STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001022	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIGESTIVE HEALTH CENTER	1120 AAA WAY CARMEL, IN 46032

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Q000000	The visit was for a re-certification survey. Facility Number: 005043 Survey Date: 5-12-14 to 5-14-14 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Nancy Otten, RN Public Health Nurse Surveyor QA: claughlin 05/28/14	Q000000		
Q000043	416.41(c) DISASTER PREPAREDNESS PLAN (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with State and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to test the plan's effectiveness.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan. Based upon document review and interview, the center failed to coordinate its emergency preparedness program and document its participation with community, state and/or federal emergency and disaster preparedness agencies. Findings: 1. On 5-12-14 at 1130 hours, staff A2 and A7 were requested to provide documentation of participation with community, state and/or federal emergency and disaster preparedness agencies and no documentation was provided prior to exit. 2. The Emergency Preparedness Plan (approved 7-12) failed to indicate a provision for coordinating the disaster preparedness plan with State and/or local authorities. 3. Safety Committee minutes dated 6-28-13, 10-01-13, 12-23-13 and 4-07-14 failed to indicate evidence of center staff participation with a local, State or federal emergency and disaster preparedness activity.	O000043	1. At the time of the survey, surveyors recommended Anne Haddix as a contact person for this information and provided her email address. On 6/5/14, the Safety Director sent an email of inquiry to Anne Haddix regarding emergency preparedness meetings in District 5. Upon receipt of Ms. Haddix's response, the Safety Director will arrange to participate in regular meetings. This will be documented in the QA and in the Safety Report. 2. Once information about regular meetings is obtained, we will add the meetings as an item on our Safety Checklist to ensure adequate participation. 3. The Safety Director is responsible for the above. 4. This will be implemented by 6/30/14.	06/30/2014

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	4. During an interview on 5-14-14 at 1135 hours, staff A7 confirmed that no documentation was available regarding participation with District 5 disaster management events or quarterly district 5 meetings.			
Q000083	416.43(d) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations. (2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results Based on document review and interview, the center failed to conduct and document performance improvement projects including a rationale for the project and an evaluation of the project's effectiveness. Findings: 1. The Continuous Quality Improvement (CQI) Plan (approved 6-13) indicated the following: "QA audits will be completed as problems arise and are identified by the staff. Each problem will be discussed, goals established, possible solutions identified, one or more	O000083	1. Our center is constantly implementing performance improvement projects to improve patient safety and health outcomes. We will specifically document these improvement projects in the QA moving forward. As an example, our facility switched to EMR in March 2014. Our Medical Records Consultant did a review in April and discovered that based on the timestamp, Dr. Stout was recording his History and Physical at the same time as the procedure record. Even though Dr. Stout completed his History and Physical on paper prior to the start of the procedure, Dr. Stout changed his workflow to	06/30/2014

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	solutions chosen and implemented. Then the results will be monitored and assessed at the following meeting. Further audits or studies may be necessary depending on the evaluation of the outcome." 2. On 5-12-14 at 1130 hours, staff A2 was requested to provide documentation of current or recent performance improvement project(s) for improving patient safety or health outcomes in the center and none was provided prior to exit. 3. The Quality Assurance/Risk Management minutes dated 6-28-13, 9-30-13, 12-23-13 and 4-07-14 failed to indicate documentation of patient safety or quality improvement projects being conducted and reviewed by the committee. 4. During an interview on 5-13-14 at 1440 hours, staff A2 confirmed that the center lacked documentation of a performance improvement project conducted during the past 12 months that included a reason for implementing the project, expected outcomes, and an evaluation of the project's effectiveness.		electronically document the History and Physical before the start of the procedure. This will ensure that the History and Physical was completed prior to the start of the procedure. 2. As mentioned, these projects are constantly being performed, so we will dedicate a section for them in our quarterly QA reports. 3. The Administrator and Director of Nursing are responsible. 4. This will be completed by 6/30/14.	
Q000181	416.48(a)			

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	ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on policy and procedure review, document review, observation, and interview, the facility failed to ensure the destruction of expired samples was accomplished, per facility policy, in one drug cabinet observed while on tour of the recovery area. Findings: 1. Review of the policy "Sample Drug Administration", policy number MM 4.40, with an "updated" date of 5/1/12, indicated: a. under "Purpose", it reads: "To provide safe administration of all sample medications...To remove from inventory any drugs which have or are about to be expired." b. under "Policy/Procedures", it reads: "...6. All expired sample medications will be removed from the inventory before their expiration date and properly disposed of in accordance with state and federal regulations for waste disposal..." 2. Review of the document "Pharmacy Quarterly Inspection Checklist", dated with a last inspection date of March 17, 2014 at 1500 hours, indicated: a. the sample drug cabinet located in the recovery area is not listed on this	O000181	1. The Pharmacy Nurse conducts a quarterly inspection and report of all administered drugs in the facility. We will add a check point on the inspection to check, remove, and dispose of any expired medications in the sample cabinet. The quarterly pharmacy inspection is noted in the QA reports. 2. We will prevent this from occurring again by using the checklist. 3. The Director of Nursing is responsible for these items. 4. The checklist will be updated by 6/11/14.	06/11/2014

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	form b. it is unknown if the sample cabinet was inspected during the most recent quarterly review by staff 3. While on tour of the recovery area of the surgery center at 9:40 AM on 5/13/14, in the company of staff member #52, the director of nursing, it was observed that in the sample cabinet, the "Kristolose one dose" box of medication had expired 8/13 4. Interview with staff member #52 at 9:40 AM on 5/13/14 and 12:00 PM on 5/14/14 indicated: a. there was agreement that the Kristolose was expired b. the sample cabinet is not listed on the quarterly medication review/inspection form c. it is unknown when the expiration dates in the sample cabinet were last checked			
Q000220	416.50 NOTICE - POSTING ... The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable.			

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	Based on observation and interview, the center failed to ensure that the posted patient rights notice included 3 of 14 required elements. Findings: 1. The patient rights document posted in the reception area failed to indicate the following: a. Notice of the physicians with a financial interest or ownership in the ASC center. b. Notice of the center policy on advance directives in the event of a patient emergency and notice of the availability of a copy of the State advanced directive forms upon request. c. Notice of the patient right to receive care in a safe setting 2. During an interview on 5-13-14 at 0900 hours, staff A2 confirmed that the posted information lacked the indicated requirements.	Q000220	1. The Patient Rights and Responsibilities notice was modified on 5/16/14 to include the phrase "to receive care in a safe setting." The updated notice and information regarding advance directives and financial interest will be posted by 6/30/14. 2. Posting these documents will satisfy the deficiency. 3. The Administrator is responsible for the items above. 4. The Patient Rights Notice was modified on 5/16/14 and approved by the Medical Advisory and Governing Board the same day. The posted notices will be completed by 6/30/14.	06/30/2014
Q000221	416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.			

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	Based on document review and interview, the center failed to ensure that the patient rights information given to a patient, patient representative or surrogate prior to the procedure included 1 of 14 required elements. Findings: 1. The document Patient Rights and Responsibilities failed to indicate the patient right to receive care in a safe setting. 2. During an interview on 5-14-14 at 1407 hours, staff A2 confirmed that the notice of patient rights lacked the indicated requirement.	Q000221	1. The Patient Rights and Responsibilities notice was modified and approved on 5/16/14 to include the phrase "to receive care in a safe setting." The notice was presented to patients beginning on 5/19/14. 2. Modifiying the notice satisfies the deficiency. 3. The Administrator is responsible for the items above. 4. The Patient Rights Notice was modified on 5/16/14 and approved by the Medical Advisory and Governing Board the same day.	05/16/2014
Q000225	416.50(d)(4),(5), & (6) SUBMISSION AND INVESTIGATION OF GRIEVANCES The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC. The following criteria must be met: (1) The grievance process must specify timeframes for review of the grievance and the provisions of a response. (2) The ASC, in responding to the grievance, must investigate all grievances made by a patient, the patient's representative, or the patient's surrogate regarding treatment or care that is (or fails to be) furnished. (3) The ASC must document how the grievance was addressed, as well as provide the patient, the patient's representative, or			

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	the patient's surrogate with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the result of the grievance process and the date the grievance process was completed. Based on document review, observation and interview, the grievance policy/procedure failed to indicate criteria when a complaint must be regarded as a grievance and failed to indicate specific timeframes for grievance investigation, determination, and providing the written notification of determination to the patient. Findings: 1. The policy/procedures Complaint Process (approved 7-12) and Patient Grievance (approved 7-12) observed in the quality assessment policy binder failed to indicate the center criteria for determining when a complaint will be considered a grievance (including when a complaint is submitted in writing, requested by a patient, postponed for later resolution, involves an investigation or involves allegations of abuse, neglect or mistreatment) and failed to indicate specific timeframes for review of the grievance and the provisions of a response(including a written notice of the determination).	O000225	1. By 6/30/14, a review of our patient grievance policy and procedures will be completed. Criteria will be specified for determining when a complaint is to be considered a grievance. The timeframes for a review and response will also be modified. The Administrator will contact the patient within 7 days of the receiving the grievance for the purpose of discussing and solving the grievance. Then within 14 days, the Administrator will provide documentation to the patient regarding the solving of the grievance and any the action taken. These modifications to this policy will be recorded in the QA and presented to the Medical Advisory and the Governing Board. 2. We will avoid this deficiency in the future by amending this policy. 3. The Adminstrator is responsible. 4. This wil be completed by 6/30/14.	06/30/2014

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	2. During an observation on 5-13-14 at 0902 hours, in the patient waiting area of the center, the document Grievance Policy failed indicate evidence that the document was an approved policy/procedure of the center. 3. During an interview on 05-14-14 at 1140 hours, staff A7 confirmed that no evidence of policy adoption and approval for the grievance document on display in the patient waiting area was available and confirmed that the policy/procedures Complaint Process (approved 7-12) and Patient Grievance (approved 7-12) observed in the quality assessment policy binder failed to indicate when a complaint shall be treated as a grievance or indicate specific timeframes for the grievance process and written notice of determination.			
Q000226	416.50(d)(1), (2), & (3) GRIEVANCES - MISTREATMENT, ABUSE .... The following criteria must be met: (1) All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented. (2) All allegations must be immediately reported to a person in authority in the ASC. Only substantiated allegations must be reported to the State authority or the local			

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	authority, or both. Based on document review and interview, the center failed to ensure that all allegations of patient abuse, neglect, or mistreatment involving a staff member will be fully documented, immediately reported to the responsible person at the center and reported to the State and/or a local authority if authenticated. Findings: 1. On 5-12-14 at 1130 hours, staff A2 and A7 were requested to provide a policy/procedure indicating a center response to an observation or allegation of patient abuse, neglect or mistreatment involving a staff member and none was provided prior to exit. 2. The policy/procedures Complaint Process (approved 7-12), Patient Grievance (approved 7-12) and Domestic Abuse (approved 7-12) failed to indicate a process for responding to allegations involving mistreatment, neglect, verbal, mental, sexual, or physical abuse alleged to have occurred at the center. 3. During an interview on 5-13-14 at 1405 hours, staff A2 confirmed that the center lacked a policy/procedure for responding to allegations of abuse, neglect, or mistreatment by staff.	O000226	1. A policy with be written for the response to allegations of patient abuse or mistreatment by staff. The policy will apply for situations involving mistreatment, neglect, verbal, mental, sexual, or physical abuse alleged to have occured at our facility. It will specify the proper reporting steps, to whom the report should be given, the process of investigation, and employee disciplinary action or suspension. 2. We will avoid future definciencies by implementing this policy. 3. The Safety Director is responsible. 4. This policy with be written, recorded in the QA, and presented to the Medical Advisory and Governing Boards for approval by 6/30/14.	06/30/2014

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Q000241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on document review, observation, video review, and interview, the facility failed to ensure that the daily cleaning processes were completed, as expected per the contract with a housekeeping company to provide a sanitary environment for providing surgical services. Findings: 1. Review of the contracted housekeeping document for daily cleaning indicated that in the "Exam Rooms, Procedure Rooms and Recovery Room:...Wet wipe exam chairs and tables as well as all horizontal surfaces and equipment with approved disinfectant...Thoroughly clean walls, doors, doorframes, kick plates and baseboards with approved disinfectant. Clean, disinfect, and polish all sinks and counters with approved disinfectant..." 2. At 10:50 AM on 5/14/14, while observing a patient in the recovery room area, it was observed that there was an	O000241	1. On May 21, 2014, the Director of Nursing, Administrator, and Medical Director met with the housekeeping company's Operations Manager and President to discuss the severity of the deficiencies observed on the surveillance video at the time of the survey. The Director of Nursing, Administrator, and Medical Director presented the housekeeping representatives with a letter stating that the contract would be terminated if the deficiences were not corrected within the week. The company's respresentatives acknowledged the deficiencies and indicated that a supervisor would be going through the facility with the cleaners to monitor and correct the cleaning procedure. After a review of the surveillance video on 5/22/14, it was observed that the deficiencies had been corrected including, but not limited to, the cleaning of horizontal surfaces (such as desks and procedure room counters), cabinet tops and fronts, railings, recovery room gurneys, and procedure room monitors. 2. The cleaners will	05/22/2014

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	accumulation of dust (and a hair present) on the lower portion of two of 3 gurneys 3. Interview with staff member #52, the director of nursing, at 10:50 AM on 5/14/14 indicated: a. the last monthly "walk through" with the operations manager, staff member #56, was on 5/9/14 b. housekeeping is not doing daily cleaning of the gurneys or there would not be an accumulation of dust present 4. At 12:40 PM on 5/14/14, video review of the contracted housekeeping staff on 5/6/14 from 5:20 PM to 6:08 PM and on 5/8/14 from 5:15 PM to 8:18 PM, indicated: a. one cleaning person was noted to empty trash cans and mop the floors of procedure rooms #1 and #2 and the recovery room floor and hallway b. there was no video indication that the procedure room walls were cleaned, that the horizontal surfaces (such as nursing desk, medication area counter top, physician dictation desk) were cleaned, that the gurneys in the recovery area were cleaned, that the scrub sink between procedure rooms was cleaned, or that doors and kickplates were cleaned with a disinfectant, as per the contract documents listed in 1. above		continue to be randomly monitored by surveillance video. In addition, the Director of Nursing will continue to perform and document monthly quality assurance walk-throughs with the housekeeping company's Operations Manager. Random cleanliness checks are performed by the Director of Nursing on areas such as cabinet tops, gurneys, and railings to ensure cleanliness. 3. The Infection Control Nurse is responsible. 4. This was completed on 5/22/14.	

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	5. Interview with staff member #51, the office administrator, at 12:45 PM on 5/14/14, while observing the videos of 5/8/14 and 5/6/14, indicated the housekeeping staff are not cleaning per the requirements of the contract			
Q000242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. Based on policy and procedure review, employee file review, observation and interview, the facility failed to ensure that surgical attire was changed between patients to prevent the transmission of disease between patients, as per standards of practice and failed to ensure implementation of its INFECTION CONTROL POLICY FOR EMPLOYEE OCCUPATIONAL HEALTH regarding lack of evidence of immunization records for Rubella, Rubeola, or Varicella in two (employee #4 and employee #5) of two instances of newly hired employees.	O000242	1. The procedure nurse will don a new cover-up gown prior to the time-out and start of the procedure per recommendations of AORN. Regarding missing immunization records for employee #4, records were presented to Ms. Otten and Ms. Plummer prior to their exit on 5/14/14 documenting immunity for Rubella and Vericella. Employee #4 will have blood drawn to verify immunity of Rubeola. Employee #5 will provide written evidence of Varicella immunity or have blood drawn to verify immunity. 2. Procedure nurse will change her gown prior to each	06/30/2014

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	Findings: 1. Review of the policy "Endoscopy Attire", no policy number, dated as last reviewed on 4/1/14, indicated: a. under "Procedure", in item 2., it reads: "Wearing apparel a) Water-resistant gowns, gloves, eye protection, and masks are worn per Standard Precautions...". 2. While observing the circulating nurse, staff member #50, at 9:50 AM on 5/14/14, it was observed that: a. staff member #50 entered the operating room (room #2) from the scope cleaning room with a cover up gown on that was used in the decontamination room from the previous patient (pt. was in room #1) b. staff member #50 did preliminary cleaning of the scope used in room #2 and then took the scope to the decontamination room and proceeded to do further cleaning of that scope c. staff member #50 left the decontamination room and entered room #1, to circulate for that patient, continuing to wear the same cover up gown used in room #2 and in the decontamination room 3. Interview with staff member #52, the director of nursing, at 11:30 AM on		procedure. A listing of specific vaccines will be added to the "Employee File Checklist" that is stored in each employee's file to ensure the receipt of these immunization records prior to starting their position. 3. The Director of Nursing is responsible to monitor the changing of the procedure cover-up gowns. The Adminstrator is responsible for the completion of new employee's health records. 4. These deficiences will be corrected by 6/30/14.	

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	5/14/14 indicated: a. this staff member agreed that staff member #50 wears the same cover up gown for all procedures of the day "unless it is visibly soiled or wet" b. the infection control committee has approved the use of AORN (association of peri-operative registered nurses) c. due to the practice of assisting with the endoscopy procedures, pre cleaning of the scopes in the procedure rooms, transporting the scopes to the decontamination room and cleaning the scopes there, then proceeding on to the next endoscopy procedure, all the time wearing the same cover up gown, is not per standards of practice or recommendations per the AORN which the facility has agreed to follow 4. Review of Digestive Health Center policy INFECTION CONTROL POLICY FOR EMPLOYEE OCCUPATIONAL HEALTH (no policy number or date of review found) indicated in Policy, Health Care Personnel, G., Pre-placement health assessment, a., A health assessment, which includes communicable disease and immunization history, will be completed and documented in the employee health record located in their personnel file and H., Communicable			

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	Disease in Employees, g., Prior to employment, If immunity for Rubella, Rubeola, and varicella cannot be documented, then the employee will be responsible for obtaining documentation and/or obtaining immunization from his/her Primary Care Physician, health department , or previous employer. 5. On 5/13/14 at 10:30 a.m., review of employee #4's personnel file, hired 1/30/14, indicated lack of evidence of immunization records for Rubella, Rubeola, or Varicella and employee #5's personnel file, hired 2/6/14, indicated lack of evidence of immunization records for Varicella. 6. At 11:35 a.m. on 5/13/14, employee #3, the director of nurses, confirmed that the personnel file for employee #4 lacked immunization records for Rubella, Rubeola and Varicella and #5 lacked immunization records for Varicella and agreed that the policy was not implemented as written.			
S000000				

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	The visit was for a licensure survey. Facility Number: 005043 Survey Date: 5-12-14 to 5-14-14 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor Nancy Otten, RN Public Health Nurse Surveyor QA: claughlin 05/28/14	S000000		
S000164	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H) Require that the chief executive officer develop and implement policies and programs for the following: (H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program. Based on policy and procedure review, employee file review, and interview, the facility failed to ensure its policy of	S000164	1. Employee #3 will undergo a physical examination as soon as possible to prove evidence of good health. The physical examination will be filed in the	06/30/2014

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	requiring employees to have a post-offer physical was followed in one (#5) of two instances for new employees hired. Findings include: 1. Facility policy PERSONNEL REQUIREMENTS, ORIENTATION (no policy # or review date found.) stated on page one, under HEALTH & PERSONAL HYGIENE, 2. "Employees must provide evidence of good health. Employee must be willing to demonstrate health status through the reports of a physical examination." 2. On 5/13/14 at 10:30 a.m., review of employee #5's personnel file, hired 2/6/14, indicated lack of documentation of having had an employee physical at the time of hire. 3. At 11:35 a.m. on 5/13/14, employee #3, the director of nurses, confirmed that the personnel file for employee #5 lacked an employee physical at the time of hire and agreed that the policy was not implemented as written.		employee's file. 2. The Administrator will create a written list of documents and exams necessary to be on file prior to a potential employee's start date. 3. The Administrator is responsible for the completion of the employee file. 4. This will be completed as soon as possible, but no later than 6/30/14.	

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S000230	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. Based upon document review and interview, the center lacked documentation of periodic utilization review (UR) by three licensed physicians without financial interest in the center. Findings: 1. UR documentation dated 9-3-13 and 3-3-14 indicated that the recent review activity was performed by two physicians. 2. During an interview on 5-12-14 at 1230 hours, staff A2 confirmed that the UR documentation failed to indicate that a third physician participated in the review activity and confirmed that no additional documentation was available.	S000230	1. Our representative for the physicians who typically perform our peer review has been contacted, and it was requested that 3 physicians perform the review. We will also compose a letter to include with the peer review specifically requesting that 3 physicians review the information. If the reviews are returned with anything less than 3 physicians having reviewed, we will send additional documentation to the attention of a phyisican who has not yet reviewed the charts. 2. We will prevent future deficiences by communicating effectively with our physicians' representative and including a letter with information sent for review. 3. The Administrator is responsible. 4. This will be completed by 6/30/14.	06/30/2014

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S000442	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii) 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: (viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies. Based on policy review, employee file review and interview, in two (employee #4 and employee #5) of two instances of newly hired employees, the facility failed to ensure implementation of its INFECTION CONTROL POLICY FOR EMPLOYEE OCCUPATIONAL HEALTH regarding lack of evidence of immunization records for Rubella, Rubeola, or Varicella. Findings include: 1. Review of Digestive Health Center policy INFECTION CONTROL POLICY FOR EMPLOYEE OCCUPATIONAL	S000442	1. Regarding missing immunization records for employee #4, records were presented to Ms. Otten and Ms. Plummer prior to their exit on 5/14/14 documenting immunity for Rubella and Vericella. Employee #4 will have blood drawn to verify immunity of Rubeola. Employee #5 will provide written evidence of Varicella immunity or have blood drawn to verify immunity.2. A listing of specific vaccines will be added to the "Employee File Checklist" that is stored in each employee's file to ensure the receipt of these immunization records prior to starting their position.3. The Adminstrator is	06/30/2014

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	HEALTH (no policy number or date of review found) indicated in Policy, Health Care Personnel, G., Pre-placement health assessment, a., A health assessment, which includes communicable disease and immunization history, will be completed and documented in the employee health record located in their personnel file and H., Communicable Disease in Employees, g., Prior to employment, If immunity for Rubella, Rubeola, and varicella cannot be documented, then the employee will be responsible for obtaining documentation and/or obtaining immunization from his/her Primary Care Physician, health department , or previous employer. 2. On 5/13/14 at 10:30 a.m., review of employee #4's personnel file, hired 1/30/14, indicated lack of evidence of immunization records for Rubella, Rubeola, or Varicella and employee #5's personnel file, hired 2/6/14, indicated lack of evidence of immunization records for Varicella. 3. At 11:35 a.m. on 5/13/14, employee #3, the director of nurses, confirmed that the personnel file for employee #4 lacked immunization records for Rubella,		responsible for the completion of new employee's health records.4. These deficiences will be corrected by 6/30/14.	

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	Rubeola and Varicella and #5 lacked immunization records for Varicella and agreed that the policy was not implemented as written.			
S000444	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix) 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: (ix) Requirements for personal hygiene and attire that meet acceptable standards of practice. Based on policy and procedure review, observation, and interview, the infection	S000444	1. The procedure nurse will don a new cover-up gown prior to the time-out and start of the	06/30/2014

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	control committee failed to ensure that surgical attire was changed between patients, as per standards of practice. Findings: 1. review of the policy "Endoscopy Attire", no policy number, dated as last reviewed on 4/1/14, indicated: a. under "Procedure", in item 2., it reads: "Wearing apparel a) Water-resistant gowns, gloves, eye protection, and masks are worn per Standard Precautions..." 2. while observing the circulating nurse, staff member #50, at 9:50 AM on 5/14/14, it was observed that: a. staff member #50 entered the operating room (room #2) from the scope cleaning room with a cover up gown on that was used in the decontamination room from the previous patient (pt. was in room #1) b. staff member #50 did preliminary cleaning of the scope used in room #2 and then took the scope to the decontamination room and proceeded to do further cleaning of that scope c. staff member #50 left the decontamination room and entered room #1, to circulate for that patient, continuing to wear the same cover up gown used in room #2 and in the decontamination room		procedure per recommendations of AORN. 2. Procedure nurse will change her gown prior to each procedure. 3. The Director of Nursing is responsible to monitor the changing of the procedure cover-up gowns. 4. These deficiences will be corrected by 6/30/14.	

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	3. interview with staff member #52, the director of nursing, at 11:30 AM on 5/14/14 indicated: a. this staff member agreed that staff member #50 wears the same cover up gown for all procedures of the day "unless it is visibly soiled or wet" b. the infection control committee has approved the use of AORN (association of peri-operative registered nurses) c. due to the practice of assisting with the endoscopy procedures, pre cleaning of the scopes in the procedure rooms, transporting the scopes to the decontamination room and cleaning the scopes there, then proceeding on to the next endoscopy procedure, all the time wearing the same cover up gown, is not per standards of practice or recommendations per the AORN which the facility has agreed to follow			
S001010	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the			

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	following: (A) Drug handling, storing, labeling, and dispensing. Based on policy and procedure review, document review, observation, and interview, the facility failed to ensure the destruction of expired samples was accomplished, per facility policy, in one drug cabinet observed while on tour of the recovery area. Findings: 1. review of the policy "Sample Drug Administration", policy number MM 4.40, with an "updated" date of 5/1/12, indicated: a. under "Purpose", it reads: "To provide safe administration of all sample medications...To remove from inventory any drugs which have or are about to be expired." b. under "Policy/Procedures", it reads: "...6. All expired sample medications will be removed from the inventory before their expiration date and properly disposed of in accordance with state and federal regulations for waste disposal..." 2. review of the document "Pharmacy Quarterly Inspection Checklist", dated with a last inspection date of March 17, 2014 at 1500 hours, indicated: a. the sample drug cabinet located in the recovery area is not listed on this	S001010	1. The Pharmacy Nurse conducts a quarterly inspection and report of all administered drugs in the facility. We will add a check point on the inspection to check, remove, and dispose of any expired medications in the sample cabinet. The quarterly pharmacy inspection is noted in the QA reports. 2. We will prevent this from occurring again by using the checklist. 3. The Director of Nursing is responsible for these items. 4. The checklist will be updated by 6/11/14.	06/11/2014

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	form b. it is unknown if the sample cabinet was inspected during the most recent quarterly review by staff 3. while on tour of the recovery area of the surgery center at 9:40 AM on 5/13/14, in the company of staff member #52, the director of nursing, it was observed that in the sample cabinet, the "Kristolose one dose" box of medication had expired 8/13 4. interview with staff member #52 at 9:40 AM on 5/13/14 and 12:00 PM on 5/14/14 indicated: a. there was agreement that the Kristolose was expired b. the sample cabinet is not listed on the quarterly medication review/inspection form c. it is unknown when the expiration dates in the sample cabinet were last checked			
S001172	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5) (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			

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	assured as follows: (5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: Based on document review, observation and interview, the contracted housekeeping service failed to maintain the recovery room ceiling ventilation grilles and cabinet tops in a sanitary condition without the presence of dust and particulate matter. Findings: 1. The housekeeping document Working For You (no approval date) indicated the following: " Daily ...Recovery Room ...Dust all horizontal and vertical surfaces ... " 2. During an observation on 5-13-14 at 0945 hours, the following condition was observed in the recovery room area or the center: A heavy accumulation of dark dust and particulate material was observed in the gaps between the ceiling ventilation grilles and accumulated dust was observed on the tops of cabinetry mounted to the wall. 3. During an interview on 5-13-14 at	S001172	1. Prior to this survey, we had already scheduled to have our ducts cleaned on 6/11/14. This cleaning appointment still stands. 2. Our new HVAC company will monitor the cleanliness of the ductwork and will alert us to cleaning them as needed. In addition, DHC staff will visually check the vents during the monthly cleaning walk-through; this will be added to the walk-through checklist. 3. The Administrator and Director of Nursing is responsible. 4. This will be corrected by 6/11/14.	06/11/2014

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	0945 hours, staff A2 confirmed the recovery room observation of ceiling grille ductwork and cabinet top accumulated dust.			
S001174	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(A) (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: (5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: (A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice. Based on document review, observation, video review, and interview, the facility failed to ensure that the daily cleaning processes were completed, as expected per the contract with a housekeeping	S001174	1. On May 21, 2014, the Director of Nursing, Administrator, and Medical Director met with the housekeeping company's Operations Manager and President to discuss the severity	05/22/2014

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NAME OF PROVIDER OR SUPPLIER DIGESTIVE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 AAA WAY CARMEL, IN 46032	

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	company. Findings: 1. review of the contracted housekeeping document for daily cleaning indicated that in the "Exam Rooms, Procedure Rooms and Recovery Room:...Wet wipe exam chairs and tables as well as all horizontal surfaces and equipment with approved disinfectant...Thoroughly clean walls, doors, doorframes, kick plates and baseboards with approved disinfectant. Clean, disinfect, and polish all sinks and counters with approved disinfectant..." 2. at 10:50 AM on 5/14/14, while observing a patient in the recovery room area, it was observed that there was an accumulation of dust (and a hair present) on the lower portion of two of 3 gurneys 3. interview with staff member #52, the director of nursing, at 10:50 AM on 5/14/14 indicated: a. the last monthly "walk through" with the operations manager, staff member #56, was on 5/9/14 b. housekeeping is not doing daily cleaning of the gurneys or there would not be an accumulation of dust present 4. at 12:40 PM on 5/14/14, video review of the contracted housekeeping staff on 5/6/14 from 5:20 PM to 6:08 PM and on		of the deficiencies observed on the surviellance video at the time of the survey. The Director of Nursing, Administrator, and Medical Director presented the housekeeping representatives with a letter stating that the contract would be terminated if the deficiences were not corrected within the week. The company's respresentatives acknowledged the deficiencies and indicated that a supervisor would be going through the facility with the cleaners to monitor and correct the cleaning procedure. After a review of the surveillance video on 5/22/14, it was observed that the deficiencies had been corrected including, but not limited to, the cleaning of horizontal surfaces (such as desks and procedure room counters), cabinet tops and fronts, railings, recovery room gurneys, and procedure room monitors.2. The cleaners will continue to be randomly monitored by surveillance video. In addition, the Director of Nursing will continue to perform and document monthly quallity assurance walk-throughs with the housekeeping company's Operations Manager. Random cleanliness checks are performed by the Director of Nursing on areas such as cabinet tops, gurneys, and railings to ensure cleanliness.3. The Infection Control Nurse is responsible.4. This was completed on 5/22/14.	

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	5/8/14 from 5:15 PM to 8:18 PM, indicated: a. one cleaning person was noted to empty trash cans and mop the floors of procedure rooms #1 and #2 and the recovery room floor and hallway b. there was no video indication that the procedure room walls were cleaned, that the horizontal surfaces (such as nursing desk, medication area counter top, physician dictation desk) were cleaned, that the gurneys in the recovery area were cleaned, that the scrub sink between procedure rooms was cleaned, or that doors and kickplates were cleaned with a disinfectant, as per the contract documents listed in 1. above 5. interview with staff member #51, the office administrator, at 12:45 PM on 5/14/14, while observing the videos of 5/8/14 and 5/6/14, indicated the housekeeping staff are not cleaning per the requirements of the contract			
S001188	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4) (c) A safety management program must include, but not be limited to, the following:			

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	(4) A written fire control plan that contains provisions for the following: (A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills. Based on document review and interview, the center failed to follow its policy/procedure and conduct quarterly fire drills for 1 of 4 required drills. Findings: 1. The Fire Safety Action Plan (approved 7-12) indicated that quarterly fire drills will be conducted at the center. 2. Center documentation indicated that a fire drill was conducted on 6-17-13, 8-20-13 and 3-28-14. No fire drill documentation or 12-23-13 safety committee meeting entry indicated that a 4th quarter 2013 fire drill was performed. 3. During an interview on 5-12-14 at 1500 hours, staff A7 confirmed that the center failed to conduct a fire drill during the 4st quarter in 2013.	S001188	1. For the finding regarding quarterly fire drills, the Safety Director has added quarterly alerts to an electronic calendar in order to provide notification when a fire drill is due. In addition, the Safety Checklist was modified to include a space exclusively to record quarterly fire drills. Another checklist form was created to ensure that all necessary items are documented during each quarterly fire drill. This form includes, among other things, confirmation that the signal was transmitted, the time the drill was initiated and cleared, and the response time. 2. The alerts, lines items on checklists, and fire drill checklist will prevent the deficiency from occuring in the future. 3. The Safety Director is responsible for the above actions. 4. This was completed on 6/2/14.	06/02/2014
S001196	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT			

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	MAINTENANCE, 410 IAc 15-2.5-7(c)(5) (c) A safety management program must include, but not be limited to, the following: (5) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with center policy and state and local regulations. Based upon document review and interview, the center lacked documentation of a periodic fire inspection by State and/or local fire control agencies. Findings: 1. On 5-12-14 at 1130 hours, staff A2 and A7 were requested to provide documentation of a recent fire inspection report by a State or local fire agency and none was provided prior to exit. 2. Center documentation indicated that the last State fire inspection was conducted on 12-14-10 and indicated that a local fire department inspection was completed on 1-23-12. 3. During an interview on 5-12-14 at 1525 hours, staff A2 confirmed that no documentation of a recent fire inspection was available.	S001196	1. Our Safety Director contacted the Division of Fire and Building Safety at the Department of Homeland Security inquiring about our next fire and building inspection as their last visit was 12/14/10 (their office randomly schedules these vists; we have no control over their frequency). An emailed response from Jeff Short stated that our facility is scheduled to be inspected in 2014. He noted that his staff has until 12/31/14 to complete the inspection and that it may be several months before their visit. 2. The Division of Fire and Building Safety has historically performed an unannounced inspection every 1-3 years. We have not been notified of any policy change that we need to initiate the inspection. As such and since Jeff Short indicated that we were already on the inspection schedule for 2014, we will continue to comply with the state fire marshall's inspection schedule. 3. The Safety Director is responsible. 4. As indicated by	12/31/2014

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			Jeff Short, this will be completed prior to 12/31/14.	
S001198	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6) (c) A safety management program must include, but not be limited to, the following: (6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies. Based upon document review and interview, the center failed to coordinate its emergency preparedness program and document its participation with community, state and/or federal emergency and disaster preparedness agencies. Findings: 1. On 5-12-14 at 1130 hours, staff A2 and A7 were requested to provide documentation of participation with community, state and/or federal emergency and disaster preparedness agencies and no documentation was provided prior to exit. 2. The Emergency Preparedness Plan (approved 7-12) failed to indicate a provision for coordinating the disaster	S001198	1. At the time of the survey, surveyors recommended Anne Haddix as a contact person for this information and provided her email address. On 6/5/14, the Safety Director sent an email of inquiry to Anne Haddix regarding emergency preparedness meetings in District 5. Upon receipt of Ms. Haddix's response, the Safety Director will arrange to participate in regular meetings. This will be documented in the QA and in the Safety Report. 2. Once information about regular meetings is obtained, we will add the meetings as an item on our Safety Checklist to ensure adequate participation. 3. The Safety Director is responsible for the above. 4. This will be implemented by 6/30/14.	06/30/2014

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	preparedness plan with State and/or local authorities. 3. Safety Committee minutes dated 6-28-13, 10-01-13, 12-23-13 and 4-07-14 failed to indicate evidence of center staff participation with a local, State or federal emergency and disaster preparedness activity. 4. During an interview on 5-14-14 at 1135 hours, staff A7 confirmed that no documentation was available regarding participation with District 5 disaster management events or quarterly district 5 meetings.			