STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001156	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA SKIN CANCER AMBULATORY SURGICAL CENTER LL	701 E COUNTY LINE RD STE 208 GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q000000	This visit was for a re-certification survey. Facility Number: 005648 Survey Date: 10-21/23-13 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor QA: claughlin 10/28/13	Q000000		
Q000043	416.41(c) DISASTER PREPAREDNESS PLAN (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with State and local authorities, as appropriate. (3) The ASC conducts drills, at least			

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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	annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan. Based on document review and interview, the facility failed to periodically coordinate emergency disaster and preparedness with an appropriate governmental agency. Findings: 1. Review of facility documents indicated the last time there was coordination of emergency disaster and preparedness with an appropriate governmental agency was December 19, 2007. 2. In interview, on 10-22-13 at 4:10 pm, employee #A2 confirmed the above and there was no more current documentation provided by exit.	O000043	To correct this deficiency we are going to coordinate with Region 5 when we perform our annual disaster drills.Our policy on our annual disaster drills will be updated to include coordination annually with Region 5. This deficiency will be prevented in the future by including the aspect of coordination in our monitor book. Dr. Michael Murphy will be responsible for this change.	11/11/2013
Q000061	416.42(a)(1) ANESTHETIC RISK AND EVALUATION A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Based on document review and interview, the facility failed to ensure that a physician evaluated the risk of anesthesia and of the procedure to be	Q000061	This deficiency was corrected by updating our documentation to reflect the physicians evaluation of the risk of anesthesia in our electronic medical records. This deficiency will be prevented in the	11/11/2013

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	performed for 30 of 30 medical records (MR) reviewed (Patient #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 20, 21, 22, 23 ,24, 25, 26, 27, 28, 29 and 30). Findings include: 1. review of patient #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 20, 21, 22, 23 ,24, 25, 26, 27, 28, 29 and 30's MRs indicated that each had a procedure performed with local anesthesia and the MR lacked documentation of a physician evaluating the risk of anesthesia and of the procedure being performed. 2. On 10-22-13 at 1205 hours, staff #40 confirmed that patient #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 20, 21, 22, 23 ,24, 25, 26, 27, 28, 29 and 30's MRs lacked documentation of the physician evaluating the risk of anesthesia and of the procedure being performed.		future by daily evaluation for inclusion of the physicians evaluation of the risk of anesthesia in all patient's charts. This will be added to the portion of our notes called the "ASC admission checklist". Daily audits of all medical records are performed and will include evaluation for the presence of this item in all patient records. Dr. Michael Murphy is responsible for this change	
Q000224	416.50(c)(1)(2)(3) ADVANCED DIRECTIVES The ASC must comply with the following requirements: (1) Provide the patient or, as appropriate,			

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	the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms. (2) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. Based on document review and interview, the facility failed to give the patient or their representative complete information on the facility's policy regarding advance directives. Findings: 1. Review of documents indicated the facility had a policy regarding information that the facility would honor the patient's advanced directive. 2. Review of a document given to the patient or their representative entitled FINANCIAL POLICY/HIPAA POLICY/HCFA RELEASE, APPROVED 8-27-13, indicated The Indiana Skin Cancer Center does have a policy on Advanced Directives which is available upon request.	O000224	To correct this deficiency we are going to update our policy on Advance Directives and update the wording on the form which is provided to the patient in advance of their surgery. This deficiency will be prevented in the future by our daily chart/pt form audits to ensure that the updated Advance Directive verbiage is present.Dr Michael Murphy is responsible for this change	11/11/2013

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	3. In interview, on 10-22-13 at 11:45 am, employee #A1 confirmed the above and no further documentation was provided prior to exit.			
Q000241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on document review, interview and observation the facility failed to provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice in 2 instances. Findings include: 1. Review of the 2001 edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" indicated the following: 1. 9.5.E1 Soiled workroom. This room shall be physically separated from all other areas of the department. Workspace shall be provided to handle the gross cleaning, cleaning, and	O000241	This deficiency has been addressed and corrected. All instruments are now wrapped on the clean workroom side and all clean instrument wrappers are stored on the clean workroom side. All personal items have been removed from the shelves where clean scrubs are stored. The deficiency will be prevented in the future by ongoing daily monitoring of correct practices for both instrument handling and scrub storage.Dr. Michael Murphy is responsible for the correction of this deficiency	10/28/2013

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	disinfection of all medical/surgical instruments and equipment. The soiled workroom shall contain work surface(s), sink(s), flush-type device(s), and washer/sterilizer decontaminators or other decontamination equipment as appropriate to the functional program. 9.5.E2 Clean assembly/workroom. This room shall contain sterilization equipment. This workroom shall contain handwashing station, workspace, and equipment for terminal sterilizing of medical and surgical equipment and supplies. Clean and soiled work areas shall be physically separated. Access to the sterilization room shall be restricted. The clean assembly room shall have adequate space for the designated number of work areas as defined in the functional program as well as space for storage of clean supplies, sterilizer carriages and instrumentation. 2. On 10-22-13 at 1040 hours, staff #43 confirmed that clean instrument wrappers are stored on the dirty workroom side and			

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	the clean instruments are wrapped on the dirty workroom side before taking to the clean workroom side for sterilization. 3. During the facility tour on 10-22-13 at 1030 hours, the following was observed in the dressing room: 7 personal drinks, personal purses, cell phones, keys and snacks were on the same shelves as the the clean surgical scrubs.			
S000000	This visit was for a State licensure survey. Facility Number: 005648 Survey Date: 10-21/23-13 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor QA: claughlin 10/28/13	S000000		

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S000400	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on document review, interview and observation, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients in 2 instances. Findings include: 1. Review of the 2001 edition of the "Guidelines for Design and Construction of Hospital and Health Care Facilities" indicated the following: 1. 9.5.E1 Soiled workroom. This room shall be physically separated from all other areas of the department. Workspace shall be provided to handle the gross cleaning, cleaning, and disinfection of all medical/surgical instruments and equipment. The soiled workroom shall contain work surface(s), sink(s), flush-type device(s), and washer/sterilizer decontaminators	S000400	This deficiency has been addressed and corrected. All instruments are now wrapped on the clean workroom side and all clean instrument wrappers are stored on the clean workroom side. All personal items have been removed from the shelves where clean scrubs are stored. The deficiency will be prevented in the future by ongoing daily monitoring of correct practices for both instrument handling and scrub storage.Dr. Michael Murphy is responsible for the correction of this deficiency	10/28/2013

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	or other decontamination equipment as appropriate to the functional program. 9.5.E2 Clean assembly/workroom. This room shall contain sterilization equipment. This workroom shall contain handwashing station, workspace, and equipment for terminal sterilizing of medical and surgical equipment and supplies. Clean and soiled work areas shall be physically separated. Access to the sterilization room shall be restricted. The clean assembly room shall have adequate space for the designated number of work areas as defined in the functional program as well as space for storage of clean supplies, sterilizer carriages and instrumentation. 2. On 10-22-13 at 1040 hours, staff #43 confirmed that clean instrument wrappers are stored on the dirty workroom side and the clean instruments are wrapped on the dirty workroom side before taking to the clean workroom side for sterilization. 3. During the facility tour on 10-22-13 at 1030 hours, the following was observed			

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	in the dressing room: 7 personal drinks, personal purses, cell phones, keys and snacks were on the same shelves as the the clean surgical scrubs.			
S000622	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(6) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows: (6) The center shall have a system of coding and indexing medical records which allows for timely retrieval of records by diagnosis and procedure, physician, and condition on discharge, in order to support continuous quality assessment and improvement activities. Based on document review and interview, the facility failed to have documentation of a system which allowed for timely retrieval of records by condition on discharge. Findings: 1. Review of facility documents	S000622	This deficiency was corrected by updating of our documentation on our system for timely retrieval of records on the condition of discharge. Every patient chart is audited for condition on discharge. If any patient is outside of our discharge parameters this is recorded in our complications log which is immediately retrievable and	11/11/2013

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	indicated there could not be timely retrieval of records by condition on discharge. 2. In interview, on 10-21-13 at 3:15 pm, employee #A1 confirmed the above and no further documentation was provided by exit.		discussed quarterly in our ASC meeting. Our policy on timely retrieval of this data was updated. This deficiency will be prevented in the future by our updated policy on timely retrieval of condition on discharge. Dr. Michael Murphy is reponsible for this change.	
S000884	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(E) Requirement for surgical services include: (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: (E) A requirement that the patient register is complete and up to date. Based on document review and interview, the facility failed to ensure a policy that the patient register is to be complete and up to date. Findings: 1. Review of facility documents indicated there was not a policy that the	S000884	This deficiency was addressed by the creation of a new policy reflecting that our patient registry will be complete and up to date. This deficiency will be prevented in the future by the creation of the policy showing that our patient registry is complete and up to date. Dr. Murphy is responsible for the correction of this deficiency.	11/11/2013

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	patient register is to be complete and up to date. 2. In interview, on 10-23-13 at 10:05 am, employee #A1 confirmed the above and no other documentation was provided prior to exit.			
S001198	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6) (c) A safety management program must include, but not be limited to, the following: (6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies. Based on document review and interview, the facility failed to periodically coordinate emergency disaster and preparedness with an appropriate governmental agency. Findings: 1. Review of facility documents indicated the last time there was coordination of emergency disaster and preparedness with an appropriate	S001198	To correct this deficiency we are going to coordinate with Region 5 when we perform our annual disaster drills.Our policy on our annual disaster drills will be updated to include coordination annually with Region 5. This deficiency will be prevented in the future by including the aspect of coordination in our monitor book. Dr. Michael Murphy will be responsible for this change.	11/11/2013

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	governmental agency was 12-19-07. 2. In interview, on 10-22-13 at 4:10 pm, employee #A2 confirmed the above and there was no more current documentation provided by exit.			