

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001087	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/17/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 5445 E 16TH ST INDIANAPOLIS, IN 46218
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Q 0000 Bldg. 00	This visit was for a re-certification survey. Facility Number: 010817 Survey Date: 6-15/17-2015 QA: cjl 06/22/15	Q 0000		
Q 0041 Bldg. 00	416.41(a) CONTRACT SERVICES When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner. Based on document review and interview, the facility failed to include a monitor and standard for 1 service furnished by a contractor in its quality assessment and performance improvement (QAPI) program. Findings: 1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the contracted service of physical therapy. 2. In interview, on 6-17-2015 at 11:15	O 0041	1 Physical Therapy services added to the existing document titled Outsourced Services which is a part of the overall QA program 2 All joint patients medical records reviewed to confirm that physical therapy services were provided to these patients prior to discharge 3 instituted changes to existing form 4 All future events/concerns around physical therapy services will be documented on a variance form and reviewed by the QA committee on a quarterly basis 5 Executive Director will be responsible	08/10/2015

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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Q 0101 Bldg. 00	<p>am, employee #A2, Executive Director, confirmed the above and no other documentation was provided prior to exit.</p> <p>416.44(a)(1) PHYSICAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on document review and interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 5 systems of equipment, and the facility failed to document defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator</p> <p>Findings:</p> <p>1. Review of documentation of preventive maintenance for the heating, ventilation, air conditioning, fire alarm and/or smoke detector systems, and emergency generator, indicated there was no documentation of operational and maintenance control records having been</p>	Q 0101	<p>1 Preventative Maintenance (PM) for the heating, ventilation, air conditioning, fire alarm and/or smoke detector systems, and emergency generator will be conducted according to the manufacturer's recommendation at least triennially The spare/back-up battery for the Zoll R Series Defibrillator will be stored in clinical engineering per approval letter from manufacture (Zoll). Uploaded to POC 2 All above mentioned items will be requiring a PM will be placed on a schedule per manufacturer's recommendation and reviewed annually 3 Clinical Engineering, Maintenance and Administrator will be responsible for ongoing compliance monitoring 4 Monthly checks will be conducted for ongoing compliance over the next 6</p>	09/01/2015	

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	<p>analyzed at least triennially.</p> <p>2. In interview on 6-16-2015 at 3:00 pm, employee #A4, Maintenance Technician, confirmed there was no documentation of the operational and maintenance control records for the above-stated systems having been analyzed at least triennially. No other documentation was provided prior to exit.</p> <p>3. Review of the Zoll R Series Defibrillator operating manual indicated the facility was to perform daily checks per the Operator's Checklist for R Series Product that included Condition - check case intact, and for broken, loose, or worn power cable, and Batteries - fully charged spare battery available [accompanies the unit].</p> <p>4. Review of the following facility documents indicated a check for the above-stated items was not included: GENERAL POLICY - SUBJECT: CRASH CART CHECKS, approved 4-16-2015 ZOLL ACLS & BLS CRASH CART SIGNATURE LOG, approved 4-16-2015 Defibrillator Testing with Hands-Free Therapy Electrodes, approved 4-16-2015 DEFIBRILLATOR/MONITOR LOG, MONTH Oct 2014</p>		months	

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Q 0162 Bldg. 00	<p>5. In interview, on 6-16-2015 at 2:40 pm, employee #A2, Executive Director, confirmed the defibrillator checks were not done in accordance with the manufacturer's specification and no further documentation was provided prior to exit.</p> <p>416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ul style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on document review and interview, the</p>	O 0162	1 All transfer patients will have a	08/10/2015

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Q 0266 Bldg. 00	<p>facility failed to ensure that the medical records (MR) of 3 of 3 transfer patients were accurate and complete.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of patients #2 and 3's MR lacked evidence of the transfer form titled "Transfer Record". Review of patients #1, 2 and 3's MR lacked evidence that the patient and family was informed of the need for hospital admission by the surgeon or anesthesiologist. Review of policy/procedure titled "Transfer of CSC (Community Surgery Center) Patient To Hospital" last approved by the Operations Committee on 4/16/15 indicated: Procedure: C. The attending surgeon and/or anesthesiologist will: b. Inform the patient and family of the need from hospital admission. E. The patient's attending nurse will: f. Complete Transfer Record On 6/17/15 at 1100 hours staff #43 (Medical Director) verified that MR #1, 2 and 3 did not show evidence of an order to transfer to hospital #1. On 6/17/15 at 1600 hours staff #41 (Executive Director) verified that MR # 2 and 3 did not include a Transfer Record. <p>416.52(c)(2) DISCHARGE - ORDER [The ASC must -]</p>		<p>completed transfer form placed in the patients medical record once the surgeon and/or anesthesiologist inform the patient and family of the need for hospital admission 2 All patients transferred did have an admission note in the EMR to confirm that patients/families were informed of the need for hospital admission 3 Patient Rooms staff re-educated on the policy and importance of complete and timely documentation of the transfer form 4 The Administrator and the Director of Nursing will monitor compliance by conducting quarterly audits through our QI program</p>	

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S 0110 Bldg. 00	<p>Facility Number: 010817</p> <p>Survey Date: 6-15/17-2015</p> <p>QA: cjl 06/22/15</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review, the facility's governing board failed to review reports of the quality assessment performance improvement (QAPI) program for 1 contracted service during calendar year 2014.</p> <p>Findings:</p> <p>1. Review of the governing board meeting minutes for calendar year 2014 indicated the governing board failed to</p>	S 0110	<p>1 Physical Therapy services will be included in the facility wide Quality Assessment Performance Improvement plan 2 This QAPI plan will be reviewed quarterly by the Governing board of managers 3 Updated existing contracted services form to include physical therapy 4 The Administrator will be responsible for ongoing compliance</p>	08/10/2015

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S 0310 Bldg. 00	<p>review QAPI activities for the contracted service of physical therapy.</p> <p>2. In interview, on 6-17-2015 at 11:15 am, employee #A2, Executive Director, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include a monitor and standard for 1 service furnished by a contractor in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the contracted service of physical therapy.</p>	S 0310	<p>1 Physical Therapy services added to the existing document titled Outsourced Services which is a part of the overall QAPI program 2 Changes to the existing form have been completed to include physical therapy 3 All future events/concerns around physical therapy services will be documented on a variance form and reviewed by the Operations Committee and the Board of Managers on a quarterly basis 4 The Administrator will be responsible</p>	08/10/2015

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S 0630 Bldg. 00	<p>2. In interview, on 6-17-2015 at 11:15 am, employee #A2, Executive Director, confirmed the above and no other documentation was provided prior to exit.</p> <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 6 of 30 medical records (MR) had evidence of a discharge/transfer order.</p> <p>Findings:</p> <p>1. Patient #3's MR indicated that the patient was transferred to hospital #1 after his/her outpatient procedure. The MR lacked evidence of a transfer order.</p> <p>2. Patients #4, 5, 23, 24 and 26 MR's lacked evidence of a discharge order.</p> <p>3. Review of policy/procedure "Anesthesia - Criteria For Discharge From CSCE(Community</p>	S 0630	<p>1 All patients requiring hospital admission or discharged from the facility will have an order from the attending physician 2 All nursing staff will review the policy, "Anesthesia - Criteria for Discharge from CSC-East 3 Quarterly medical record audits will be conducted to monitor the presence of an order for those patients needing admission to the hospital or discharged from the facility 4 The Administrator will be responsible</p>	08/10/2015

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S 0672 Bldg. 00	<p>Surgery Center East)" approved by Operations Committee on 4/16/15 indicated: A. Discharge from the Community Surgery Center will require: 1. An order from the attending physician.</p> <p>4. On 6/17/15 at 1500 hours, staff #44 (Registered Nurse) verified that the above orders were not in the medical records.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(13) A copy of the transfer form, if the patient is referred to a hospital or other facility. Based on document review and interview, the facility failed to ensure that the medical records (MR) of 3 of 3 transfer patients were accurate and complete.</p> <p>Findings:</p> <p>1. Review of patients #2 and 3's MR lacked evidence of the transfer form titled "Transfer Record".</p> <p>2. Review of patients #1, 2 and 3's MR lacked evidence that the patient and family was informed of the need for hospital admission by the surgeon or anesthesiologist.</p> <p>3. Review of policy/procedure titled "Transfer of CSC (Community Surgery Center) Patient To</p>	S 0672	<p>1 All transfer patients will have a completed transfer from placed in the patient's medical record once the surgeon and/or anesthesiologist inform the patient and family of the need for hospital admission 2 All patients transferred did have an admission order in the EMR to confirm that patients/family were informed of the need for hospital admission 3 Patient Room staff re-educated on the policy and importance of complete and timely documentation of the transfer from 4 The Administrator and the Director of Nursing will be responsible and will conduct ongoing quarterly audits through</p>	08/10/2015

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S 1154 Bldg. 00	<p>Hospital" last approved by the Operations Committee on 4/16/15 indicated: Procedure: C. The attending surgeon and/or anesthesiologist will: b. Inform the patient and family of the need from hospital admission. E. The patient's attending nurse will: f. Complete Transfer Record</p> <p>4. On 6/17/15 at 1100 hours staff #43 (Medical Director) verified that MR #1, 2 and 3 did not show evidence of an order to transfer to hospital #1.</p> <p>5. On 6/17/15 at 1600 hours staff #41 (Executive Director) verified that MR # 2 and 3 did not include a Transfer Record.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(C)</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>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Operational and maintenance control records must be established and analyzed at least triennially. These records must be readily</p>		our QI program				

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S 1170 Bldg. 00	<p>available on the premises. Based on document review and interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 5 systems of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of documentation of preventive maintenance for the heating, ventilation, air conditioning, fire alarm and/or smoke detector systems, and emergency generator, indicated there was no documentation of operational and maintenance control records having been analyzed at least triennially. In interview on 6-16-2015 at 3:00 pm, employee #A4, Maintenance Technician, confirmed there was no documentation of the operational and maintenance control records for the above-stated systems having been analyzed at least triennially. No other documentation was provided prior to exit. <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</p> <p>(b) The condition of the physical</p>	S 1154	<p>1 Preventative maintenance (PM) for the heating, ventilation, air conditioning, fire alarm and/or smoke detector systems, and emergency generator will be conducted according to the manufacturer's recommendation at least triennially The spare/back-up battery for the Zoll R Series Defibrillator will be stored directly on the unit as outlined in the manufacturer's manual 2 All above mentioned items will require a PM will be placed on a schedule per manufacturer's recommendation and reviewed annually 3 Clinical Engineering, Maintenance and Administrator will be responsible for ongoing compliance monitoring</p>	08/10/2015	

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	<p>plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to document defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator</p> <p>Findings:</p> <p>1. Review of the Zoll R Series Defibrillator operating manual indicated the facility was to perform daily checks per the Operator's Checklist for R Series Product that included Condition - check case intact, and for broken, loose, or worn power cable, and Batteries - fully charged spare battery available [accompanies the unit].</p> <p>2. Review of the following facility</p>	S 1170	<p>1 New Daily crash cart checklist logs provided by the manufacture will be implemented at the start of the next full month (October) to fulfill the requirement</p> <p>2 Monthly audits will be conducted to monitor ongoing compliance</p> <p>3 The Clinical Director in conjunction with Executive Director will be responsible</p> <p>4 New checklist implemented October 2015</p>	08/10/2015			

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	<p>documents indicated a check for the above-stated items was not included: GENERAL POLICY - SUBJECT: CRASH CART CHECKS, approved 4-16-2015 ZOLL ACLS & BLS CRASH CART SIGNATURE LOG, approved 4-16-2015 Defibrillator Testing with Hands-Free Therapy Electrodes, approved 4-16-2015 DEFIBRILLATOR/MONITOR LOG, MONTH Oct 2014</p> <p>3. In interview, on 6-16-2015 at 2:40 pm, employee #A2, Executive Director, confirmed the above and no further documentation was provided prior to exit.</p>				