

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| Q0000 | <p>This visit was for a recertification survey.</p> <p>Facility Number: 005973</p> <p>Survey Date: 10-29/31-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 11/08/12</p> | O0000 | | | | | |

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.

| | | | | | |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | |
| (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 | |
| Q0043 | <p>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 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.</p> <p>Based on document review and interview, the facility failed to document any disaster drill for year 2011 and from January 1, 2012 through October 31, 2012.</p> <p>Findings:</p> <p>1. On 10-29-12 at 10:00 am, employee #A1 was requested to provide documentation of any disaster drill performed in year 2011 and from January 1, 2012 through October 31, 2012. No documentation was provided.</p> <p>2. In interview, on 10-31-12 at 3:30 pm, employee #A1 indicated there was no documentation of any disaster drill performed in year 2011 and from January</p> | Q0043 | To ensure participation in and documentation of, disaster drills will be placed as a standing agenda item on the every other month Safety Committee Meeting. Participation in drills will be reviewed and documented in the minutes. The Peri-anesthesia educator who serves as the liaison between the Center and the hospital partner, will submit documentation of drills. A disaster drill will be held at least once annually. Responsible Party: Safety Committee will implement and monitor correction of this deficiency. | 12/07/2012 | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | 1, 2012 through October 31, 2012. No other documentation was provided prior to exit. | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| Q0104 | <p>416.44(b) SAFETY FROM FIRE</p> <p>(1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101@ 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to http://www.archives.gov/federalregister/code_of_federal-regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.</p> <p>(2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.</p> <p>(3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>adequately protects patients in an ASC.</p> <p>(4) An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006.</p> <p>(5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if:</p> <p>(i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;</p> <p>(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;</p> <p>(iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and</p> <p>(iv) The dispensers are installed in accordance with the following provisions:</p> <p>(A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m);</p> <p>(B) The maximum individual dispenser fluid capacity shall be:</p> <p>(1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors</p> <p>(2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms</p> <p>(C) The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other;</p> <p>(D) Not more than an aggregate of 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet;</p> <p>(E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code;</p> <p>(F) The dispensers shall not be installed over or directly adjacent to an ignition source;</p> <p>(G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments; and</p> <p>(v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.</p> <p>Based on document review and interview, the facility failed to follow its fire control plan to conduct fire drill each quarter for each shift for 5 of 12 shifts.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a facility policy entitled fire drill procedure, approved 11-11-11, indicated the day and time will be such that staff from all shifts will have the opportunity to participate. It also indicated the day and time will not be the same from quarter to quarter. In interview, on 10-20-12 at 10:00 am, employee #A1 indicated there were shifts. Review of documentation of fire drill indicated no drill in 2011 was conducted during the first quarter for the 2nd and 3rd shifts, the third quarter for the 1st shift, and the fourth quarter for the 2nd and 3rd | 00104 | <p>Correction/Prevention To ensure completion and documentaiton of, fire drills will remain a standing agenda item on the every other month Safety Committee Meeting. The previoulsy defined three work shifts will be redefined into two: days and nights. Documentation from various day shift departments will be combined into one report. The same will be done for nights. This will set the expectation that there will be only two reports (days and nights) each quarter. Moving forward, the time of a drill for any of the two shifts will not be duplicated within any of the four quarters of any calendar year and will vary at least by one hour. Please see attached updated Fire Drill Procedure</p> <p>Responsible Party: Safety Committee will implement and monitor correction and compliance of this deficiency.</p> | 12/07/2012 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | shifts. 4. On 10-31-12 at 3:20 pm employee #A1 confirmed the above documentation and no further documentation was provided prior to exit. | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| Q0106 | <p>416.44(d) EMERGENCY PERSONNEL Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC. Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice or facility policy for 10 (MD#1, MD#3, MD#4, MD#5, MD#6 and MD#7, MD#8, MD#9, MD#10 and MD#11) of 11 physician credential files reviewed.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled LIFE SUPPORT COMPETENCY REQUIREMENTS, revised September, 2012, indicated Medical staff members who perform procedures are considered CPR competent by virtue of maintaining at least one of the following:</p> <ul style="list-style-type: none"> Completes annual CPR competency assessment questionnaire (attached). Sustaining an active practice in their field of specialty, this by the very nature of [sic] demonstrates competency in the maintenance and management of cardiopulmonary function (i.e. anesthesiology). Maintains CPR certification and/or | 00106 | <p>Correction/PreventionThe Center's policy on CPR competency has been updated to more accurately define direct patient care health worker and demonstrate that an appropriate number of cardiopulmonary resuscitation competent health care workers are on site and avaialbe at any time a patient(s) is present in the facility. Please see attached policy.The (re)credentialing process will esnure qualifications are appropriately documented for proof of competence.Please refer to attached policyResponsible Party: Executive Director will implement and monitor compliance and correction of this deficiency.</p> | 01/04/2013 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|--|--|--|--|--|
| | <p>ACLS certification.</p> <p>2. Review of 11 physician credential files indicated files MD#1, MD#3, MD#4, MD#5, MD#6 and MD#7, MD#8, MD#9, MD#10 and MD#11 did not have any documentation of CPR competence in accordance with current standards of practice (hands-on demonstration competency, not just a questionnaire), or facility policy.</p> <p>3. On 10-30-12 at 1:00 pm, employee #A1 was requested to provide a facility policy indicating CPR competency requirements for physicians. No further documentation was provided prior to exit.</p> | | | |
|--|--|--|--|--|

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| Q0181 | <p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on document review and interview, the facility failed to ensure that medications were administered with a physician's order for 2 of 30 medical records (MR) reviewed (Patient #21 & 28).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of patient #21's MR indicated the patient was administered Valium 2 mg IVP on 09-04-12 at 0839 hours while in the post anesthesia care unit (PACU). The patient's MR lacked documentation of a physician's order to administer the Valium. 2. Review of patient #29's MR indicated the patient was administered Valium 2 mg IVP on 09-25-12 at 1535 hours while in the PACU. The patient's MR lacked documentation of a physician's order to administer the Valium. 3. On 10-31-12 at 1455 hours, staff #41 confirmed there was no physician order to administer the Valium in the PACU. | 00181 | <p>Correction/Prevention On 11/6/2012, the Center went live with the EPIC electronic medical record. A medication cannot be documented as administered unless there is a corresponding order for the same medication and dosage. This will ensure discrepancies are prevented and addressed prior to the patient's visit ending. Responsible Party: Executive Director</p> | 11/06/2012 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
|--|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| Q0201 | <p>416.49(a) LABORATORY SERVICES</p> <p>If the ASC performs laboratory services, it must meet the requirements of Part 493 of this chapter. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of this chapter. The referral laboratory must be certified in the appropriate specialties and subspecialties of services to perform the referral test in accordance with the requirements of Part 493 of this chapter. Based on document review and interview, the facility failed to ensure a policy and procedure that indicated a list of lab procedures and procedure for request of same, for tests to be done by a contracted lab, failed to ensure policies and procedures that required the incorporation of laboratory reports into patient records and failed to ensure a policy and procedure indicating employees performed laboratory tests according to manufacturer requirements/recommendations and/or standards of practice for 2 of 4 laboratory tests performed by facility employees.</p> <p>Findings:</p> <p>1. Review of facility policies, approved on 11-11-11, indicated there were none that indicated a list of lab procedures and procedure for request of same, for tests to be done by a contracted lab. In interview,</p> | Q0201 | <p>Correction/PreventionThe attached policy (Lab: Obtaining Off Site Labs) has been created to provide information and direction to staff on appropriately obtaining and transporting ordered labs that are not able to be performed on site. The policy gives direction to posted information which contains a list of lab tests, website and phone support for any lab provided by the contracted laboratory.Responsible Party: Executive Director will monitor correction and compliance of this deficiency and ensure updates are communicated.</p> | 12/07/2012 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>on 10-31-12 at 2:05 pm, employee #A1 confirmed this and no documentation was provided prior to exit.</p> <p>2. Review of facility policies, approved on 11-11-11, indicated there were none for the incorporation of laboratory reports into patient records. In interview on 10-31-12 at 2:05 pm, employee #A1 confirmed this and no further documentation was provided prior to exit.</p> <p>3. Review of facility policies, approved on 11-11-11, indicated the facility performed CLIA i-stat, accucheck, coag check and urine pregnancy test. Further review indicated there were policies and procedures for the i-stat and urine pregnancy tests, but none for the accucheck and coag check tests. In interview, on 10-31-12 at 2:05 pm, employee #A1 confirmed this and no further documentation was provided prior to exit.</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | |
| (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 | |
| Q0221 | <p>416.50(a)(1) NOTICE OF RIGHTS The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands. Based on document review and interview, the patient rights given to the patient or their representative verbally and in writing prior to surgery did not contain 6 of 13 required elements.</p> <p>Findings:</p> <p>1. Review of a document entitled PATIENT RIGHTS & RESPONSIBILITIES, approved 11-11-11, given to the patient or their representative verbally and in writing prior to surgery, did not contain the following patient rights:</p> <p>Specific names of the physician's who have a financial interest or ownership in the facility</p> <p>If requested by the patient, the Indiana State Advanced Directive brochure</p> <p>Patients can voice grievances regarding treatment or care that is or fails to be furnished</p> | O0221 | <p>Correction/PreventionThe Center's Patient Rights Document has been updated to address each of the areas noted in the stated deficiency. The updated document is attached and changes are highlighted in yellow.Responsible Party: Executive Director</p> | 11/21/2012 | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, 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.</p> <p>The patient has a right to receive care in a setting free of contaminated materials and unwanted visitors</p> <p>The patient has a right to be free from all forms of staff abuse, neglect or harassment</p> <p>2. In interview, on 10-30-12 at 2:45 pm, employee #A2 confirmed the above elements were not included in the patient rights given to the patient or their representative verbally and in writing prior to surgery. No further documentation was provided prior to exit.</p> | | | |

| | | | | | |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | |
| (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 | |
| Q0222 | <p>4166.50(a)(1)(i) NOTICE - POSTING In addition, the ASC must - Post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. Based on document review and interview, the posted patient rights did not contain 6 of 13 required elements.</p> <p>Findings:</p> <p>1. Review of a document entitled PATIENT RIGHTS & RESPONSIBILITIES, approved 11-11-11, given to the patient or their representative verbally and in writing prior to surgery, did not contain the following patient rights:</p> <p>Specific names of the physician's who have a financial interest or ownership in the facility</p> <p>If requested by the patient, the Indiana State Advanced Directive brochure</p> <p>Patients can voice grievances regarding treatment or care that is or fails to be</p> | O0222 | <p>Correction/PreventionThe Center's Patient Rights Document has been updated to address each of the areas noted in the stated deficiency. The updated document is attached and changes are highlighted in yellow.Responsible Party: Executive Director</p> | 11/21/2012 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | |
| (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 | |
| | <p>furnished</p> <p>If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, that the rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf. Or, 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.</p> <p>The patient has a right to receive care in a setting free of contaminated materials and unwanted visitors</p> <p>The patient has a right to be free from all forms of staff abuse, neglect or harassment</p> <p>2. In interview, on 10-30-12 at 2:45 pm, employee #A2 confirmed the above elements were not included in the posted patient rights. No further documentation was provided prior to exit.</p> | | | | |

| | | | | | | | |
|--|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| Q0223 | <p>416.50(a)(1)(ii) NOTICE - PHYSICIAN OWNERSHIP The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure.</p> <p>Based on document review and interview, the facility failed to have a policy and procedure indicating the specific names of all physicians who have financial interests or ownership in the facility</p> <p>Findings:</p> <p>1. Review of a facility policy entitled PATIENT RIGHTS & RESPONSIBILITIES, approved 11-11-11, indicated it did not include the names of specific physicians who have financial interests or ownership in the facility.</p> <p>2. In interview, on 10-30-12 at 2:45 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p> | O0223 | Correction/PreventionThe Center's Patient Rights Document has been updated to address each of the areas noted in the stated deficiency. The updated document is attached and changes are highlighted in yellow.Responsible Party: Executive Director | 11/21/2012 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|-------|---|-------|--|------------|
| Q0224 | <p>416.50(a)(2) ADVANCE DIRECTIVES The ASC must comply with the following requirements:</p> <p>(i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with 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.</p> <p>(ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care.</p> <p>(iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>Based on document review and interview the facility failed to ensure when a patient had an advance directive and was transferred to a hospital that a copy of the advance directive was sent with the patient's medical record (MR) for 3 of 5 transfer MRs reviewed. (Patient #3, 6 & 8)</p> <p>Findings include;</p> <p>1. Review of patient #3's MR indicated the patient had a living will. The patient's MR indicated the patient was transferred to a hospital and the MR lacked documentation that a copy of the living will was sent to the hospital.</p> <p>2. Review of patient #6's MR indicated the patient had advance directives. The patient's MR indicated the patient was transferred to a hospital and the MR lacked documentation that a copy of the advance directives will was sent to the hospital.</p> | O0224 | <p>Correction/Prevention Documentat ion of the existance of an Advance Directive will continue to be made in the medical record for all patients through the (pre)registration process. If in existance, a copy of the Advance Directive will be requested. Moving forward, it will also be noted in the medical record whether or not the patient provided a copy of the Advance Directive. In the event a patient is transferred, the receiving facility will be knowledgeable of the existance of an Advance Directive and will be able to access the document by either reviewing a copy within the medical record or requesting a copy from the patient. Please see attachced Center policy and</p> | 12/07/2012 |
|-------|---|-------|--|------------|

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| | <p>3. Review of patient #8's MR indicated the patient had a living will. The patient's MR indicated the patient was transferred to a hospital and the MR lacked documentation that a copy of the living will was sent to the hospital.</p> <p>4. On 10-31-12 at 0915 hours staff #41 confirmed that patient #3, 6 & 8's advance directive information was not sent to the hospital when transferred.</p> <p>Based on document review and interview, the facility failed to have a policy of and description and availability of the applicable State health and safety laws, and the State advanced directive brochure.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled PATIENT RIGHTS & RESPONSIBILITIES, approved 11-11-11, indicated it failed to include a description and availability of the applicable State health and safety laws, and the State advanced directive brochure.</p> <p>2. In interview, on 10-30-12 at 2:45 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p> | | <p>procedure on Advance Directives. Changes are highlighted in yellow. By the date noted above, the process will be reviewed and re-emphasized with all staff fulfilling the (pre)registration function. Responsible Party: Executive Director</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | |
| (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 | |
| Q0228 | <p>416.50(b)(1)(ii) EXERCISE OF RIGHTS - GRIEVANCES [The patient has the right to -] Voice grievances regarding treatment or care that is (or fails to be) furnished. Based on document review and interview, the facility failed to have a policy indicating patients have a right to voice grievances regarding treatment of care that is or fails to be furnished.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled PATIENT RIGHTS & RESPONSIBILITIES, approved 11-11-11, indicated it failed to include patients have a right to voice grievances regarding treatment of care that is or fails to be furnished.</p> <p>2. In interview, on 10-30-12 at 2:45 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p> | O0228 | <p>Correction/PreventionThe Center's Patient Rights Document has been updated to address each of the areas noted in the stated deficiency. The updated document is attached and changes are highlighted in yellow.Responsible Party: Executive Director</p> | 11/21/2012 | |

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| Q0232 | <p>416.50(c)(2) SAFETY [The patient has the right to -] Receive care in a safe setting Based on document review and interview, the facility failed to include in its policy that the patient has a right to receive care in a setting free of contaminated materials and unwanted visitors.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled PATIENT RIGHTS & RESPONSIBILITIES, approved 11-11-11, indicated it failed to include that the patient has a right to receive care in a setting free of contaminated materials and unwanted visitors.</p> <p>2. In interview, on 10-30-12 at 2:45 pm, employee #A2 confirmed the above-stated policy failed to include in its policy that the patient has a right to receive care in a setting free of contaminated materials and unwanted visitors. No other documentation was provided prior to exit.</p> | Q0232 | <p>Correction/PreventionThe Center's Patient Rights Document has been updated to address each of the areas noted in the stated deficiency. The updated document is attached and changes are highlighted in yellow.Responsible Party: Executive Director</p> | 11/21/2012 | | | |

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| Q0233 | <p>416.50(c)(3) SAFETY - ABUSE/HARASSEMENT [The patient has the right to -] Be free from all forms of abuse or harassment</p> <p>Based on document review and interview, the facility failed to have a policy that patients are to be free from all forms of staff abuse, neglect or harassment.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled PATIENT RIGHTS & RESPONSIBILITIES, approved 11-11-11, indicated it failed to that patients are to be free from all forms of staff abuse, neglect or harassment.</p> <p>2. In interview, on 10-30-12 at 2:45 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p> | O0233 | <p>Correction/PreventionThe Center's Patient Rights Document has been updated to address each of the areas noted in the stated deficiency. The updated document is attached and changes are highlighted in yellow.Responsible Party: Executive Director</p> | 11/21/2012 | | | |

| | | | | | | | |
|--|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| Q0262 | <p>416.52(a)(2) PRE-SURGICAL ASSESSMENT Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals.</p> <p>Based on document review and interview, the facility failed to ensure that each patient admitted by a physician who has been granted such privileges by the medical staff, had a history and physical update done in accordance with facility policy & procedure for 7 of 30 medical records (MR) reviewed (Patient #4, 9, 10, 14, 17, 20 & 22).</p> <p>Findings include:</p> <p>1. Review of policy/procedure Medical Records - Explanation of Medical Record Chart indicated the following: "2. A H & P is required prior to the performance of a procedure and must be completed no further than thirty (30) days in advance of the procedure. A notation will be made on the day of surgery by the surgeon or anesthesiologist that the H & P has been reviewed and reflects any</p> | 00262 | Correction/Prevention H&Ps may be updated either in writing or electronically via the EPIC electronic medical record. The following steps will be taken to ensure the H&P is updated prior to surgery. 1. It will be re-emphasized with all nursing staff that all patients must have an updated H&P prior to going to surgery. In the event an H&P has not been updated, nursing staff will contact the surgeon and request the update to be made. 2. The requirement for patient H&Ps to be updated on the day of surgery will continue to be audited through the quarterly medical record review. 3. Results of the audit will be reviewed at the quarterly QA meeting and steps to address non-compliance will be discussed and implemented. Responsible Party: Executive Director | 12/07/2012 | | | |

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| | <p>changes." This policy/procedure was last reviewed/revised on 08/11.</p> <p>2. Review of the following MRs indicated the following: Patient #4's MR indicated the patient had surgery at the facility on 10-28-12. The H & P was done on 10-27-12 and the update was signed on 11-09-12. Patient #9's MR indicated the patient had surgery at the facility on 06-08-12. The H & P was done on 05-10-12 and lacked documentation of an update. Patient #10's MR indicated the patient had surgery at the facility on 05-07-12. The H & P was done on 05-04-12 and lacked documentation of an update. Patient #14's MR indicated the patient had surgery at the facility on 08-10-12. The H & P lacked documentation when completed. Patient #17's MR indicated the patient had surgery at the facility on 08-20-12. The H & P indicated it was faxed to the facility on 08-17-12 and was signed on 08-23-12. Patient #20's MR indicated the patient had surgery at the facility on 08-27-12. The H & P was done on 08-22-12 and the update was signed on 09-06-12. Patient #23's MR indicated the patient had surgery at the facility on 09-10-12. The H & P was done on 09-05-12 and lacked documentation of an update.</p> | | | | | | |

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|---|--|--|--|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------------|---|---------------------|--|----------------------------|
| S0000 | <p>3. On 10-31-12 at 1500 hours, staff #41 confirmed the dates of H&Ps and H&P updates.</p> <p>This visit was for a State licensure survey.</p> <p>Facility Number: 005973</p> <p>Survey Date: 10-29/31-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 11/08/12</p> | S0000 | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|--|----------------------|
| S0162 | <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice or facility policy for 10 (MD#1, MD#3, MD#4, MD#5, MD#6 and MD#7, MD#8, MD#9, MD#10 and MD#11) of 11 physician credential files reviewed.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled LIFE SUPPORT COMPETENCY REQUIREMENTS, revised September, 2012, indicated Medical staff members who perform procedures are considered CPR competent by virtue of maintaining at least one of the following: Completes annual CPR competency assessment questionnaire (attached).</p> | S0162 | <p>Correction/PreventionThe Center's policy on CPR competency has been updated to more accurately define direct patient care health worker and demonstrate that an appropriate number of cardiopulmonary resuscitation competent health care workers are on site and available at any time a patient(s) is present in the facility. Please see attached policy.The (re)credentialing process will ensure qualifications are appropriately documented for proof of competence.Please refer to attached policyResponsible Party: Executive Director will implement and monitor compliance and correction of this deficiency.</p> | 01/04/2013 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>Sustaining an active practice in their field of specialty, this by the very nature of [sic] demonstrates competency in the maintenance and management of cardiopulmonary function (i.e. anesthesiology). Maintains CPR certification and/or ACLS certification.</p> <p>2. Review of 11 physician credential files indicated files MD#1, MD#3, MD#4, MD#5, MD#6 and MD#7, MD#8, MD#9, MD#10 and MD#11 did not have any documentation of CPR competence in accordance with current standards of practice (hands-on demonstration competency, not just a questionnaire), or facility policy.</p> <p>3. On 10-30-12 at 1:00 pm, employee #A1 was requested to provide a facility policy indicating CPR competency requirements for physicians. No further documentation was provided prior to exit.</p> | | | |

| | | | | | | | |
|--|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| S0630 | <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on document review and interview, the facility failed to ensure that the medical record (MR) contained sufficient information to justify the treatment for 2 of 30 MRs reviewed (Patient #21 & 28).</p> <p>Findings include:</p> <p>1. Review of patient #21's MR indicated the patient was administered Valium 2 mg IVP on 09-04-12 at 0839 hours while in the post anesthesia care unit (PACU). The patient's MR lacked documentation of a physician's order to administer the Valium.</p> <p>2. Review of patient #29's MR indicated the patient was administered Valium 2 mg IVP on 09-25-12 at 1535 hours while in the PACU. The patient's MR lacked documentation of a physician's order to administer the Valium.</p> | S0630 | <p>Correction/Prevention On 11/6/2012, the Center went live with the EPIC electronic medical record. A medication cannot be documented as administered unless there is a corresponding order for the same medication and dosage. This will ensure discrepancies are prevented and addressed prior to the patient's visit ending. Responsible Party: Executive Director will implement and monitor compliance with this deficiency.</p> | 11/06/2012 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | 3. On 10-31-12 at 1455 hours, staff #41 confirmed there was no physician order to administer the Valium in the PACU. | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| S0772 | <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review and interview, the facility failed to ensure that each patient admitted by a physician who has been granted such privileges by the medical staff, had a history and physical update done in accordance with facility policy & procedure for 7 of 30 medical</p> | S0772 | Correction/Prevention H&Ps may be updated either in writing or electronically via the EPIC electronic medical record. The following steps will be taken to ensure the H&P is updated prior to surgery. 1. It will be re-emphasized with all nursing staff that all patients must have | 12/07/2012 |

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 | |
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | | |
| (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 | | | |
| | <p>records (MR) reviewed (Patient #4, 9, 10, 14, 17, 20 & 22).</p> <p>Findings include:</p> <p>1. Review of policy/procedure Medical Records - Explanation of Medical Record Chart indicated the following: "2. A H & P is required prior to the performance of a procedure and must be completed no further than thirty (30) days in advance of the procedure. A notation will be made on the day of surgery by the surgeon or anesthesiologist that the H & P has been reviewed and reflects any changes." This policy/procedure was last reviewed/revised on 08/11.</p> <p>2. Review of the following MRs indicated the following: Patient #4's MR indicated the patient had surgery at the facility on 10-28-12. The H & P was done on 10-27-12 and the update was signed on 11-09-12. Patient #9's MR indicated the patient had surgery at the facility on 06-08-12. The H & P was done on 05-10-12 and lacked documentation of an update. Patient #10's MR indicated the patient had surgery at the facility on 05-07-12. The H & P was done on 05-04-12 and lacked documentation of an update. Patient #14's MR indicated the patient had</p> | | <p>an updated H&P prior to going to surgery. In the event an H&P has not been updated, nursing staff will contact the surgeon and request the update to be made. 2. The requirement for patient H&Ps to be updated on the day of surgery will continue to be audited through the quarterly medical record review. 3. Results of the audit will be reviewed at the quarterly QA meeting and steps to address non-compliance will be discussed and implemented. Responsible Party: Executive Director</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>surgery at the facility on 08-10-12. The H & P lacked documentation when completed.</p> <p>Patient #17's MR indicated the patient had surgery at the facility on 08-20-12. The H & P indicated it was faxed to the facility on 08-17-12 and was signed on 08-23-12.</p> <p>Patient #20's MR indicated the patient had surgery at the facility on 08-27-12. The H & P was done on 08-22-12 and the update was signed on 09-06-12.</p> <p>Patient #23's MR indicated the patient had surgery at the facility on 09-10-12. The H & P was done on 09-05-12 and lacked documentation of an update.</p> <p>3. On 10-31-12 at 1500 hours, staff #41 confirmed the dates of H&Ps and H&P updates.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|--|----------------------|
| S1010 | <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</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>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on document review and interview, the facility failed to follow its policy for monthly monitoring of outdated medications.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled MEDICATIONS - ADMINISTERING, STORAGE, AND ORDERING/RECEIVING, reviewed 08/11, indicated all medication storage areas will be monitored monthly for outdates. Attached to the policy was a document entitled Outdates Check list, indicating the Location, Exp Date and Initials for the areas of Medication/Suture Room, Refrigerator, Crash Cart, MH Box, Arterial Line Box and Monnitol (OR 7 Warmer), which was to be completed during the monthly checks.</p> | S1010 | <p>Correction/PreventionThe Center does have in place a policy and procedure where by all medications are checked monthly for expiration dates. At the time of the survey, the Center was unable to provide written documentation that such checks were being completed on a monthly basis. It was discovered the manager had been throwing away the worksheet that staff used to check the medication outdates. Moving forward, the worksheets will be kept and filed in order to provide documentation that outdate checks are being done per policy.Responsible Party: Executive Director will implement and monitor compliance with this deficiency.</p> | 11/21/2012 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| | <p>2. Facility staff was requested to provide documentation of the monthly checks and no documentation was provided.</p> <p>3. In interview, on 10-31-12 at 1:45 pm, employee #A1 confirmed there was no documentation of monthly checks and no other documentation was provided prior to exit.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|-------|---|-------|---|------------|
| S1116 | <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(a)(4)(A)</p> <p>(4) In new construction, renovations, and additions, the center site and facilities, or nonlicensed facilities acquired for the purpose of providing center services shall meet the following:</p> <p>(A) The 2001 edition of the national "Guidelines for Design and Construction of Hospitals and Health Care Facilities" (Guidelines). Based on document review, observation and interview, the facility failed to ensure after renovation that the facility followed the 2001 edition of the national "Guidelines for Design and Construction of Hospitals and Health Care Facilities" (Guidelines) by having a housekeeping room within the surgical services area.</p> <p>Findings include:</p> <p>1. Review of the Guidelines indicate the following: "9.5.F5 The following services shall be provided in surgical service areas: m. Housekeeping room. Space containing a floor receptor or service sink and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite."</p> | S1116 | <p>Correction/PreventionThe Center has identified a room that will be designated as the housekeeping room specific to the surgical suite. The Center will work with the property management to ensure a service sink will be added to this room no later than 1/31/2013.12/31/2012 A contractor has been identified and will begin work to meet compliance after the holidays. Work orders have been approved.Responsible Party: Executive Director</p> | 01/31/2013 |
|-------|---|-------|---|------------|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------------|--|---------------------|--|----------------------------|
| | <p>2. On 10-29-12 at 1320 hours during the facility tour of the surgical services area, there was no housekeeping room observed for use in the surgical suite.</p> <p>3. On 10-30-12 at 1030 hours, staff #40 & 41 confirmed the facility did not have a housekeeping room for the surgical services area.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|---|---------------|--|----------------------|
| S1188 | <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 did not follow its fire control plan to conduct fire drill each quarter for each shift for 5 of 12 shifts.</p> <p>Findings:</p> <p>1. Review of a facility policy entitled fire drill procedure, approved 11-11-11, indicated the day and time will be such that staff from all shifts will have the opportunity to participate. It also indicated the day and time will not be the same from quarter to quarter.</p> <p>2. In interview, on 10-20-12 at 10:00 am, employee #A1 indicated there were shifts.</p> | S1188 | <p>Correction/Prevention To ensure completion and documentaiton of, fire drills will remain a standing agenda item on the every other month Safety Committee Meeting. Prveioully defined three work shifts will be redefined into two: days and nights. Documentation from various day shift departments will be combined into one report. The same will be done for nights. This will set the expectation that there will beonly two reports (days and nights) each quarter.Moving forward, the time of a drill for any of the two shifts will not be duplicated within any of the four quarters of any calendar year and will vary at least by one hour.Please see attached updated Fire Drill</p> | 11/21/2012 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | <p>3. Review of documentation of fire drill indicated no drill in 2011 was conducted during the first quarter for the 2nd and 3rd shifts, the third quarter for the 1st shift, and the fourth quarter for the 2nd and 3rd shifts.</p> <p>4. On 10-31-12 at 3:20 pm employee #A1 confirmed the above documentation and no further documentation was provided prior to exit.</p> | | ProcedureResponsible Party: Safety Committee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 | | |
| (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 | |
| S1198 | <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the facility failed to document any disaster drill for year 2011 and from January 1, 2012 through October 31, 2012.</p> <p>Findings:</p> <p>1. On 10-29-12 at 10:00 am, employee #A1 was requested to provide documentation of any disaster drill performed in year 2011 and from January 1, 2012 through October 31, 2012. No documentation was provided.</p> <p>2. In interview, on 10-31-12 at 3:30 pm, employee #A1 indicated there was no documentation of any disaster drill performed in year 2011 and from January 1, 2012 through October 31, 2012. No other documentation was provided prior to exit.</p> | S1198 | To ensure participation in and documentation of, disaster drills will be placed as a standing agenda item on the every other month Safety Committee Meeting. Participation in drills will be reviewed and documented in the minutes. The Peri-anesthesia educator who is the liaison between the Center and the hospital partner that disaster drills are done in conjunction with will submit documentation of drills. Disaster drills will occur a minimum of once annually. Responsible Party: Safety Committee will implement and monitor compliance with this deficiency. | 11/21/2012 | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/31/2012 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER NORTH | STREET ADDRESS, CITY, STATE, ZIP CODE 8040 CLEARVISTA PKWY STE 150 INDIANAPOLIS, IN 46256 |
|--|---|

| (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 |
|--------------------------|--|---------------------|--|----------------------------|
| | | | | |