

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NAAB ROAD SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
S 0000  Bldg. 00	This visit was for a state licensure survey of an Ambulatory Surgery Center.  Facility Number: 010525  Survey Dates: 8-2-2021 to 8-3-2021  QA: 8/5/21	S 0000		
S 0428  Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)  The infection control committee responsibilities must include, but are not limited to:  (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:  (i) Sanitation. Based on observation and interview, the facility failed to provide a safe and sanitary environment.  Findings Include:  1. Tour of the pre/post operative areas on 08/02/21 at approximately 11:20 am, this surveyor observed visible and wipeable dust on: a. Room 1 - top of shelf, patient cart and top of wall rail. b. Top of blanket warmer. c. Room 10 - cobwebs around window, dust on windowsill and shelf.	S 0428	On August 2, 2021 the Naab Road Surgery Center was in the process of switching its cleaning company, due to the exact reasons that were discovered by the surveyor. We had communicated with the previous cleaning crew on multiple occasions with little to no improvement. A 30 day notice was given to the previous cleaning crew on June 30, 2021 detailing our reason for cancelling our contract. This email and letter	08/30/2021

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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:  15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/03/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  NAAB ROAD SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260
--	---

(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
S 0888 Bldg. 00	<p>d. Top of code cart.</p> <p>2. Interview on 08/02/21 with S2 (Clinical Director) at approximately 11:30 am confirmed visible and wipeable dust on:</p> <p>a. Room 1 - top of shelf, patient cart and top of wall rail.</p> <p>b. Top of blanket warmer.</p> <p>c. Room 10 - cobwebs around window, dust on windowsill and shelf.</p> <p>d. Top of code cart.</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 the operative note was completed day of surgery in 3 of 29 medical records reviewed (Patients 3, 17 and 20).</p>	S 0888	<p>was presented to the surveyor. The new cleaning company is in the process of correcting the deficiencies the previous company could not rectify. The Clinical Director will complete spot checks of the facility to ensure cleaning has improved. The clinical director will be responsible for monitoring this activity.</p> <p>The center will continue to work with physicians and reeducate them on the need for immediate dictation of an operative note. The executive director and Medical</p>	08/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2021
NAME OF PROVIDER OR SUPPLIER  NAAB ROAD SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	
S 1010 Bldg. 00	<p>Findings Include:</p> <ol style="list-style-type: none"> <li>1. Review of Medical Staff Rules and Regulations, last approved 03/13/19, indicated "The Patient's medical record must also contain an operative summary with a complete description of the operative procedure, any complications, indications for surgery and discharge summary by the surgeon and with the surgeon's signature to be dictated immediately following surgery".</li> <li>2. Review of Patient 3's medical record (MR) indicated surgery was on 11/11/20 and the Operative Note was dictated on 11/12/10. MR lacked documentation of handwritten note immediately after surgery.</li> <li>3. Review of Patient 17's MR indicated surgery was on 10/14/20 and the Operative Note was dictated on 10/15/20. MR lacked documentation of handwritten note immediately after surgery.</li> <li>4. Review of Patient 20's MR indicated that surgery was on 01/18/21 and the Operative Note was dictated on 01/19/21. MR lacked documentation of handwritten note immediately after surgery.</li> <li>4. Interview on 08/03/21 at approximately 3:00 pm confirmed that 3 patients (Patients 3, 17 and 20) had their operative reports dictated the following day.</li> </ol> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p>		Records coordinator will work with physicians to remind them of the need for an immediate operative note. The Medical Record coordinator will notify the executive director when this not completed. The executive director will be responsible for monitoring this activity.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/03/2021
NAME OF PROVIDER OR SUPPLIER  NAAB ROAD SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP COD 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260		
(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	
S 1154	<p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing. Based on document review, observation and interview, the facility failed to ensure proper labeling on 22 of 22 bags of 1000 milliliters of Lactated Ringers.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of policy titled: Medication Labeling (policy 8.05) last approved in 2019, indicated that all medications that are removed from their original containers must be properly labeled.</li> <li>On tour of the pre/post operative area on 08/02/21 at approximately 11:00 am with S2 (Clinical Director), this surveyor observed 22 - 1000 milliliter IV (intravenous) bags of Lactated Ringers that had tubing lying on the top of the individual bags and both fluids and tubing were out of the original packaging, each with hand written labels pre-dated for 08/03/21 and pre-timed for spiking of bag at 0500.</li> <li>Interview on 08/02/21 with S2 at 11:05 am confirmed that 22 1000 milliliter IV (intravenous) bags of Lactated Ringers with tubing lying on the top of the individual bags and both fluids and tubing were out of the original packaging, each with hand written labels pre-dated for 08/03/21 and pre-timed for 0500.</li> </ol> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT</p>	S 1010	Staff of the center will be reeducated on proper labeling of IV bags and solutions. The Clinical Director and nursing supervisor will conduct spot checks to ensure this is completed for all staff. The clinical director will be responsible for monitoring this activity and compliance.	08/30/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NAAB ROAD SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP COD 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 00	<p><b>MAINTENANCE,</b> 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 available on the premises. Based on document review and interview, the facility failed to document triennial analysis on four (4) pieces of equipment (emergency generator, fire alarms, smoke detectors, and heating ventilation air conditioning (HVAC)).</p> <p>Findings include:</p> <p>1. Review of facility preventative maintenance records lacked documentation indicating a triennial analysis was conducted on four (4) pieces of equipment (emergency generator, fire alarms, smoke detectors, and heating ventilation air conditioning (HVAC)).</p> <p>2. In interview on 8-3-2021 at 1600 hours, employee S2, clinical director, confirmed the lack of any documentation of triennial analysis being conducted on the above listed equipment . No</p>	S 1154	The center will work with building maintenance staff and landlord to develop triennial analysis of maintenance records on equipment maintained by the landlord as part of the centers lease. The executive director will work will ask for written confirmation from the landlord that this triennial analysis is added to the equipment PMs. The executive director will be responsible for monitoring this activity.	08/30/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2021  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  15C0001079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/03/2021
NAME OF PROVIDER OR SUPPLIER  NAAB ROAD SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP COD 8260 NAAB ROAD, SUITE 100 INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	
	additional information was provided prior to exit.				