association for Professionals in Infection Control and Epidemiology (APIC) will **be highly recommended** to stay abreastof critical issues and conditions." Infection prevention officer for facility will be encouraged to acquire and maintain APIC certification within 1 year of appointment date torole of IP officer. Our current IPofficer will have 1 year from date of notification to attain certification. Responsible parties: executive director, clinical director,IP officer	08/31/2015

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	approximately 1113 hours, confirmed staff 4 (Infection Control Officer) lacked demonstation and/or documentation of membership in APIC. 4. Staff 4 was interviewed on 6/30/15 at approximately 1430 hours and confirmed they lacked demonstation and/or documentation of membership in APIC as required by facility policy and procedure.			
S 0328 Bldg. 00	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b) (b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows: (1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care. Based on document review and interview, it could not be determined the facility took effective action and follow-up to address an opportunity for improvement found through its quality assessment and performance (QAPI) program in 1 instance.	S 0328	For all future QI studies the AAAHC template will be followed for each study. A minimum of 2 studies will be conducted each year. At the completion of the study results will be analyzed to see if goal was met. If goal was not met, data will be reevaluated in order to pursue additional	08/31/2015

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	Findings: 1. Review of a document entitled Quality Assessment Performance Improvement Study, conducted February 2014 - April 2014, indicated the purpose was to improve first case on time starts for surgical operations, with a goal based on industry benchmarks of 80% first case on time start as best practice. 2. Further review of the study indicated: Data was collected for the first 45 days of the study, the result being 2% first case on time starts. At the end of this time, the facility took various actions to improve the outcome. At the end of 90 days, review of the study indicated data will continue to be collected to monitor any improvement in the on start time of the first case of the day. Policies and procedures will continue to be updated and implemented to insure 80% compliance with start time. No further data was collected to indicate if the actions taken resulted in improvement of the outcome. Thus, the study was		actions for follow up (extend study, implement tnew techniques to reach goal, reevaluate goal if it was determined to be unattainable, etc.)Responsible Parties: Executive Director and clinical director	

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	incomplete because it could not be determined the facility took effective action and follow-up to address an opportunity for improvement 3. In interview, on 7-1-2015 at 9:45 am, employee #A3, Clinical Director, confirmed all the above and indicated the facility stopped gathering data after 90 days because it didn't seem there was any problem with the issue. On that day and time, the employee was requested to provide documentation showing the goal had been met and the employee indicated there was no other documentation to support the conclusion of reaching the goal.			
S 0404 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(b) (b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance,			

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	investigation, control, and prevention of infections and communicable diseases in patients and health care workers. Based on document review and staff interview, the facility failed to maintain a written, active, and effective center-wide infection control program related to tuberculosis risk assessment. Findings: 1. Email communication from corporate representative was reviewed on 6/29/15 at approximately 1500 hours, and indicated a document related to tuberculosis risk assessment could not be provided. 2. Policy titled, "Tuberculosis (TB) Infection Control Program", revised/reapproved 1/14/15, was reviewed on 6/29/15 at approximately 1515 hours, and indicated on pg. 3 of 5, under section IV. Risk Assessment, points A. B. and C., "Shall be done by the Executive Director. A. The 'Risk Assessment' is determined by an ongoing analysis of: 1. The epidemiology of our TB population. 2. PPD (purified protein derivative) test conversion data; B. Risk categories will be determined based on the risk assessment; C. Epidemiology of our TB population shall include (refer to Figure 2)." Figure 2 was not provided to	S 0404	Annual TB risk assessment will be completed by Executive director in conjunction with the quality management support in the Network. The risk assessment template that is already completed for the network will be utilized at the surgery center. Responsible party: executive director	08/31/2015

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	surveyor. 3. Staff 9 (Executive Director) was interviewed on 6/30/15 at approximately 1530 hours, and confirmed they lacked documentation of a TB risk assessment as required by facility policy and procedure.			
S 0780 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days. Based on document review, medical record review, and staff interview, the medical staff failed to ensure all practitioner orders are in writing or acceptable computerized form and authenticated by a responsible practitioner as allowed by medical staff policies for 2 of 20 (Patient 1 and 4) closed patient medical records reviewed.	S 0780	The QA committee will begin audits on drugs given with corresponding order. A random sampling of 10 charts each month will be selected and each drug administration will be reviewed toensure that the ordered drug is also the drug/dosage/route administered. Results will be provided to the QA committee and any misses will be addressed with the individuals involved.Responsible	08/31/2015

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	Findings: 1. Policy titled, "Pharmacy Services", revised/reapproved 1/14/15, was reviewed on 6/29/15 at approximately 1600 hours, and indicated on pg. 2 of 4, under Procedure section, points G. Physician Orders and J. Drug Administration to the Patient, "In addition to Standing Orders; physicians may prescribe drugs for patients during the patient's stay in the Center using the Physician's Order Form portion of the patient's chart. The specific drug and dosage are entered on the form and signed by the physician. The Registered Nurse will prepare and issue the drugs as prescribed...All drugs will be administered to the patients only upon the order of the Physician in charge of the patient." 2. Review of medical records on 6/29/15 at approximately 1258 hours, confirmed per Recovery Room Record, patient: A. 1: a. received Toradol 30 mg, IV (intravenously) at 0726 hours on 2/12/15. b. lacked a physician order for Toradol 30 mg, IV. B. 4: a. received Tylenol with Codeine Elixir 10 ml, PO (by mouth) at 1140 hours on 1/28/15.		parties: Executive director, clinical director, QA committee	

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	b. lacked a physician order for Tylenol with Codeine Elixir 10 ml, PO 3. Staff 1 (Clinical Director) was interviewed on 6/29/15 at approximately 1310 hours, and confirmed the above-mentioned patient medical records lacked physician orders as required by facility policy and procedure for medications administered.			
S 0826 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E) 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: (E) Safety training required of personnel. Based on document review and interview, the facility failed to provide documentation of safety training in areas where anesthetics are used for 4 of 7 credential files reviewed (MD#1, MD#2, MD#3, and MD#6). Findings: 1. Review of 7 medical staff credential files indicated files MD#1, podiatrist, MD#2, podiatrist, MD#3, podiatrist, and	S 0826	OR safety training has been updated to include a video with accompanying attestation of having viewed video. This training will be distributed to all medical staff who do not have it on file at initial appointment and those whoapply for reappointment who do not have the one time safety training. If not completed reappointment and initial appointment could be delayed. Responsible party: medical director, executive director,credentialing coordinator	08/31/2015

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	MD#6, anesthesiologist, did not contain any documentation of safety training in areas where anesthetics are used. 2. In interview, on 7-1-2015 at 11:00 am, employee #A1, Executive Director, confirmed the above and no other documentation was provided prior to exit.			
S 1004 Bldg. 00	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(1) Pharmaceutical services must have the following: (1) A designated professional person with prescriptive authority, or a pharmacist, who is responsible for the control of drug stocks in the center. Based on document review and interview, the facility failed to ensure a licensed health care professional, who had been designated responsible for the ASC's pharmaceutical services, abided by the contract in 1 of 2 instances. Findings: 1. Review of a contract between NORTHWEST SURGERY CENTER, LLC and VISIONARY ENTERPRISES, INC, dated November 21, 2012, indicated [there will be] two on-site inspections of	S 1004	Pharmacy consultant has been contacted and requested to come 2x each year. 1 visit has occurred in2015 so far and one additional visit will be scheduled before 12/31/2015. Responsible parties: clinical director and executive director	08/31/2015

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	pharmaceutical supplies and equipment annually by a Consultant Pharmacist. 2. Review of facility documents indicated for calendar year 2014, there was only 1 inspection report, on 6-12-2014. 3. In interview, on 7-1-2015 at 11:45 am, employee #A1, Executive Director, confirmed the above-stated documentation and no other documentation was provided prior to exit.			
S 1168 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii) (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: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical			

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	current leakage checks and analyzed at least triennially. Based on document review and interview, the facility failed to conduct triennial analysis of preventive maintenance (PM) for 1 of 12 pieces of patient care equipment. Findings: 1. Review of PM for 11 pieces of patient care equipment indicated a triennial analysis of PM was not done for a sterilizer 2. In interview, on 7-1-2015 at 12:45 pm, employee #A1, Executive Director, confirmed there was no documentation of triennial analysis for the above-stated piece of equipment and no other documentation was provided prior to exit.	S 1168	Sterilizer will be set to have triennialinspection beginning in 2015. The PMwill be reviewed on a triennial basis to ensure that manufacturer'sinstructions are being followed in performing all annual PMs. This will be completed by the companyservicing the sterilizers at the time. Responsible party: executive director	08/31/2015
S 1170 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv) (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:			

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	(4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained. 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. Findings: 1. Review of the OPERATOR'S CHECKLIST FOR R SERIES ZOLL DEFIBRILLATOR, indicated it was recommended the facility was to perform daily checks per that checklist provided by the manufacturer that included, but were not limited to, Batteries- fully charged spare battery available, Disposable supplies - defib gel or gel patches,hands-free therapy electrodes in sealed packages - 3 sets, ECG electrodes, recorder paper, alcohol wipes, and razors. 2. Review of a facility document entitled OPERATOR'S CHECKLIST FOR R SERIES ZOLL DEFIBRILLATOR, dated	S 1170	The daily operator's checklist has been reviewed with all staff who has opportunity to check the defibrillator daily (RNs). All items on checklist must be attended to/checked on a daily basis and indicated on the checklist. A monthly audit of the checklist will be completed for the duration of 2015 to ensure that it is completed in its entirety. Any omissions will be addressed with the individual who checked the defibrillator on that day and coaching will occur. Responsible party: clinical director	07/31/2015

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	Jan 5, 6, 7, 8, and 9, for year 2014, indicated it did not include the above daily checks. 3. In interview on 7-1-2015 at 12:50 pm, employee #A1, Executive Director, confirmed the above and no further documentation was provided prior to exit.			
S 1188 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4) (c) A safety management program must include, but not be limited to, the following: (4) A written fire control plan that contains provisions for the following: (A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills. Based on document review and interview, the facility failed to include in its written fire control plan a provision for cooperation with firefighters in 1 instance.	S 1188	Fire control plan updated to include “wewill cooperate with any direction provided by firefighting authorities”. Responsible party: executive director	07/31/2015

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	Findings: 1. Review of the facility's fire control plan, approved 1-14-2015, did not indicate a provision for cooperation with firefighting authorities. 2. In interview, on 6-29-2015 at 3:05 pm, employee #A1, Executive Director, confirmed the above and no further documentation was provided prior to exit.			