

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/03/2012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY SURGERY CENTER NORTHWEST	STREET ADDRESS, CITY, STATE, ZIP CODE 8651 TOWNSHIP LINE ROAD INDIANAPOLIS, IN 46260
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005974</p> <p>Survey Date: 07/02-03/12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 07/13/12</p>	S000000		
S000110	<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>			

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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	<p>Based on document review and interview, the facility's governing board failed to review reports of the quality assessment performance improvement (QAPI) program for 1 of 4 quarters in calendar year 2011 and failed to review 1 contracted service (tissue transplant) and 3 other activities (discharges, transfers and medication errors) during calendar year 2011 as part of the facility's QAPI program.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the governing board meeting minutes for calendar year 2011 indicated the governing board reviewed QAPI activities on June 8, August 24 and November 9.</li> <li>2. In interview, on 7-3-12 at 1:40 pm, employee #A2 indicated there was no governing board review of QAPI activities during the first quarter of calendar year 2011 and no other documentation was provided prior to exit.</li> <li>3. Review of the the governing board meeting minutes for calendar year 2011 indicated the governing board failed to review QAPI activities for the contracted service of tissue transplant and the activities of discharges, transfers and</li> </ol>	S000110	Tissue transplant, discharges, transfers and medication error have been added to QA documents (contracted services and nursing) starting with the July 23, 2012 meeting. These documents will be reviewed at each quarterly QAPI and Board meeting starting July 23, 2012. Responsible Person: Maribeth T. Hart, RN Executive Director See Attachment	07/23/2012			

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S000162	<p>medication errors.</p> <p>4. In interview, on 7-3-12 at 1:40 pm, employee #A2 indicated there was no governing board review of QAPI activities for the activities of discharges, transfers and medication errors and no other documentation was provided prior to exit.</p> <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 4 of 7 medical staff credential files reviewed.</p> <p>Findings:</p>	S000162	The requirement of CPR competence for the podiatrists is on the August 7, 2012 board meeting agenda for approval. Once approved by the Board, the podiatrists will have three (3) months to obtain the certification. Responsible Person: Maribeth T. Hart, RN Executive Director	08/07/2012

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	<p>1. Review of a facility policy enbtitled LIFE SUPPORT COMPETENCY REQUIREMENTS indicated Center Anesthesiologists will maintain current Advanced Care Life Support (ACLS) certification. Medical Staff will be considered CPR competent as a result of:</p> <ol style="list-style-type: none"> <li>1. Maintaining medical staff privileges at the Center</li> <li>2. Maintaining medical staff privileges in at least one hospital within Marion county or a county adjacent to Marion county</li> </ol> <p>2. Review of the medical staff rules did not indicate that either of the above-stated conditions were identified in the privileging process to assure CPR competence.</p> <p>3. Review of 7 physician credential files indicated files MD#2, MD#3, MD#4 and MD#7 did not have any documentation of CPR competence in accordance with current standards of practice or facility policy.</p> <p>4. On 7-2-12 at 3:30 pm, employee #A2 was requested to provide documentation of inclusion of the above-stated conditions in the privileging process. The employee was also requested to provide documentation of CPR competence in accordance with current</p>			

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S000172	<p>standards of practice or facility policy for the 4 above-stated physicians. No other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review and interview, the facility failed to ensure that personnel records for tuberculin tests were maintained for 2 of 8 clinical personnel (Staff #5 &amp; 6).</p> <p>Findings include:</p> <p>1. Review of policy/procedure Employee Occupational Health indicated the following: "A. Pre-Placement Medical Examination:</p>	S000172	The two-step TB process for new employees is currently in place at the Center. A monthly audit of employee files will be conducted for completion and inclusion of the two-step TB process documentation. Responsible Person: Maribeth T Hart, RN Executive Director	07/23/2012

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	<p>1. A PPD, or documented proof of a PPD within the last 30 days, will also be required." This policy/procedure was last reviewed/revise on 01/2012.</p> <p>2. Review of the Centers for Disease Control and Prevention's (CDC) Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005 indicated the following: "Baseline test results 1) Provide a basis for comparison in the event or known exposure to M. tuberculosis 2) Facilitate the detection and treatment of LTBI or TB disease in an HCW before employment begins and reduces the risk to patients and other HCWs. If tuberculin skin test (TST) is used for baseline testing, two step testing is recommended for HCWs whose initial TST results are negative, the second step TST should be administered 1-3 weeks after the first TST was read. A second TST is not needed if the HCW has a documented TST result from any time during the previous 12 months."</p> <p>3. Review of staff #5's personnel file indicated that he/she was hired as a preoperative and postoperative RN on 03-05-12 and only had 1 TST</p>			

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S000228	<p>documented on 03-02-12 as negative.</p> <p>4. Review of staff #6's personnel file indicated that he/she was hired as a preoperative and postoperative RN on 10-17-11 and only had 1 TST documented on 03-14-12 as negative.</p> <p>5. On 07-02-12 at 1405 hours, requested from staff #40 for documentation of second step TST for staff #5 &amp; 6 and none was provided by exit on 07-03-12.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p>			

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	<p>Based on document review and interview, the governing board failed to assure that physicians and podiatrists performing surgery in the facility maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located for 6 (MD#1, MD#2, MD#3, MD#4, MD#5 and MD#7) of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of 7 medical staff credential files indicated files MD#1, MD#2, MD#3, MD#4, MD#5 and MD#7 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.</li> <li>2. In interview, on 7-2-12 at 3:30 pm, employee #A2 indicated there was no documentation of the above medical staff members 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 facility is located. No other documentation was provided prior to exit.</li> </ol>	S000228	<p>Obtaining of admitting privileges to Community Hospital North is on the August 7, 2012 board meeting agenda for approval. Once approved, the podiatrists who currently do not have admitting privileges at Community Hospital North will request these privileges. These podiatrists will have until November 30, 2012 to obtain admitting privileges as obtaining privileges is a 60-90 day process. Responsible Person: Maribeth T Hart, RN Executive Director</p>	08/07/2012			

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S000230	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</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>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the facility failed to ensure an utilization review committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Findings:</p> <p>1. Review of documents indicated there was no utilization review by a committee of 3 physicians, each with no financial interest (ownership) in the facility.</p> <p>2. In interview, on 7-3-12 at 1:55 pm, employee #A2 indicated there was no utilization review by a committee of 3 physicians, each with no financial interest (ownership) in the facility and no further documentation was provided prior to</p>	S000230	<p>The utilization review committee will consist of the following MD's: Pathologist; Chief Operating Officer; and Medical Director. The above MD's have agreed to be serve on the Utilization Review committee as of July 23, 2012. This committee will begin the utilization review process beginning October 1, 2012, where the third quarter, 2012 charts will be reviewed. None of these three physicians have a financial interest in the Center. Responsible Person: Maribeth T Hart, RN Executive Director</p>	07/23/2012			

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S000310	<p>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 tissue transplant.</p> <p>2. In interview, on 7-3-12 at 4:25 pm, employee #A2 indicated there was no documentation of inclusion of the above activity. No other documentation was provided prior to exit.</p>	S000310	Tissue transplant has been added to QA documents (contracted services) starting with the July 23, 2012 meeting. These documents will be reviewed at each quarterly QAPI and Board meeting starting July 23, 2012. Responsible Person: Maribeth T. Hart, RN Executive Director See Attachment	07/23/2012

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S000320	<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 activities of discharge, transfer and medication errors 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 the activities of discharge, transfer and medication errors.</p> <p>2. In interview, on 7-3-12 at 4:25 pm, employee #A2 was requested to provide documentation of the inclusion of the</p>	S000320	Discharges, transfers and medication error have been added to QA documents (nursing) starting with the July 23, 2012 meeting. These documents will be reviewed at each quarterly QAPI and Board meeting starting July 23, 2012. Responsible Person: Maribeth T. Hart, RN Executive Director See Attachment	07/23/2012			

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S000326	<p>above activities. No 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)(3)</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>(3) All services performed in the center with regard to appropriateness of diagnoses and treatments related to a standard of care and anticipated or expected outcomes.</p> <p>Based on document review and interview, the facility failed to include a review of appropriateness of diagnosis and treatments related to a standard of care for 2 of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 7 medical staff credential files indicated file MD#6 and MD#7 did not have any documentation of review of appropriateness of diagnosis and treatments related to a standard of care.</p>	S000326	<p>A review of appropriateness of diagnosis and treatments related to a standard of care is currently performed at the time of initial and re-credentialing. This process was effective January 1, 2012. Documentation was unable to be located at the time of the survey.</p> <p>Responsible Person: Maribeth T Hart, RN Executive Director See Attachment</p>	07/23/2012	

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S000444	<p>2. On 7-2-12 at 3:30 pm, employee #A2 was requested to provide documentation of the above review and no documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on document review, observation and interview, the facility failed to ensure that requirements for operating room attire met acceptable standards of practice for 1 operating room.</p> <p>Findings include:</p> <p>1. Review of policy/procedure Dress Code - Clinical Staff indicated the following:</p>	S000444	Effective July 19, 2012 staff must wear disposable hat over personal hat covers. The facility policy has been changed to reflect this update. Effective July 19, 2012 staff must wear personal protective devices according to manufacturer's recommendations. Personal protective devices cannot be altered to fit the needs of the employee. These changes will be added to the July 30, 2012 staff meeting. These updates have	07/23/2012

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	<p>"Purpose: This policy complies with the AORN Standards and Recommended Practices which states "surgical attire is worn to provide a barrier to contamination that may pass from personnel to patient, as well as from patient to personnel".</p> <p>Guidelines:</p> <p>D. Within restricted areas all head and facial hair (excluding eyebrows and eyelashes) must be covered completely by a clean, disposable hair cover or a clean non-disposable, low-lint surgical cap.</p> <p>I2. Protective eye wear or face shields must be worn when activities could place one at risk for splash or spraying of contaminated fluid. Protective eyewear or face shields are worn to reduce the incidence of contamination of mucous membranes of the mouth, nose and eyes." This policy/procedure was last reviewed/revised on 01/2012.</p> <p>2. Review of the AORN Journal dated August 2010 indicated the following: "Fabric head coverings should cover the hair and scalp completely. Fabric head coverings should be laundered daily in a health care-approved or accredited laundry."</p> <p>3. On 07-03-12 at 1100 hours in operating room #3, staff #41 was</p>		<p>been added to the quarterly Infection Control audit form Responsible Person: Maribeth T Hart, RN Executive Director See Attachment</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001034	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/03/2012
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY SURGERY CENTER NORTHWEST	STREET ADDRESS, CITY, STATE, ZIP CODE 8651 TOWNSHIP LINE ROAD INDIANAPOLIS, IN 46260
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S000732	<p>observed performing scrub responsibilities of assisting the surgeon with surgery and was wearing a personal fabric head cover that left hair in the back of the head exposed and was wearing face shields with the face shields bent out away from the face increasing the possibility of exposure of body fluid splash to the eyes.</p> <p>4. On 07-03-12 at 1315 hours, staff #40 confirmed that staff wash their personal fabric caps at their homes and the personal fabric caps are not laundered at an accredited laundry facility.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based on document review and interview, the medical staff failed to ensure review of the medical staff rules at least once every three (3) years.</p> <p>Findings:</p> <p>1. Review of the medical staff rules (policies) indicated there was no approval of these by the medical staff.</p>	S000732	The entire policy book is scheduled to be approved at the August 7, 2012 board meeting. Responsible Person: Maribeth T Hart, RN Executive Director	08/07/2012

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S001164	<p>2. In interview, on 7-3-12 at 12:30 pm, employee #A2 indicated the medical staff had never reviewed the medical staff rules.</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</p>	S001164	The PM on the sterilizers were performed after installation.	07/23/2012

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S001210	<p>interview, the facility failed to conduct preventive maintenance (PM)/testing of 3 pieces of equipment in accordance with acceptable standards of practice or in accordance with the manufacturer's recommended maintenance schedule.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the facility's biomedical engineering reports indicated there was no PM within the past 12 months conducted on the emergency call (code) system a piece of radiology equipment and sterilizer.</li> <li>In interview, on 7-3-12 at 4:00 pm, employee #A2 indicated there was no documentation available for PM within the past 12 months conducted on the above-stated pieces of equipment and no further documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1)</p> <p>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:</p>		<p>Future PM's will occur based on manufacturer's recommendationsThe PM on the radiology equipment was conducted on July 17, 2012. Future PM's will occur on a yearly basisThe emergency call (code) system is due to be installed by September 30, 2012. After installation, a monthly audit of its functioning will occurResponsible Person: Maribeth T Hart, RN Executive DirectorSee Attachments</p>		

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	<p>(1) Radiology services must be supervised by a radiologist or radiation oncologist. Based on document review and interview, the facility failed to document radiology services conducted in the facility were supervised by a radiologist or radiation oncologist.</p> <p>Findings:</p> <p>1. On 7-2-12 at 10:00 am, employee #A1 was requested to provide documentation that radiology services conducted in the facility were supervised by a radiologist or radiation oncologist.</p> <p>2. In interview, on 7-3-12 at 10:55 am, employee #A2 indicated there was no documentation of radiology services conducted in the facility having been supervised by a radiologist or radiation oncologist. No further documentation was provided prior to exit.</p>	S001210	Documentation of radiology services supervision by a radiologist was conducted on July 9, 2012. Reviews of this information will be conducted annually by the radiologist Responsible Person: Maribeth T Hart, RN Executive Director See Attachment	07/23/2012	