

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a state licensure survey. Facility Number: 012397 Survey Date: 09-26-2017 to 09-28-2017 QA: 12/1/17	S 000		
S 220	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e) (e) 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: This RULE is not met as evidenced by: Based on document review and interview, the governing board could not ensure the activity of discharges were provided in a safe and effective manner because the facility failed to include it in its quality assurance and performance improvement program (QAPI) reports to the governing board for calendar year 2016. Findings include: 1. Review of the facility's QAPI program for calendar year 2016 and governing board meeting minutes for calendar year 2016, indicated the governing board did not review reports for the activity of discharges.	S 220		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S 220	Continued From page 1 2. In interview on 09-28-2017 at 4:00 pm, employee #A1, Clinical Operations Manager, confirmed the above and no other documentation was provided prior to exit.	S 220		
S 230	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5) 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: (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. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to have a properly composed utilization review committee meet as a committee, and no other committee properly composed for utilization review, in 1 instance. Findings include: 1. Review of a document titled Utilization Review Committee Meeting, dated October 20, 2016, indicated 3 physicians who had no financial interest in the facility, had performed utilization	S 230		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S 230	Continued From page 2 review activities for the facility as follows: MD#14 - reviewed 18 cases on 10-14, and 2 cases on 10-16 MD#15 - reviewed 6 cases on 10-5, and 9 cases on 10-7 MD#16 - reviewed 6 cases on 10-12 and 9 cases on 10-11 2. In interview on 09-28-2017 at 4:00 pm, employee #A6, Director of Clinical Operations, confirmed the above and also indicated the above-stated reviewers individually completed the review but did not meet as a committee, and there were no minutes of them having met as a committee, either in person or via telecommunication. 3. Review of a document titled OPERATIONS/QUALITY ASSURANCE COMMITTEE, dated October 20, 2016, indicated the members were MD#17, MD#18, MD#19, MD#20, MD#21, MD#22, and MD#23. Further review of this document indicated this committee reviewed 50 charts by the Utilization Committee. However, as previously indicated in interview of employee #A6, there was no meeting of the Utilization Committee as a committee. 4. In interview on 09-28-2017 at 4:00 pm, employee #A6 indicated MD#17 and MD#23 had a financial interest in the facility, and confirmed the members of the OPERATIONS/QUALITY ASSURANCE COMMITTEE. No other documentation was provided prior to exit.	S 230		
S 400	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM	S 400		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S 400	<p>Continued From page 3</p> <p>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> <p>This RULE is not met as evidenced by: Based on document review, interview and observation the facility failed to ensure a safe and healthful environment that minimizes infection exposure and risk to patients in one crash cart and one operating suite supply room.</p> <p>Finding include:</p> <ol style="list-style-type: none"> 1. Review of facility policy, Code Cart Contents and Checking, approved 1/30/17, Code carts shall be checked in accordance with the procedures in this policy to ensure that all designated supplies/ equipment are available, secured, and non-expired. 2. Review of facility, Code Cart Check Sheet indicated, expired adult and pediatric defibrillator pads on 9/21/2017 through 9/26/2017. 3. On tour 9/26/2017, at approximately 12:45 pm, in the preoperative/recovery unit, with N1 (Clinical Operations Manager) the following was observed , adult and pediatric defibrillator pads were expired. 4. Interview on 9/27/2017, at approximately 8:32 am, with N1 confirmed, defibrillator pads expired on 9/21/17 and were not replaced until 9/26/2017. 5. On tour 9/27/2017, at approximately 10:45 am, 	S 400		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S 400	<p>Continued From page 4</p> <p>in the preoperative/recovery unit, with N1 the following was observed, in the crash cart, 4th drawer normal saline syringes expiration date of April 2015, 5th drawer Medline exam gloves manufactured in 2008/01 and 2007/04, sterile gloves manufactured in 04/07.</p> <p>6. On tour 9/27/2017, at approximately 10:45 am, in the preoperative/recovery unit, with N1 the following was confirmed, in the crash cart, 4th drawer normal saline syringes expiration date of April 2015, 5th drawer Medline exam gloves manufactured in 2008/01 and 2007/04, sterile gloves manufactured in 04/07.</p> <p>7. Interview on 9/27/2017, at approximately 3:01 pm, with N1 confirmed, Medline exam gloves shelf life 3 to 5 years. Gloves on crash cart expired.</p> <p>8. Interview on 9/27/2017, at approximately 3:53 pm, with N1 confirmed, sterile gloves shelf life 3 to 5 years. Sterile gloves found on crash cart manufacture in 04/07. Gloves on crash cart expired.</p>	S 400		
S 450	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM</p> <p>410 IAC 15-2.5-1(g)</p> <p>(g) Sterilization of equipment and supplies must be provided, within the scope of the service offered, in accordance with acceptable standards of practice or manufacturer's recommendations and applicable state laws and rules, 410 IAC 1-4. Sterilization services must be</p>	S 450		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S 450	<p>Continued From page 5</p> <p>directed by a qualified person or persons and must provide for the following:</p> <p>This RULE is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure sterilization of equipment and supplies must be provided, within the scope of the service offered, in accordance with acceptable standards of practice or manufacturer's recommendations in one operating suite supply room.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of manufacturer recommendations, Sterilcontainer Validation Summary 2012, (Aesculap), page 3, the containers maintained sterility during the 360 day storage period. 2. On tour 9/27/2017, at approximately 12:20 pm, with N2 (Registered Nurse Shift Coordinator Operating Room) the following was observed, pediatric instrument pan was sterilized in 2014. 3. Interview on 9/27/2017, at approximately 12:20 pm, with N2 (Registered Nurse Shift Coordinator Operating Room) the following was confirmed, pediatric instrument pan was sterilized in 2014. 	S 450		
S 612	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN.</p> <p>410 IAC 15-2.5-3(c)(1)</p>	S 612		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S 612	<p>Continued From page 6</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure medical records (MR) are documented accurately and in a timely manner in six (patient 1, 2, 4, 6, 15, 21) of 30 MRs reviewed.</p> <p>Findings include:</p> <p>1. Review of facility policy, Content Of Medical Records, approved, 1/30/17, indicated, page 2, B: the medical record shall contain patient-specific information including: 7. The diagnosis or diagnostic impression. The policy indicated on page 5. b: the H&P (history and physical) must be updated the day of the procedure.</p> <p>2. Review of patient 2's MR indicates, on History and Physical, history of present illness/diagnosis, polydactyly R (right) hand excision. Consent for procedure indicates, Excision polydactyly Left hand and other indicated procedures. Operative Note, indicates, Excision of left hand postaxial polydactyly.</p> <p>3. Review of the following MR's indicated the following; Review of patient 1's H&P (History and Physiscal)</p>	S 612		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S 612	Continued From page 7 of 4/11/2017, unable to determine time of completion. Review of patient 4's, H&P of 4/11/2017, unable to determine time of completion Review of patient 6's, H&P of 4/11/2017, unable to determine time of completion. Review of patient 15's H&P of 6/13/2017, unable to determine time of completion. Review of patient 21's H&P, of 7/11/2017, unable to determine time of completion. 4. Interview on 9/27/2017, at approximately 8:14 am, with N3 (Shift Coordinator Post Anesthesia Care Unit) confirmed, procedure consent and operative note indicated left side and physical and history indicated right side. MR History and Physicals lacked indication of time completed.	S 612		
S 650	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(2) All patient records must document and contain, at a minimum, the following: (2) Appropriate medical history and results of a physical examination completed within the time frames in section 4(b)(3)(M) of this rule. This RULE is not met as evidenced by: Based on document review and interview, the facility failed to ensure medical records (MR) contained a history and physical (H&P) according to policy, in 2 of 30 MRs reviewed (patients 19	S 650		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S 650	Continued From page 8 and 20). Findings include: 1. Review of facility policy, Content Of Medical Records, indicates page 4, E: Content of the Medical Record includes, 1. History and Physical Examination, a. A complete history and physical examination shall be completed prior to surgery. The history should include the following: Inventory of body systems (including mental status). 2. Review of the following MRs indicated; Patient 19's and 20's History and Physical (H&P) of 7/11/2017, lacked documentation of systems reviewed. 3. Interview on 9/27/2017, at approximately 8:14 am, with N3 (Shift Coordinator Post Anesthesia Care Unit) confirmed, patient 19's and 20's MR, lacked system review.	S 650		
S1210	410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1) (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: (1) Radiology services must be supervised by a radiologist or radiation oncologist.	S1210		

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012397	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2017
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ROC SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 705 RILEY HOSPITAL DR SUITE 0201 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) COMPLETE DATE
S1210	<p>Continued From page 9</p> <p>This RULE is not met as evidenced by: Based on document review and interview, the facility failed to document that radiology services conducted in the facility were supervised by a radiologist or radiation oncologist in 1 instance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 09-26-2017 at 10:00 am, employee #A1, Clinical Operations Manager, was requested to provide documentation that radiology services conducted in the facility were supervised by a radiologist or radiation oncologist. In interview, on 09-28-2017 at 4:00 pm, employee #A1 indicated the above-requested documentation was not available and no other documentation was provided prior to exit. 	S1210		