

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140
--	---

(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
S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005669</p> <p>Survey Date: 4-15/17-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 05/02/13</p> <p>7/2/13 revised due to IDR</p>	S000000		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140			
(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			
S000228	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that podiatrists performing surgery in the facility maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located, nor met the conditions indicated in a waiver for 1 of 10 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. A waiver issued by the Indiana State Department of Health, entitled Standing</p>	S000228	<p>1. All podiatrists credentialed and privileged to perform surgical procedures at the Hancock Surgery Center (HSC) pursuant to Indiana Code and credentialed and privileged to perform surgical procedures at Hancock Regional Hospital (HRH) will provide documentation to the HSC demonstrating that he/she has an agreement with the Medical Director or his designee that states the Medical Director or his designee agrees to admit podiatric patients in cases in which a transfer is necessary. Both the Medical Director or his designee have admitting</p>	09/16/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140		
(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>Waiver for 410 IAC 15-2-1(e)(4), effective November 21, 2012, indicated if podiatrists do not have admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located, they must provide documentation to the Ambulatory Surgery Center demonstrating that he/she has an agreement with one or more physicians, with admitting privileges at the same hospital in which the podiatrist haws surgical privileges, agrees to admit podiatric patients in cases in which a transfer is necessary.</p> <p>2. Review of 10 medical staff credential files indicated file MD#2, a podiatrist, did not have documentation of admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located, nor had documentation of an agreement with another surgery center physician, as indicated, above.</p> <p>3. In interview, on 4-16-13 at 11:55 am, employee #A\1 indicated there was no documentation of the above medical staff member having admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the</p>		<p>privileges at the same hospital in which the podiatrist has surgical privileges, 2. Hancock Regional Hospital (HRH) provided documentation to the HSC that verifies the podiatrists with privileges at HRH have an agreement in place with the Hospitalists at HRH to provide medical care to his/her patients in cases in which a transfer to HRH is necessary; per HRH's Medical Staff Rules and Regulations. The Hancock Regional Surgery Center, LLC has maintained a written transfer agreement with Hancock Regional Hospital for immediate acceptance of patients who develop complications or require postoperative confinement and includes podiatric patients. The Hospitalist will receive the patient immediately upon transfer to HRH by the Medical Director or his designee. 3. It will be the responsibility of the Credentialing Coordinator and the Executive Director in conjunction with the Medical Director to assure all credentialed podiatrists with privileges at HSC maintain in writing an agreement with the Medical Director or his designee to admit their patients to HRH in cases were transfer is necessary.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/17/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140
--	---

(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
S000310	<p>facility is located, or an agreement with another surgery center physician, as indicated above. 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 directly-provided service (housekeeping) in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI</p>	S000310	<p>1. A program that includes a standard and a process for monitoring directly-provided housekeeping activities will be developed and implemented. The actual monitoring will begin September 1, 2013 for clean data collection. The program will be an ongoing audit of directly-provided housekeeping activities.2. Monthly audits will be performed and will be reviewed for compliance with regulatory standards</p>	09/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140			
(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			
S000320	<p>program indicated it did not include a monitor and standard for the directly-provided service of housekeeping.</p> <p>2. In interview, on 4-1-13 at 4:00 pm, employee #A1 confirmed the above. 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)(2)</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>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for the activity of discharges in its quality assessment and performance improvement (QAPI) program.</p>	S000320	<p>in completing directly-provided housekeeping activities. Results, concerns and/or changes will be communicated at monthly staff meetings and become a standing agenda item. 3. It is the responsibility of the OR Coordinator, Patient Rooms Coordinators and the Clinical Team Leader in conjunction with the Executive Director to address and counsel any employee not meeting the expectations of their job duties. See Attachment 1</p> <p>1. A QAPI program that includes a standard and a process for monitoring patient discharge activities will be developed and implemented. The actual monitoring will begin June 1, 2013 for clean data collection. The program will be an ongoing audit of patient discharge</p>	05/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140		
(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	
S000328	<p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the activity of discharges.</p> <p>2. In interview, on 4-16-13 at 4:00 pm, employee #A1 indicated there was no monitor and standard for the activity of discharges. No further documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the facility failed to have a quality assessment program that was effective and documented the outcome of the actions for follow-up and impact on patient care for 3 of 11 activities</p>	S000328	<p>activities.2. Monthly audits will be performed and a percentage of the patients seen will be reviewed for presence of discharge instructions, completeness, signature of the patient/parent, and additional physician instructions. Results, concerns and/or changes will be communicated at monthly staff meetings and become a standing agenda item.3. It will be the responsibility of the Patient Rooms Coordinators and the Clinical Team Leader in conjunction with the Executive Director. See Attachment E</p> <p>1. Monthly results for the 3 activities relating to patient satisfaction will be reviewed at the monthly staff meetings. Results will be posted in the staff lounge for further review and discussion. 2. Patient Satisfaction Survey results will be a standing agenda</p>	05/13/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013																			
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140																					
(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>relating to patient satisfaction survey results.</p> <p>Findings:</p> <p>1. Review of the facility's QA Plan indicated in Section X.C. entitled Post-Discharge Patient Follow-up, opportunities for improvement are specifically identified through patient satisfaction surveys and follow-up process on post op phone calls.</p> <p>2. Review of a document entitled Hancock Surgery Center 2012 Quarterly Patient Satisfaction Survey Results, indicated the following for the first 2 quarters of 2012:</p> <table border="0"> <tr> <td>YTD 2012</td> <td>Target</td> </tr> <tr> <td>[Survey Activity]</td> <td></td> </tr> <tr> <td>Average</td> <td>Average</td> </tr> <tr> <td>Family/Friends overall experience</td> <td></td> </tr> <tr> <td>84.2%</td> <td>86.00%</td> </tr> <tr> <td colspan="2">Anesthesia staff was courteous and friendly</td> </tr> <tr> <td>96%</td> <td>88.4%</td> </tr> <tr> <td colspan="2">Anesthesia staff spent time reviewing my anesthesia care and answering questions</td> </tr> <tr> <td>86.7%</td> <td>96.00%</td> </tr> </table>	YTD 2012	Target	[Survey Activity]		Average	Average	Family/Friends overall experience		84.2%	86.00%	Anesthesia staff was courteous and friendly		96%	88.4%	Anesthesia staff spent time reviewing my anesthesia care and answering questions		86.7%	96.00%		<p>item at the month staff meetings and any additional discussion during the meeting will be documented.3. It will be the responsibility of the Executive Director.</p>				
YTD 2012	Target																								
[Survey Activity]																									
Average	Average																								
Family/Friends overall experience																									
84.2%	86.00%																								
Anesthesia staff was courteous and friendly																									
96%	88.4%																								
Anesthesia staff spent time reviewing my anesthesia care and answering questions																									
86.7%	96.00%																								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013	
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140			
(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			
S000630	<p>3. In interview, on 4-15-13 at 9:30 am, employee A1 was requested to provide documentation of actions taken to address the above QA issues that did not meet standard. The employee indicated that although actions were discussed, there was no documentation of those actions. No further 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 the medical record (MR) contained sufficient information to justify the treatment and documented accurately the course of the patient's stay in the center and the results for 3 of 30 MRs reviewed (Patient #1, 4, 6 & 12).</p> <p>Findings include;</p>	S000630	<p>1. For findings # 1, 3, 4, and 5 noted in the deficiency statement the "Post Anesthesia Care Orders - Physician Orders" will be updated to include the commonly administered medications ; Norco 5mg./325mg PO and Toradol 30mg IV. 2. Staff will bere-educated on the requirement to obtain and document appropriately any medication order received verbally from the physician.at the</p>	05/24/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140		
(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>1. Review of patient #1's MR indicated the patient was administered toradol 30 mg on 04-16-13 at 1120 hours. Review of the patient's MR lacked documentation of an order to administer toradol.</p> <p>2. Review of patient #4's MR indicated the patient was a 51 year old and the following Physician Orders were written; "3. CHEM 8 done per ISTAT on all patients 17 years old or greater. 6. EKG on all patients over 40 years." Review of the patient's MR lacked documentation that the ISTAT and EKG was completed.</p> <p>3. Review of patient #6's MR indicated the patient was administered Norco 5 mg on 11-20 12 at 2021 hours and on 11-21-12 at 0013 hours, 0404 hours and 1135 hours. Review of the patient's MR lacked documentation of an order to administer Norco.</p> <p>4. Review of patient #12's MR indicated the patient was administered Norco 5 mg on 03-01-13 at 1354 hours. Review of the patient's MR lacked documentation of an order to administer Norco.</p> <p>5. On 04-17-13 at 1500 hours, staff #41</p>		<p>next staff meeting held on 5/13/2013. They will also be re-educated at the staff meeting on the need to document on the Pre-Anesthesia Order sheet if an EKG and/or lab results have been obtained from another source and meet the criteria or if waived per the anesthesiologist. For findings # 1 - Patient #4 as noted in the deficiency statement was found to have the EKG and Laboratory tests performed on 11/26/2012. As written per the policy titled "Admission Criteria to Hancock Surgery Center" and the "Pre-Anesthesia Order - Physician's Orders", it states:Any patient over the age of 40 or with a positive heart history must have an electrocardiogram (EKG) that is less than 6 months old. All attempts will be made to obtain a copy of an EKG from another healthcare provider; however, if one cannot be obtained and the patient meets the criteria above, one will be performed prior to surgery. Anesthesia will be notified of all results and dates of testing. Repeat EKGs will be done at the discretion of the anesthesiologist or per physician order. Pre-operative labs performed at an outside laboratory are accepted as valid results and replace the order for an i-Stat Chem 8 when performed within 7 days of the date of surgery.3. It will be the responsibility of the Patient Rooms Coordinators, and the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140		
(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	
S000888	<p>confirmed there were no orders to administer the Norco and Toradol.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review and interview, the facility failed to ensure that Operative Reports were written or dictated immediately following surgery for 6 of 30 medical records (MR) reviewed (Patient # 6, 14, 20, 23, 27 & 30).</p> <p>Findings include:</p> <p>1. Review of policy/procedure Medical</p>	S000888	<p>Clinical Team Leader in conjunction with the Executive Director. See Attachment F</p> <p>1. The Hancock Surgery Center's policy; "Medical Records - Documentation Requirements"; states that "a complete account of every operation must be dictated or written by the operating surgeon at the conclusion of an operation". A letter from the Medical Director and the Executive Director will be sent to each physician on the medical staff stipulating the expectation of the Center that they abide by this policy. A copy of the policy will be</p>	05/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140		
(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 - Documentation Requirements indicated the following: "12. Operative Note Exception: None Explanatory Notes: A complete account of every operation must be dictated or written by the operating surgeon at the conclusion of an operation." This policy/procedure was last reviewed/revised on 02-28-13.</p> <p>2. Review of the following MRs indicated the following: Patient #6 had a procedure on 11-20-12 and the Operative Report was dictated on 11-21-12. Patient #14 had a procedure on 02-08-13 and the Operative Report was dictated on 02-11-13. Patient #20 had a procedure on 01-23-13 and the Operative Report was dictated on 01-26-13. Patient #23 had a procedure on 01-11-13 and the Operative Report was dictated on 01-15-13. Patient #27 had a procedure on 02-20-13 and the Operative Report was dictated on 02-26-13. Patient #30 had a procedure on 01-04-13 and the Operative Report was dictated on 01-07-13.</p> <p>3. On 04-17-13 at 1535 hours, staff #41 confirmed when the Operative Reports</p>		<p>sent with the letter for their reference. 2. Daily audits of incomplete records and the transcription log by the Medical Records department will be conducted. Any physician who has not completed their transcription at the conclusion of an operation will receive a deficiency and notification to complete the transcription.3. It will be the responsibility of the Medical Director and the Executive Director to develop and send a letter the active members of the medical staff at the Hancock Surgery Center by May 30, 2013. It will be the responsibility of the Medical Records department and Business Office Team Leader in conjunction with the Executive Director to audit the charts daily for transcription and incomplete medical records starting immediately. It will also be the responsibility of the Medical Records department to deficiency and notify the physicians of incomplete medical records. See Attachment G</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140		
(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	
S001164	<p>were dictated for patient #6, 14, 20, 23, 27 & 30.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule. Based on document review and interview, the facility failed to conduct preventive maintenance (PM) on 1 code blue equipment system in accordance with the manufacturer's recommended maintenance schedule.</p>	S001164	<p>1. The vendor instructed, onsite, the routine maintenance/full testing of the R4KPR400 Code Blue system. The testing will be completed quarterly as per manufacturer's recommended maintenance schedule. The following education was provided:a. Measurement of the</p>	04/19/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001160	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER HANCOCK SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE ONE MEMORIAL SQ STE 1000 GREENFIELD, IN 46140		
(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>Findings:</p> <p>1. Review of a document entitled Rauland tech bulletin, No. H3308TB, dated August 30, 2004, SUBJECT: RESPONDER 4000 MODEL R4KBR400 BATTERY BACK-UP UNIT BATTERY MAINTENANCE PROCEDURE, indicated do a "Battery Back-up" test every 3 months by powering off the R4KPR400 AC for 10 minutes. If this is not feasible, replace the internal battery (Rauland part BD0111) once a year.</p> <p>2. In interview, on 4-16-17 at 3:45 pm, employee #A1 indicated there was no documentation of following the above-stated manufacturer's recommendation within the past 12 months and no further documentation was provided prior to exit.</p>		<p>DC voltage at the R4KPR400 terminals with a digital voltmeter.</p> <p>b. Turned off the R4KPR400s AC switch for ten minutes. The R4KPR400 CD LED remained lit and the terminals remained above 11.5V for the entire 10 minutes.c. The R4KPR400's AC switch was positioned "ON" after the ten minutes.The vendor verified that the Battery Back-up was functioning properly.2. The manufacturer's recommended maintenance testing of the Battery Back-up will be completed quarterly in conjunction with the quarterly Code Blue buttons testing. 3. It will be the responsibility of the the Building Maintenance employees in conjunction with Safety Committee members to perform the quarterly testing and verify the proper functioning of the Battery Back-up. A new form will be implemented to record the completed quarter testing of the Battery Back-up and will be filed in the Safety Manual. Paperwork for the work order #B304119001 for the vendor, SWC of Indianapolis, available upon request.See Attachment H</p>		