

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202
--	---

(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: 005408</p> <p>Survey Date: 10-6/9-14</p> <p>Surveyor: Jack I. Cohen, MHA Medical Surveyor</p> <p>QA: clauglin 10/28/14</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> <p>Based on document review and interview, the facility's governing board failed to review 1 contracted service (heating, ventilation and air conditioning</p>	S000110	<p>S110 1.(addressing410 IAC 15-2.4-1 (a)(5)) Contracted Services Evaluation was completed on IrishMechanical 10-13-2014</p>	10/14/2014

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: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/09/2014
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202		
(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>maintenance) and 1 other activity (discharges) during calendar year 2013 as part of the facility's quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the governing board meeting minutes for calendar year 2013 indicated the governing board failed to review QAPI activities for the contracted service of heating, ventilation and air conditioning maintenance and the activity of discharges. In interview, on 10-9-14 at 11:40 am, employee #A1, Director of Nursing, confirmed the above and no other documentation was provided prior to exit. <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>(Contracted Service Evaluation attached). The Quality Assessment and Performance Improvement Committee reviewed patient discharges 10-14-2014(QAPI project attached). Contracted Services Evaluations and QAPI project were reviewed by the QAPI committee (see attached meeting minutes) and submitted and approved by the Governing Body 10-14-2014 (see attached meeting minutes).</p> <ol style="list-style-type: none"> The QAPI Committee will continue to review the contracted services and patient discharges quarterly and report to the Governing Body. This will correct future deficiencies. Jennifer Knepp, LPN, Administrator and Katie Ralston, RN, Director of Nursing responsible. Deficiency corrected 10-14-2014. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202
--	---

(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
S000400	<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> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's QAPI program indicated it did not include a monitor and standard for the activity of discharges. In interview, on 3-15-10 at 2:35 pm, employee #A1 confirmed the above and no documentation was provided prior to exit. <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p>	S000320	<p>S320</p> <p>1.(addressing410 IAC 15-2.4-2 (a) (2)) The Governing Board approved addendum to policy 5.11Quality Improvement Program bullet 17. The addendum states Discharges: Standard: 100% of patients will be discharge for SCES within 23 hoursfrom admission. Monitored by QualityAssurance and Improvement Committee by reviewing patient charts for admissionand discharge times (see attached for entire policy). 2.TheQAPI Committee will continue to monitor the patient discharges quarterly andreport to the Medical Staff Committee and Governing Body. This will correctfuture deficiencies. 3.KatieRalston, RN, DON responsible. 4.Deficiencycorrected 10-14-2014.</p>	10/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202
--	---

(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>Based on observation, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors in the pre/post operative area.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 10-8-14 at 2:35 pm in the presence of employee #A2, Administrator, and employee #A3, Assistant Director of Nursing, it was observed in the pre/post operative area there were 12 ceiling light fixtures, 5 of which had some sort of debris which appeared to include insects. The above situations created a potential for infection exposure and risk. <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> <ol style="list-style-type: none"> identify the patient; support the diagnosis; justify the treatment; and document accurately the course of 	S000400	<p>S400</p> <ol style="list-style-type: none"> (addressing 410 IAC 15-2.2-1 (a)) The Director of Nursing and Administrator addressed the cleaning of the light fixtures with facilities maintenance. The light covers were removed and fixtures thoroughly cleaned before resuming patient care the following week. The cleaning company City Wide was also advised of debris in light fixtures and need for through cleaning. Visual inspections of light fixtures in the Pre/Post Operative areas will occur. The Contracted Services Evaluation will be done quarterly. A Quarterly Cleaning Performance Evaluation Checklist will be done periodically during the quarter to spot check the effectiveness of the cleaning of the facility. This will prevent future deficiencies. Jennifer Knepp, LPN, Administrator responsible. Deficiency corrected 10-10-2014. 	10/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202
--	---

(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>the patient's stay in the center and the results.</p> <p>Based on document review and interview, the facility failed to have sufficient information to document accurately the patient's stay in the facility in 30 of 30 medical records reviewed (Pt#1-30).</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of 30 medical records (Pt#1-30) indicated the following abbreviations were used at least one or more times in each record: A/C AC APC ASA AtOX BID COD DSG ESI HC L.E. NFQ NS PARS PC Q2H Q3h QD QID RLS SCH TID Review of MEDICAL RECORDS - POLICY 4.12, entitled Legibility of Medical Record Documentation, approved 1/14, indicated only abbreviations listed in the organization's list of approved abbreviations will be allowed for use in medical record documentation. Review of a facility document entitled SURGERY CENTER OF EYE SPECIALISTS OF IN, P.C. ABBREVIATIONS, approved 1-14, 	S000630	<p>S630</p> <ol style="list-style-type: none"> (addressing 410 IAC 15-2.5-3 (d)) The Governing Board approved the addition of policy 4.14 Approved Abbreviations to the policy and procedure manual. The policy provides an attached list of the practices approved abbreviations (see attach policy and list). The list of approved abbreviations will prevent further deficiencies and the use of unauthorized abbreviations in the medical record. The list was reviewed by the staff at the last staff meeting so everyone is familiar with approved abbreviations. Katie Ralston, RN, DON responsible Deficiency corrected 10/14/2014. 	10/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202
--	---

(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
S001154	<p>indicated that none of the above-stated abbreviations were defined in this document's list.</p> <p>4. In interview, on 10-7-14 at 10:15 am, employee #A1, Director of Nursing, confirmed the above-stated abbreviations were not defined in the ABBREVIATIONS list and no other documentation was provided by exit.</p> <p>5. The result of the abbreviation not being defined was that some of them may have more than one meaning or the reader may not have any knowledge/understanding of the abbreviation's meaning in the context of which it was used.</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>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202
--	---

(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) 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 available on the premises.</p> <p>Based on interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 3 systems of equipment.</p> <p>Findings:</p> <p>1. On 10-6-14 at 11:15 am, employee #A1, Director of Nursing, was requested to provide documentation of the operational and maintenance control records for the heating, ventilation, and air conditioning (HVAC) system, fire alarm and/or smoke detector system, and emergency generator, having been analyzed at least triennially.</p> <p>2. In interview on 10-9-14 at 2:30 pm, employee #A2, Administrator, indicated there was no documentation of the operational and maintenance control records for the above-stated systems having been analyzed at least triennially. No documentation was provided prior to</p>	S001154	<p>S1154</p> <p>1.(addressing410 IAC 15-2.5-7 (b)(3)(C)) Documentation of the operational and maintenancecontrols on the heating, ventilation, and air conditioning (HVAC) system wasfound dating 4/25/2014 by Irish Mechanical Services, Inc. PM was performed, filters changed on allsystems, checked belts, lube, and surgery room unit and checked operation. No problems indicated (see attached workorder). Documentation was found foroperational and maintenance controls for fire alarm and smoke detector systemfrom Koorsen Fire & Security for inspections and test to system performed4/11/2014 (see attached document). Allpull stations and smoke detectors were verified functioning. The emergency generator documentation wasfound for operational and maintenance controls on inspections done by BuckeyePower Sales on 2/1/2014 (see attached document). The battery, lubricating system,</p>	10/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/09/2014
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202		
(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	
S001168	<p>exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</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>coolingsystem, fuel system, engine, exhaust system, electrical system/generator,automatic transfer switch, and operational readings were recorded. Routine annual maintenance was performed andall systems passed inspection.</p> <p>2.Theoperational and maintenance control documentation was available for the abovebut was not found during survey. Theinspections are done at least annually on the above systems and bi-annually onsome systems, or as needed. Thedocumentation will be kept in a binder label "State Board Book" for retrievalduring subsequent surveys. The QAPICommittee will review the inspections triennially and report finding andrecommendations to the Governing Board and Medical Staff Committee. This will correct future deficiencies.</p> <p>3.JenniferKnepp, LPN, Administrator responsible.</p> <p>4.Deficiencycorrected 10/14/2014.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202
--	---

(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>(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>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the facility failed to analyze, at least triennially, records pertaining to equipment maintenance, repairs, and electrical current leakage checks for 1 piece of equipment (EKG machine).</p> <p>Findings:</p> <p>1. On 10-6-14 at 11:15 am, employee #A1 was requested to provide documentation of triennial analysis of records pertaining to equipment maintenance, repairs, and electrical current leakage checks for an EKG machine.</p> <p>2. In interview, on 10-9-14 at 2:30 pm, employee #A2, Administrator, indicated there was no documentation of triennial analysis of the above-stated equipment. No documentation was provided prior to exit.</p>	S001168	<p>S1168</p> <p>1.(addressing410 IAC 15-2.5-7 (b)(4)(B)(iii)) Documentation on the EKG machine Welch Allyn Propaq CS for maintenance,repairs, and electrical current leakage was found. The inspection was performed by K&RMedical Equipment Repair, Inc. 9/6/2013 and also 3/31/2014 (see attacheddocumentation). The checks wereperformed and pass inspection on both dates.</p> <p>2.The documentation for the above was not found during the state survey. The inspections are done on a bi-annual basisto ensure the safety of all equipment. Thedocumentation of maintenance, repairs and electrical current leakage will belocated in a binder labeled "State Board Book" for retrieval during subsequentsurveys. The QAPI Committee will reviewthe inspections triennially and report finding and recommendations to theGoverning Board and Medical</p>	10/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202
--	---

(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
S001170	<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 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 interview, it could not be determined if the defibrillator performed a weekly self-test according to the manufacturer.</p> <p>Findings:</p> <p>1. Review of the Welch Allyn AED 10 Users Manual indicated the AED 10 will</p>	S001170	<p>Staff Committee. This will correct future deficiencies.</p> <p>3. Jennifer Knepp, LPN, Administrator</p> <p>4. Deficiency corrected 10/14/2014.</p> <p>S1170</p> <p>1. (addressing 410 IAC 15-2.5-7(b)(4)(B)(iv)) The Welch Allyn AED 10 users' manual indicates an automatically performed weekly self-test (see attached). A weekly log will be kept with the AED to indicate the green READY indicator is on and no issues presented with self-test. If issues are indicated they will be</p>	10/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/09/2014
NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202		
(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>automatically perform a weekly self-test.</p> <p>2. On 10-8-14 at 11:35 am, employee #A3, Assistant Director of Nursing, was requested to provide documentation of the weekly self-testing. In interview on that date and time, the employee indicated there was no documentation of the self-testing.</p> <p>3. Because of no documentation, the facility could not ensure the defibrillator was in good working condition.</p>		<p>corrected by manufacture specifications.</p> <p>2. Theweekly log for self-test on AED will ensure monitoring of the function andreadiness of the AED. This log willprevent future deficiencies.</p> <p>3. KatieRalston, RN, DON responsible.</p> <p>4. Deficiencycorrected 10/13/2014.</p>		