

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001168	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/26/2013
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NAME OF PROVIDER OR SUPPLIER ST FRANCIS MOORESVILLE SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 HADLEY RD STE 100 MOORESVILLE, IN 46158
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 012149</p> <p>Survey Date: 9-24/26-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/08/13</p>	S000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S000162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on document review and interview, the facility failed to follow its job description requirements for pediatric advanced life support (PALS) for 1 (Staff #7) of 1 agency registered nurse (RN).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the job description for a RN - Preop / Recovery indicated the following; "Qualifications PALS certified." 2. Review of staff #7's personnel file indicated that staff #7 worked on 09-23-13 in recovery and staff #7's personnel file lacked documentation of being PALS certified. 	S000162	<p>Job Description for "Registered Nurse: Surgery" & "Registered Nurse: Pre-op/Recovery" have been revised to exclude "Qualifications" regarding agency & PRN nurses and attached. Changes have been sent to the MAC for recommendation to the Board of Managers Approval will be requested at the Board of Managers Meeting (BOM) Deficiencies will be prevented in the future once these changes have been approved by the BOM. Responsibility: Director of the Center</p>	11/18/2013			

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S000228	<p>3. On 09-24-13 at 1315 hours, staff #40 confirmed that staff #7 did not have current PALS certification.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that podiatrists performing surgery in the facility maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located for 1 of 1 podiatrist credential file reviewed.</p> <p>Findings:</p>	S000228	Admitting privileges for Dr. Neville were in place during the survey, but not seen. Proof is attached. If similar deficiencies happen in the future, they will be handled in the same manner as this one, providing the proof needed. Responsibility: Director of the Center	09/26/2013

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	<p>1. Review of medical staff credential file MD#2, a podiatrist, indicated the practitioner did not have documentation of admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located. Further review indicated the practitioner did not have a written agreement, signed by both parties, with another facility-credentialed physician who did have admitting privileges at the same hospital with which the facility had a transfer agreement, that the physician would admit patients to the hospital, if needed.</p> <p>2. In interview, on 9-26-13 at 11:45 am, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p>			

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S000756	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(J)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(J) A requirement that each physician's services, , dentist's services, and podiatrist's services are to be reviewed and analyzed at specified intervals at regular meetings, including, but not limited to, the following:</p> <p>(i) Appropriateness of diagnoses and treatments rendered related to a standard of care and anticipated or expected results. (ii) Performance evaluation based on clinical performance indicated in part by the results or outcome of surgical intervention. (iii) Scope and frequency of procedures.</p> <p>Based on document review and interview, the facility failed to review the performance at all for 3 of 3 allied health credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 3 allied health credential files indicated files AH#1, AH#2, and AH#3 did not contain any documentation of review of the</p>	S000756	An "Allied Health Quality Assurance" form has been developed and is attached. The form has been sent to the MAC for recommendation to the Board of ManagersApproval will be requested at the Board of Managers Meeting (BOM)Deficiencies will be prevented in the future once these changes have been approved by the BOM.Responsibility: Director of the Center	11/18/2013			

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S000888	<p>individual's performance.</p> <p>2. In interview, on 9-26-13 at 11:45 am, employee #A2 confirmed the above and no further 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(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 document review and interview, the facility failed to follow its policy/procedure on immediately writing or dictating an Operative Report after a procedure for 5 of 30 medical records (MR) reviewed (Patient # 1, 7, 13, 15 and 25).</p>	S000888	Education to the physicians has been done regarding immediate dictation of the Operative Record The Newsletter has been sent & Posted in the dictation room. Approval will be requested at the Board of Managers Meeting (BOM)A collegial discussion will take place if needed to prevent	11/07/2013

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	<p>Findings include:</p> <p>1. Review of policy/procedure Medical Records indicated the following: "9. A written or dictated Operative Report describing techniques, findings, tissue removed or altered, post-operative diagnosis, and the name of the primary surgeon and the name of any assistants involved. a. If a dictated report is not performed immediately, a progress note must be entered in the medical record." This policy/procedure was last reviewed/revised on 02-20-12.</p> <p>2. Review of the following MRs indicated the following: Patient #1 had a procedure on 07-08-13 and the Operative Report was done on 09-24-13. Patient #7 had a procedure on 04-02-13 and the Operative Report was done on 04-29-13. Patient #13 had a procedure on 05-17-13 and the Operative Report was done on 05-19-13. Patient #15 had a procedure on 08-19-13 and the Operative Report was done on 08-21-13. Patient #25 had a procedure on 05-13-13 and the Operative Report was done on 05-20-13.</p>		<p>future deficienciesResponsibility: Director of the Center & Medical Director</p>				

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S001178	<p>Each MR lacked documentation of a Progress Note being done after the procedure.</p> <p>3. On 09-26-13 at 1005 hours, staff #40 confirmed the date each Operative Report was completed.</p> <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</p>	S001178	"Trash Removal" Policy has been written & attached. The MAC has reviewed & is recommending approval to the BOM. Approval will be requested at the Board of	11/18/2013			

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	<p>garbage.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a document entitled FRANCISCAN ST. FRANCIS HEALTH CARMEL, INDIANAPOLIS, AND MOORESVILLE CAMPUSES ENVIRONMENTAL and LINEN SERVICES indicated this was a policy of Franciscan St. Francis Health, a hospital. 2. In interview, on 9-25-13 at 3:45 pm, employee #A2 indicated this policy had not been approved (adopted) by the surgery center. No other documentation was provided prior to exit. 		<p>Managers Meeting (BOM) Deficiencies will be prevented in the future once the policy has been approved by the BOM. Responsibility: Director of the Center</p>		

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S001188	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(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.</p> <p>Based on document review and interview, the facility failed to conduct fire drills in accordance with facility for 1 of 3 quarters in the time period of January, 2013, through September, 2013.</p> <p>Findings:</p> <p>1. Review of facility policy 02.02.18., entitled Fire Plan, Reviewed DATE: 02.21.2011, indicated Fire Drills will occur quarterly to ensure fire safety preparedness.</p> <p>2. Review of fire drills for the period January, 2013 through September, 2013, indicated there were fire drills conducted</p>	S001188	<p>Fire Drills were done & provided for the following dates prior to the surveyors departure: 1/10/13 (1st Quarter)6/12/13 (2nd Quarter)7/22/13 (3rd Quarter)Additionally 1 drill occurred on 3/14/13 (1st Quarter) as well & is attached. If similar deficiencies happen in the future, they will be handled in the same manner as this one, providing the proof needed. Additionally, a schedule has been set up with the person who does our Facility Maintenance in cooperation with the Fire Alarm company.Responsibility: Director of the Center & Facility Maintenance</p>	09/26/2013			

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	<p>on 1/10/13, 6-12-13 and 7-22-13. Thus, there was no fire drill conducted in the 2nd quarter of year 2013.</p> <p>3. In interview, on 9-25-13 at 3:10 pm, employee #A2 confirmed the above and no further documentation was provided prior to exit.</p>			