

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2013
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NAME OF PROVIDER OR SUPPLIER EAGLE HIGHLANDS SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6850 PARKDALE PLACE INDIANAPOLIS, IN 46254
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 004756</p> <p>Survey Date: 7-15/17-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 07/30/13</p>	S000000	Agreed	
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</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>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. Based on document review and interview, the facility's governing board failed to review 6 contracted services and 1 other activity during calendar year 2012 as part of the facility's quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the governing board meeting minutes for calendar year 2012 indicated the governing board failed to review QAPI activities for the contracted services of medical records, 2 security services, transcription, device reprocessing, employee health services, and discharge activity.</p> <p>3. In interview, on 7-16-12 at 3:15 pm, employee #A3 confirmed the above and no other documentation was provided prior to exit.</p>	S000110	<p>1. The contracted services spreadsheet has been updated to include the 6 contracted services listed in the citation. The standards and expectation are clearly delineated for each of the contracted services. The contracted service report has been added as a standing agenda item for the center's QAPI committee meetings for review and the report has been added as a standing agenda item for each of the Governing Board meetings. The discharge activity is being monitored through the medical records auditing reports. This activity has been added as a standing agenda item for the center's QAPI committee meetings for review and the QAPI committee discharge activity reports has been added as a standing agenda item for the Governing Board meetings. 2. Adding as standing agenda items for the center's QAPI committee and Governing Board meeting agendas will prevent the failure of the reviews from recurring. 3. The Eagle Highlands Surgery Center Director is responsible for ensuring</p>	08/05/2013	

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S000156	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on employee file review and interview, the chief executive officer failed to ensure that the infection preventionist received a job description for that position in which the performance standards specific to that obligation were indicated:</p> <p>Findings: 1. at 2:30 PM on 7/15/13, review of the employee file for the infection preventionist (staff member P1/also #54),</p>	S000156	<p>compliance with this regulation.4. The updated spreadsheet for the contracted services was completed on 08/05/2013. The items noted was added to the QAPI and Governing Board meeting agendas on 08/05/2013.</p> <p>1. The surgery center employee identified as the Infection Control RN for the surgery center is in the appropriate Job Code per our company's criteria for her RN level of responsibilities. The Job Descriptions within the system are tied to the Job Codes; therefore, the additional duties required to fulfill the facility Infection Control RN role was added to the official Job Description as an addendum. The RN noted in the citation has been re-educated to this fact and</p>	08/06/2013

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	<p>indicated that only a RN (registered nurse) job description was present in the file</p> <p>2. at 1:40 PM on 7/16/13, review of the Infection Control binder indicated the facility possessed a specific job description for the infection preventionist</p> <p>3. interview with staff member #54, the RN infection preventionist, at 1:45 PM on 7/16/13, indicated:</p> <p>a. this staff member became the infection control person 9/2010</p> <p>b. there was no specific job description given this staff member for the infection preventionist position</p> <p>4. interview with staff member #51, the facility director, at 3:00 PM on 7/17/13 indicated:</p> <p>a. there is an addendum to the nurses' job descriptions that relates to infection prevention</p> <p>b. it was found that the last line of the addendum indicates staff are to work with/consult with the infection control nurse--this is not a specific job description as was found in the infection control binder</p> <p>c. it was unknwn that staff member #P1/#54 was not given the specific infection control practitioner job description</p>		<p>the RN Job Description and the Infection Control RN Addendum has been placed in the Infection Control Binder. The center's employees have been re-educated to this fact as well.2. Periodic staff education will prevent the confusion from recurring.3. The Clinical Managers of the facility are responsible to ensure compliance with this regulation.4. The items in this plan of correction were completed on 08/06/2013.</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 hospital failed to ensure cardiopulmonary resuscitation (CPR) for all health care workers, in accordance with current standards of practice and facility policy for 4 of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of Policy Number MS 2.02, approved June, 2013, entitled CARDIOPULMONARY RESUSCITATION (CPR) COMPETENCE FOR PHYSICIANS, ALLIED HEALTH PROFESSIONS, AND SUPERVISED ALLIED HEALTH PROFESSIONALS, section V., indicated:</p>	S000162	<p>1. The CPR for Medical Staff will be revised to state that Practitioners (physicians) are "licensed health professionals" who are not considered direct care providers of patient care and do not require documentation of CPR competence. The Medical Staff member whose CPR competency has expired will be required to provide proof of CPR competency renewal by 08/15/2013. The CPR instructors at the facility can assist with renewal if needed.2. The Administrative Assistant will maintain a log of Medical Staff requiring CPR competency, which will include the expiration dates of their competencies. Medical Staff members will be reminded via email of their approaching expiration dates. The Administrative Assistant will</p>	08/15/2013

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	<p>A. Cardiopulmonary resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) competence is required for the following physicians:</p> <ol style="list-style-type: none"> Those physicians who must demonstrate CPR/ACLS competence to comply with Policy MS 2.13 Procedural Sedation. All residents hold and maintain current ACLS and/or PALS certification as a residency requirement. <p>2. The above-stated policy did not indicate any alternative competency requirement for the remaining physicians. Therefore, they are required to have competence in accordance with current standards of practice; i.e. Basic Life Safety (BLS), CPR, ACLS, PALS, as applicable.</p> <p>3. Review of 7 physician credential files indicated MD#4 had an expired BLS competency as of 3-31-13, and MD#2, MD#6, and MD#7 had no documentation of competence in accordance with current standards of practice.</p> <p>4. In interview, on 7-15-13 at 4:25 pm, employee #A4 confirmed the above and no other documentation was provided</p>		<p>provide follow-up to ensure compliance with this regulation.3. The Clinical Director is ultimately responsible to ensure this plan of correction is completed.4. All items in this plan of correction will be completed by 08/15/2013.</p>	

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S000310	<p>prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include a monitor and standard for 2 services furnished by a contractor in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the contracted services of 1 of 3 security services and employee health.</p> <p>2. In interview, on 7-16-13 at 53:15 pm, employee #A3 confirmed the above and no other documentation was provided prior to exit.</p>	S000310	<p>1. The surgery center's contracted service spreadsheet has been revised to include the 3 security services and the IU Health Employee Health service and the standards and expectations have been clearly delineated. The presentation of the contracted services was added as a standing item on the QAPI committee meeting agenda for review. 2. The addition of the contracted services presentation as a standing item on the QAPI committee meeting agenda and the revision of the contracted services spreadsheet to include the standards and expectations will prevent the surgery center from repeating a deficiency in this regulation.3. The QAPI Chairperson is responsible for the consistant compliance of this regulation.4. The plan to correct this deficiency was completed on 08/05/2013.</p>	08/05/2013

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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 observation, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors in 1 instance.</p> <p>Findings:</p> <p>1. On 7-17-13 at 1:50 pm, in the presence of employee #A3, it was observed at the outside trash dumpster that there was a considerable amount of miscellaneous trash (bottles, papers, etc.) on the ground all around the dumpster.</p>	S000400	<p>1. The building maintenance was contacted on 07/17/2013 and the condition of the area around the trash dumpster was reported and an immediate clean up was requested. This area was added to the environmental checklist to be monitored monthly. 2. The addition of this area to the environmental checklist will ensure monthly checks to ensure compliance with keeping the area free of debris. Noncompliance will be reported immediately to the facility Clinical Managers, who will contact the building owners.3. The facility Safety Officer is responsible for monitoring the cleanliness and safety of the facility's environment.4. The area surrounding the dumpster was cleaned by the building maintenance on 07/18/3013.</p>	07/18/2013
S000404	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a</p>			

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	<p>written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on policy and procedure review, employee health file review, and staff interview, the infection control committee failed to ensure that an effective infection prevention program, related to immunization status of employees and contracted staff, was established for 8 of 10 personnel files reviewed (staff members P1, P2, P3, P4, P5, and P8 plus contracted radiology techs P11 and P12).</p> <p>Findings:</p> <p>1. at 10:05 AM on 7/17/13, review of the policy and procedure "Pre-Placement Health Assessment", policy number CL 3.06, with an effective date of 1/1/97 and a revision date of 5/23/07, indicated:</p> <p>a. on page 3 under "2. Rubeola (Measles)/Mumps/Rubella (German Measles)...b. Criteria for determination of a candidate's immune status is as follows: Candidates born in 1957 or later can be considered immune to measles, mumps, or rubella only if they have documentation of (a) physician-diagnosed measles or mumps</p>	S000404	<p>1. To comply with the policy noted, the employees noted in tag # S_0404 will have titers drawn and the results will be maintained in their health file at IU Employee Health, a contracted service of Eagle Highlands Surgery Center.</p> <p>2. Since the employees' hire dates and/or date of birth excluded them from being required to provide documented verification of Varicella or Rueola, the titer will ensure compliance with the "Preplacement Health Assessment" policy.3. The facility Infection Control RN will be responsible to ensure that each of the named employees' appropriate titers are drawn and the results reviewed for acceptability. If an employee's titer falls outside of the acceptable range, the Infection Control RN will collaborate with the IU Health Employee Health department for appropriate actions.4. The plan has been approved by the Eagle Highlands Surgery Center Clinical Director and the IU Health Employee Health Nurse Practitioner as of 08/14/2013. The actual task of getting the</p>	08/30/2013

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	<p>disease or (b) laboratory evidence of measles, mumps, or rubella immunity or (c) appropriate vaccination against measles, mumps, and rubella..."</p> <p>b. on page 3 under "3. Varicella (Chicken Pox) a... Candidates are considered immune to Varicella if they self-report a positive history of Chicken Pox..."</p> <p>2. at 4:15 PM on 7/15/13, review of the policy and procedure "Pre-Placement Health Assessment", policy number CL 3.06, with an effective date of 1/1/97 and a revision date of 2/2012, indicated:</p> <p>a. on page 3 under "C. Immunization status:...1. Rubeola (Measles)/Mumps/Rubella (German Measles)...b. Criteria for determination of immune status to Measles, Mumps and Rubella: i. Candidates born before 1957 will be considered immune only if they have documentation of: (a) history of one or more MMR vaccinations; or (b) laboratory evidence of immunity to all three diseases; or (c) health-care provider diagnosed Measles or Mumps disease along with laboratory evidence of Rubella immunity..."</p> <p>3. at 4:15 PM on 7/15/13, review of the policy and procedure "Varicella Screening", policy number CL 3.09, with an effective date of 7/1/02 and a revision</p>		<p>titers drawn and sent to the appropriate lab will require a slight extension of time and is expected to be completed by 08/30/2013.</p>	

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	<p>date of 5/2011, indicated:</p> <p>a. under section "IV. Policy Statements", it reads: "A. Employees are considered immune if they provide one of the following acceptable forms of documentation for varicella: 1. positive varicella titer 2. documentation of healthcare provider diagnosed varicella or herpes zoster (shingles) 3. proof of 2 varicella vaccines, at least 28 days apart..."</p> <p>4. at 2:30 PM on 7/15/13, review of personnel files P1, P2, P3, P4, P5, and P8, and contracted radiology technician personnel files P11 and P12 indicated:</p> <p>a. all were hired prior to the 5/2011 update of the policies listed in 1., 2., and 3. above</p> <p>b. all of these staff members self reported having had chicken pox (Varicella) disease</p> <p>c. staff member P5 was born prior to 1957 and self reported having had Rubeola in the past</p> <p>5. interview with staff member #51, the facility director, at 4:15 PM on 7/15/13, indicated:</p> <p>a. per a phone call with the employee health staff, only employees who "transfer to another facility within the health system" have their health files reviewed with a follow up to the self</p>			

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S000432	<p>reported immunization status completed at that time (a varicella titer would be drawn at that time since self reporting is no longer accepted)</p> <p>b. if employees do not transfer from one location to another, it is unknown what the exact immune status is for those who were hired prior to the updates of policy, which require more stringent documentation of immunity</p> <p>c. other facility employees and patients may be at risk by the unknown status of immunity for staff members P1, P2, P3, P4, P5, and P8 and radiology techs P11 and P12 making the current infection control program ineffective</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and interview, the infection control</p>	S000432	1. A process for monitoring of biologicals / testing was added to the QAPI / Infection Control	08/12/2013

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S000612	<p>committee failed to provide documentation of the monitoring and evaluation of biologicals.</p> <p>Findings:</p> <ol style="list-style-type: none"> at 12:00 PM on 7/16/13, review of the quality meeting minutes, which included infection committee reporting, indicated: <ol style="list-style-type: none"> meetings of Jan., 16, 2013; Feb. 20, 2013; March 27, 2013; April 17, 2013; and June 19, 2013 were all lacking any indication of the monitoring of biologicals/testing performed by facility staff at 11:05 AM on 7/17/13, interview with staff member #50, the clinical manager of the operating room, indicated that currently there is no monitoring, discussion, or evaluation of the biological testing performed by staff, as part of infection control information reported at the quality meetings <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented</p>		<p>committee meeting agenda for discussion and development of a monitoring log. 2. The addition to the QAPI / Infection Control committee agenda of the needed process will ensure the the issue is discussed and a solution put in place and is on-going.3. The facility Infection Control RN is responsible to ensure we are in compliance with the regulations and ultimately provide the highest level of patient safety.4. The QAPI / Infection Control committee meeting agenda was updated with this item added on 08/12/2013.</p>	

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	<p>accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the accuracy for 1 of 1 medical record by physician #55 (pt. #9), and one other patient record (pt. #3).</p> <p>Findings:</p> <p>1. at 12:10 PM on 7/17/13, review of the policy and procedure CLR 6.00 "Content of Medical Records", with a last approval date of 7/27/11 indicated:</p> <p>a. on page 3 it reads in section "V. Policy Statements...C. The following apply to all entries in the Medical Record: 1. All entries must be legible and complete, reflecting pertinent, factual, and meaningful observations and information..."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. #3 had both "yes" and "no" marked in the area where the patient was asked if they had an advance directive (on the "Pre-operative Record--page 1)</p> <p>b. patient #9 had:</p> <p>A an operative note by physician #55 which was dictated on 3/18/13 and reported the anesthesia included "...25 ml of 0.5% ropivacaine plain"</p>	S000612	<p>1. Education was provided on 07/18/2013 to the employee who incorrectly handled the documentation error in the patient's chart. The inconsistency between the physician's and the circulator's documentation of the drug is being investigated for correctness and the individual with the incorrect documentation will be instructed to correct appropriately. 2. Facility personnel and physicians will be re-educated in the appropriate process for correcting documentation errors. The policy in which this is located will be emailed to all personnel and physicians as well. Repeat personnel offenders will be approached on an individual basis and held personally accountable. Repeat physician offenders will be reported to the Medical Director for follow-up. These issues was placed on the QAPI committee meeting agenda for further review.3. The Clinical Managers will be responsible for continuous monitoring and education regarding the accuracy of patient charts.4. All issues within this tag's plan of correction will be completed by 08/15/2013.</p>	08/15/2013

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S000640	<p>B. a notation by nursing on the "IntraOp Record M-25" on page 2 that stated the patient received Bupivacaine 0.5% 30 ml"</p> <p>3. at 11:05 AM on 7/17/13, interview with staff members #50, the clinical manager of the operating room, and #53, the RN manager--by phone call verification from staff member #50, indicated:</p> <p>a. it appears that the nurse crossed out the "yes" response by the patient, but this error was not corrected per facility policy</p> <p>b. bupivacaine and ropivacaine are not the same drug</p> <p>c. the medical record for pt. #9 is inaccurate with documentation indicating two different anesthetic agents being given and two different dosages being given (25 ml vs 30 ml)</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that</p>	S000640	1. The individual responsible for the deficiencies noted in the tag will be identified and coached by the Clinical Managers on an	08/15/2013

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	<p>medical records were complete for 6 of 9 patients (pts. #1, #2, #3, #4, #5, and #8).</p> <p>Findings:</p> <p>1. at 12:10 PM on 7/17/13, review of the policy and procedure CLR 6.00 "Content of Medical Records", with a last approval date of 7/27/11 indicated:</p> <p>a. in section "V. Policy Statements", it reads: "C. The following apply to all entries in the Medical Record: 1. All entries must be legible and complete,..."</p> <p>2. patient medical record review indicated:</p> <p>a. pts. #1, #2, and #4, lacked the time of physician notation of operative information on the "Physician Documentation" form (M-25)</p> <p>b. pt. #2:</p> <p>A. lacked a time of the post op phone call on the "Post-Operative Record" form (page 2)</p> <p>B. lacked notation of whether or not the patient's advance directive was on the chart (after noting the patient did have an advance directive)</p> <p>c. pt. #3 lacked documentation on the "Pre-Operative Record" form (page 1) of whether or not the patient had an advance directive and whether or not it was on the chart</p> <p>d. pt. #5 lacked completion of the order for Demerol (on the "Post Anesthesia</p>		<p>individual basis. All personnel and physicians who document in patient charts will be re-educated on the policy and the importance of ensuring correctness of the patients' charts. RNs will be re-educated as to the need to write all verbal orders received by physicians.</p> <p>2. Surgery center personnel will perform random patient chart audits monthly and non-compliance with ensuring complete and accurate documentation will be dealt with by the Clinical Managers on an individual basis. Repeated non-compliance by the physicians will be reported to the facility's Medical Director. Medical record issues will be discussed at the QAPI committee meetings.</p> <p>3. The Clinical Managers of the Operating Room and the PACU departments are responsible for continual monitoring of the patient charts.</p> <p>4. Staff education and discussions regarding the items in #1 of this tag will be completed by 08/15/2013. Monitoring of patient charts and follow-up of deficiencies will be on-going.</p>	

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S000710	<p>Care Orders" form) for how many minutes apart the medication can be given and a dosage "not to exceed" e. pt. #8 lacked a time of the documentation by the anesthesiologist on the "Pre-Operative Sedation Physical Assessment" form</p> <p>3. interview with staff members #52, the clinical manager of PACU, and #53, the RN manager, at 12:30 PM on 7/17/13, indicated:</p> <p>a. documentation was lacking for the patient records as listed in 2. above</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p>			

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	<p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p> <p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and</p>			

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	<p>federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff. Based on document review and interview, the facility failed to document a signed statement to abide by the medical staff bylaws and rules for 2 of 3 allied health medical staff credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the medical staff bylaws, Article V, entitled PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT, Application for Appointment/Reappointment, approved 1-23-13, indicated the application shall state that the applicant has received and read these Bylaws and Medical Staff Rules, Regulations and Policies and that he agrees to be bound by the terms thereof during his/her membership on the Medical Staff. Review of 3 allied health medical staff credential files indicated files AH#1 and AH#3 did not have documentation of a signed statement to abide by the bylaws and rules of the medical staff. In interview, on 7-15-13 at 4:25 pm, employee #A4 confirmed the above and no further documentation was provided 	S000710	<ol style="list-style-type: none"> The Allied Health individuals noted in the deficiency have provided signed statements to abide by the Medical Staff rules and bylaws. The Administrative Assistant has checked the files of the other physicians and allied health on the Medical Staff to ensure these statements were present. The files of new members of the Medical Staff will be checked for completeness as they become members to ensure this deficiency does not recur. The Administrative Assistant is responsible for the maintenance of the Medical Staff Files. This issue was completed on 07/24/2013. 	07/24/2013

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S000728	<p>prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)</p> <p>(b) The medical staff shall adopt and enforce bylaws to carry out its responsibilities. These bylaws and rules must be as follows: Based on document review and interview, the medical staff failed to adopt required rules.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of required medical staff rules indicated there were medical staff rules including, but not limited to, provision for coverage of emergency care and medical histories and physicals being in accordance with medical staff requirements. 2. Review of the rules indicated they were not approved by the medical staff. 3. In interview, on 7-17-13 at at 12:20 pm, employee #A3 confirmed the above-stated rules were not approved by the medical staff staff and no other 	S000728	<ol style="list-style-type: none"> 1. A policy to provide emergency care coverage and the policy regarding medical histories and physicals was sent to the medical staff for review and approval and then sent to the members of the Governing Board for review and approval. The Medical Staff Bylaws and rules were sent to the Medical Staff members for review and approval. 2. The renewal dates for the policies and the Medical Staff Bylaws and rules has been scheduled on the calendar for the Medical Staff meeting prior to expiration. This will prevent oversight of this task and will ensure we follow the rules of the Medical Staff Bylaws. 3. The Clinical Director of the center is responsible to maintain compliance with this regulation. 4. The stated approvals were completed on 07/31/2013 	07/31/2013

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S000780	<p>documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(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.</p> <p>Based on policy and procedure review, medical staff by-laws and rules and regulations review, patient medical record review, and staff interview, the nursing and medical staff failed to implement policies related to writing and authenticating verbal orders for 2 of 9 patients (pts. #4 and #9).</p> <p>Findings: 1. at 11:30 AM on 7/17/13, review of the</p>	S000780	<p>1. Surgery center personnel who are responsible for documentation entries in the patient charts will be re-educated regarding completion of medical records. All will be required to read the "Completion of Medical Records" policy and sign they have done so. Physicians will be provided a copy of the same policy and noncompliance with the policy will be reported to the Medical Director. Physicians with documents that have missing</p>	08/15/2013

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	<p>policy and procedure "Completion of Medical Records", policy number MS 2.03, with a last approval date of July 28, 2010, indicated:</p> <p>a. under section "V. Policy Statements", it reads in item "D.": "The medical record will be considered delinquent if reports and signatures are not completed within 15 days following the date of service..."</p> <p>2. at 2:15 PM on 7/17/13, review of the policy and procedure "Verbal Orders", with a policy number AAP 10.03, and a last approval date of July 28, 2010, indicated:</p> <p>a. under section "V. Policy Statements", it reads in "A.": "...Verbal orders must be signed by the prescribing physician..."</p> <p>3. at 9:25 AM on 7/17/13, review of the medical staff by-laws and rules and regulations indicated that these documents do not address verbal orders and the time frame required for authentication</p> <p>4. review of patient medical records indicated:</p> <p>a. pt. #4: A. had a verbal order written 3/27/13 by nursing that read: "Admit as o.p. to EHSC" (admit as outpatient to Eagle</p>		<p>signatures will be reminded to sign immediately.2. Random monthly patient chart audits completed by surgery center employees will be on-going. Personnel with repeated deficiencies in documentation will be held accountable and appropriate counseling will occur to prevent recurrence of documentation deficiencies.3. The Clinical Managers of the surgery and PACU departments are responsible to monitor and address all situations as they occur.4. Education to surgery center personnel was completed and physician education and signatures will be complete by 08/15/2013.</p>	

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S000860	<p>Highlands Surgery Center"</p> <p>B. lacked physician authentication of the verbal order written in A. above</p> <p>C. had verbal orders written on 3/27/13 to give 400 mg Cipro and 500 mg Flagyl, but lacked documentation by nursing of a time for either of these orders</p> <p>b. pt. #9:</p> <p>A. had a verbal order written at 1600 hours on 3/14/13 for "Narcan 0.4 mg IVP stat" (intravenous push, now)</p> <p>B. lacked authentication by the physician of the verbal order at 1600, (had signed off on the other orders for that day at "11:00")</p> <p>5. interview with staff members #52, the clinical manager of PACU, and #53, the RN manager, at 12:30 PM on 7/17/13, indicated:</p> <p>a. nursing failed to note the time of verbal orders as written in 4. C. above</p> <p>b. authentication of verbal orders was lacking for patients #4 and #9 as written in 4. above</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(B)</p>						

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	<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>(B) A requirement that an appropriate history and physical workup must be in the chart of every patient before surgery. If this has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting practitioner which includes, but is not limited to, vital signs, allergies, any significant risk factors, and date written.</p> <p>Based on medical staff by-laws and medical staff rules and regulations review, policy and procedure review, patient medical record review, and staff interview, the medical staff failed to ensure that physicians noted the time of their history and physical exams making it impossible to determine if they were performed prior to the start of surgical procedures for 5 of 9 patients (pts. #3, #4, #7, #8, and #9).</p> <p>Findings:</p> <p>1. at 9:25 AM on 7/17/13, review of the medical staff by-laws and rules and regulations indicated that these</p>	S000860	<p>1. Physicians will be re-educated on the Medical Staff Bylaws and the Completion of Medical Records policy regarding the time requirements on the patient history and physicals on the day of the procedure. Surgery center personnel will be reminded to check the patient history and physical form during the handoff to surgery for compliance by the physician. Patients will not be released to surgery if the form is not timed. 2. Checking the form prior to surgery will ensure consistent compliance with the Medical Staff Bylaws and the Completion of Medical Records policy. 3. The Clinical Managers are responsible to ensure staff</p>	08/15/2013

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	<p>documents do not address noting a time of the history and physical to be able to determine if it was completed prior to the start of surgery</p> <p>2. at 11:30 AM on 7/17/13, review of the policy and procedure "Completion of Medical Records", policy number MS 2.03, with a last approval date of July 28, 2010, indicated:</p> <p>a. on page two it reads under "V. Policy Statements", "B. A complete History and Physical examination shall be available in the medical record prior to surgery."</p> <p>3. review of the patient medical records indicated:</p> <p>a. pts. #3, #4, #7, #8, and #9 had hand written history and physicals documented on the "Outpatient Surgery - History and Physical" form that lacked a time of documentation for each patient</p> <p>4. interview with staff members #52, the clinical manager of PACU, and #53, the RN manager, at 12:30 PM on 7/17/13, indicated physicians did not note the time history and physicals were written on the day of surgery making it impossible to determine that these were performed prior to the start of surgery</p>		<p>compliance. Non-compliance by physicians will be reported to the Medical Director.4. All education and the handoff process will be completed by 08/15/2013.</p>				

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NAME OF PROVIDER OR SUPPLIER EAGLE HIGHLANDS SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6850 PARKDALE PLACE INDIANAPOLIS, IN 46254
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S000888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the medical staff failed to ensure that operative notes were dictated within the time frame required by facility policy for 3 of 9 records reviewed (pts. #5, #6, and #9).</p> <p>Findings: 1. at 11:30 AM on 7/17/13, review of the policy and procedure "Completion of Medical Records", policy number MS 2.03, with a last approval date of 7/28/10, indicated:</p>	S000888	<p>1. Medical Staff Physicians will be re-educated the requirements of the Completion of Medical Records policy pertaining to dictation of the operative procedure. Physicians with repeated non-compliance will be reported to the Medical Director.2. Consistant reinforcement of this policy will be required to ensure the policy is followed.3. The Clinical Managers of the operating room and PACU will be responsible for record completions and reporting deficiencies to the Clinical Director and Medical Director. 4.</p>	08/15/2013

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	<p>a. under section "V. Policy Statements", it reads in item "C.": "Operative reports must be dictated, or completed, on the date of service for any surgical or invasive procedure..."</p> <p>2. at 9:25 AM on 7/17/13, review of the medical staff by-laws and rules and regulations indicated that these documents do not address operative notes and the time frame required for completion</p> <p>3. review of patient medical records indicated:</p> <p>a. pt. #5 had surgery on her feet under general anesthesia on 3/27/13 and the operative note was dictated on 4/1/13</p> <p>b. pt. #6 had an open revision of a rotator cuff reconstruction performed on 5/2/13 with the operative note dictated on 5/3/13</p> <p>c. pt. #9 had a left knee meniscus saucerization done under a general and local anesthetic on 3/14/13 with the operative report dictated on 3/18/13</p> <p>4. interview with staff members #52, the clinical manager of PACU, and #53, the RN manager, at 12:30 PM on 7/17/13, indicated:</p> <p>a. the operative reports for patients #5, #6, and #9 were not dictated the day of surgery as required by policy</p>		The education will be completed by 08/15/2013.				

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S001012	<p>b. some of the medical records contained a brief, one page, hand written operative note, but the policy listed in 1. above does not distinguish between the two types of operative notes, nor does it allow for a dictated report completion at a later date if the shorter note is completed on the day of surgery</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(B)</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>(B) Drug administration according to established center policies and acceptable standards of practice. Based on patient medical record review, and staff interview, the facility failed to ensure that medications were administered with a physician's order, or as prescribed by a physician, for 3 of 9 medical records reviewed (pts. #1, #7, and #9).</p> <p>Findings: 1. review of patient medical records indicated:</p>	S001012	<p>1. Education to surgery center RNs was provided regarding medication orders and administration of medications. The five rights of medication administration was reviewed. The Verbal Order policy was reviewed. Expectations regarding medication administration and documentation was reinforced. 2. Record audits and holding RNs accountable for non-compliance with policies will ensure compliance. 3. The Clinical</p>	07/18/2013

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	<p>a. pt. #1:</p> <p>A. was given Vicodin 5/325 two tablets at 1500 hours on 1/11/13, while in the recovery room, as per documentation on the "Post-Operative Record" form (page 1)</p> <p>B. lacked an order for Vicodin on either the "Laparoscopic Surgery Instructions" page, the "Post Anesthesia Care Orders", or the "Physician's Orders" page (T-5)</p> <p>b. pt. #7:</p> <p>A. had Demerol 25 mg IV (intravenously) ordered on 5/10/13</p> <p>B. was given 12.5 mg of Demerol in the recovery area at 1319 hours on 5/10/13, as per documentation on the "Post-Operative Record" form (page 1)</p> <p>c. pt. #9:</p> <p>A. was given Narcan 0.4 mg at 1602 hours and 1740 hours on 3/14/13 while in the recovery area, as per documentation on the "Post-Operative Record" form (page 1)</p> <p>B. had only one verbal order written on 3/14/13 for Narcan that read: "1600 Narcan 0.4 mg IVP stat" (intravenous push immediately/now)</p> <p>2. interview with staff member #50, the RN OR manager, at 11:05 AM on 7/17/13 indicated:</p>		Managers of the operating room and PACU are responsible for consistant monitoring for compliance and addressing deficiencies.4. Education was completed on 07/18/2013.	

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S001146	<p>a. anesthesia has a protocol for Narcan that nursing staff may give it as a standing order</p> <p>b. this standing order should be pre printed on the order set, or written by nursing as a verbal order per protocol, as per standards of practice</p> <p>3. interview with staff members #52, the clinical manager of recovery, and #53, the RN manager, at 12:30 PM on 7/17/13, indicated medications were given without an order for pt. #1 and not as written by the physician for pt. #7</p> <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 policy and procedure review, observation, and staff interview, the facility failed to ensure that a hazard, in regard to possible patient infections, was not maintained related to dust</p>	S001146	<p>1. Education provided to all surgery center personnel responsible to maintain cleanliness in the surgery center environment. 2. Checking the lower shelf of the blanket warmers was added to the</p>	07/18/2013

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	<p>accumulation in two areas toured.</p> <p>Findings:</p> <p>1. at 2:30 PM on 7/16/13, review of the policy and procedure "Warming Cabinets for Blankets", policy number IPC 7-17, with an approval date of 2/2013, indicated:</p> <p>a. on page two under section "VI. Cleaning Guidelines", it reads: "Use stainless steel cleaner and polish, use a damp cloth or sponge, thoroughly wipe surface then polish with clean dry cloth. Cleaning should be done on a monthly base, with cleaning between if necessary..."</p> <p>2. at 9:50 AM on 7/16/13, while on tour of OR (operating room) #5, in the company of staff member #50, the OR clinical manager, it was observed that in the Amsco blanket warmer top cabinet, there was considerable dust under the lower shelf (plenum) in which the warmed blankets had sloughed off lint</p> <p>3. at 10:35 AM on 7/16/13, while on tour of the PACU (post anesthetic care unit) in the company of staff member #50, the OR clinical manager, it was observed in the Amsco blanket warmer's top cabinet that there was considerable dust under the lower shelf (plenum) in which the warmed blankets had sloughed off lint</p>		<p>monthly cleaning checklist to prevent recurrence of this deficiency.3. The surgery and PACU Clinical Managers are responsible to ensure a clean and safe surgical environment and compliance.4. Education to staff and adding this to the monthly cleaning checklist was completed on 07/18/2013.</p>	

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S001170	<p>4. interview with staff member #50, the OR clinical manager, at 9:50 AM, 10:35 AM, and 2:30 PM on 7/16/13 indicated:</p> <p>a. it was unknown that the blanket warmers got dusty under the slotted, lower shelf</p> <p>b. the warming cabinet policy (listed in 1. above) only speaks to the cleaning of the outside of the warming cabinets and doesn't specifically address the inside</p> <p>c. the warming cabinet policy was just instituted and cleaning has not yet been scheduled</p> <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</p>			

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	<p>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> <ol style="list-style-type: none"> Review of the LIFEPAK 12 Defibrillator/Monitor Series OPERATOR'S CHECKLIST 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 substances, damages or cracks, Inspect Power Source for broken, loose, or worn battery pins, and fully charged spare batteries available. Review of a document entitled CODE CART CHECKLIST for Unit Pacu, dated 4-29 through 5-3, for year 2013, indicated it did not include the above daily checks. In interview, on 7-17-13 at 11:05 am, employee #A1 confirmed the above and no further documentation was provided prior to exit. 	S001170	<ol style="list-style-type: none"> Surgery center RNs were educated regarding the appropriate process for daily defibrillator checks following the manufacturers recommendations. The center's checklist was revised to include the manufacturer's recommendations.2. The Operator's Checklist from the manufacturer is placed on the code cart with the defibrillator to ensure proper daily checks.3. The PACU Clinical Manager is responsible for ensuring consistant compliance with recommendations from the manufactures.4. The education and revision of the checklist was completed on 07/18/2013. 	07/18/2013

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S001178	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(B)</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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following:</p> <p>(B) Refuse, biohazards, infectious wastes, and garbage must be collected, transported, sorted and disposed of by methods that will minimize nuisances or hazards according to federal, state, and local laws and rules.</p> <p>Based on document review and interview, the facility had no policy for the collection, transportation, sorting, storage and disposal of refuse and garbage.</p> <p>Findings:</p> <p>1. Review of facility policies indicated there was no policy for the collection, transportation, sorting, storage and</p>	S001178	<p>1. The process for non-contaminated trash collection, transportation, sorting, storage, and disposal was added to the existing policy "Segregation of Trash". 2. Education and observation for consistent compliance with the policy will be on-going. 3. The PACU and surgery Clinical Managers are responsible for compliance with the policy and education to new employees. 4. The revised policy was approved by the Governing</p>	08/15/2013
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	disposal of refuse and garbage. 2. In interview, on 7-17-13 at 10:55 am, employee #A3 indicated there was no policy for the collection, transportation, sorting, storage and disposal of refuse and garbage. No other documentation was provided prior to exit.		Board on 07/24/2013		