

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNITY DIGESTIVE CENTER ANDERSON	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011
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Q 0000 Bldg. 00	This visit was for a re-certification survey. Facility Number: 004174 Survey Date: 11/30-12/02/2015 QA: cjl 12/07/15	Q 0000		
Q 0081 Bldg. 00	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES (a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors. (a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC. (c)(1) The ASC must set priorities for its performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>(iii) Affect health outcomes, patient safety, and quality of care.</p> <p>Based on document review and interview, the facility failed to ensure a quality indicator (standards) for 7 services furnished by a contractor in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of a QUALITY MANAGEMENT AND IMPROVEMENT PLAN, Reviewed and/or Revised 11/2015, indicated [an objective was] to develop and monitor indicators based on standards of care ... 2. Review of the facility's QAPI program quality committee minutes and reports, indicated the documents did not include a quality indicator (standard) for the contracted services of biohazardous waste hauler, maintenance, medical records, pharmacy, security, transcription, and medical transport. 3. Interview of employee #A2, Executive Director, on 12-02-15 at 12:30 pm, confirmed the above and no other documentation was provided prior to exit. 	O 0081	The quality monitor indicators based on standards of care were added to contracted services for reporting at the quarterly QA meeting. We will be reevaluating the contracted services based on the new template. This will be monitored by the Director.	12/04/2015

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Q 0141 Bldg. 00	<p>416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. Based on document review and interview, the nurse failed to ensure the implementation of the facility policy related to weekly glucometer quality control checks, and related to checking the expiration date of the glucometer control solutions in the pre/post op area.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> Review of the policy Blood Glucose Testing, no policy number, last reviewed or revised 11/5/12, indicated under "Procedure", that the nurse will follow the glucometer recommendations in the manual. Review of the manufacturer's booklet for the EvenCare G3 glucometer (by Medline) indicated on page 23 that staff should "perform a control solution test"... "at least once per week to verify that the meter and test strips are working properly together." Review of the manufacturer's booklet for the EvenCare G3 glucometer (by Medline) indicated on page 24 that 			O 0141	Control solutions were replaced immediately with new bottles. The team leader reviewed the blood glucose testing policy and the manufactures recommended use with the clinical staff. This task will be added to the daily assignment sheet. Weekly audits of the glucometer solution and the quality log will be performed by the team leader and reported at the quarterly QA meeting.		12/03/2015

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	<p>control solutions are good three months after the opening date.</p> <p>4. Review of the Quality Control Log for the EvenCare G3 glucometer indicated that the weeks of 8/24/15 to 8/28/15, 11/2/15 to 11/6/15 and 11/16/15 to 11/20/15 lacked documentation of control solution and test strip control checking.</p> <p>5. At 10:20 AM on 12/1/15, while on tour of the pre/post op area in the company of nurse #54, it was observed that the glucometer control solutions, level 1 and level 3 vials, had expired 11/3/15.</p> <p>6. At 10:20 AM on 12/1/15, nurse #54 confirmed that the glucometer control solutions had expired on 11/3/15 and were not replaced, as they should have been.</p> <p>7. At 10:30 AM on 12/2/15, interview with staff member #50, the nursing team leader, confirmed that the quality log for checking the control solution and test strips for the glucometer had 3 weeks that lacked control checks being done, as required per the manufacturer.</p>			

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Q 0224 Bldg. 00	<p>416.50(c)(1)(2)(3) ADVANCED DIRECTIVES The ASC must comply with the following requirements:</p> <p>(1) Provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.</p> <p>(2) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care.</p> <p>(3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>Based on document review and interview, the facility failed to have a policy, provide the patient, and post a description and availability of the applicable State health and safety laws, and the State advanced directive brochure, in 1 instance and failed to document in a prominent part of the patient's medical record whether or not they had executed an advance directive for 11 of 11 medical records reviewed, Patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10 and #11.</p> <p>Findings include:</p>			O 0224	<p>Language was added to the Advance Directive policy regarding the documentation in the medical record whether or not they executed an advance directive. We will take this to the next QA meeting and the BOM meeting. Documentation of advance directive status was reviewed with staff on 12/1/15 and they were instructed to document yes if they have advance directives. If the patient says no they are asked if they want the State Advance Directive brochure and offered a copy. It has been added to the medical record audit to be completed quarterly by our medical records consultant. The team leader will</p>		12/03/2015

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	<p>1. Review of the facility's policies and procedures indicated no inclusion of a description and availability of the applicable State health and safety laws, and the State advanced directive brochure.</p> <p>2. Interview of employee #A2, Executive Director, on 12-02-2015 at 12:30 pm, confirmed the above and no further documentation was provided prior to exit.</p> <p>3. Review of the policy Patient Rights And Advanced Directives, no policy number, last reviewed or revised 11/5/12, lacked any language regarding the documentation in a patient's medical record of whether or not they have executed an advance directive.</p> <p>4. Review of the medical records for patients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11, indicated there was no documentation in the medical records related to whether or not the patient had executed an advance directive.</p> <p>5. At 11:15 AM on 12/2/15, interview with staff member #50, the nursing team leader, confirmed that the on line medical records were lacking any documentation related to whether or not the patient had executed an advance directive for all 11</p>		be responsible for reporting at the next QA meeting.	

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Q 0241 Bldg. 00	<p>medical records reviewed. No further documentation was provided prior to exit.</p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure cleanliness and sanitation in 3 pre/post op bays (#6, #7 and #8), and related to a dusty code/crash cart.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> At 10:25 AM on 12/1/15, while in the company of pre/post op nurse #54, it was observed in bays #7 and #8 that the tops of the sharps containers and wall mounted vital signs monitors had an accumulation of dust present. At 4:00 PM on 12/1/15, while in the company of staff member #50, the infection control practitioner, it was observed that a large accumulation of dust was present on the top/back of the vital signs monitor in bay #6. At 4:10 PM on 12/1/15, while in the company of staff member #50, the 	O 0241	We reviewed the cleanliness and sanitation breeches with CDC staff and contracted housekeeping staff. This will be added to the task checklist on the crash cart and added to the daily assignment sheet. A weekly QA will be done by the team leader and reported at the next QA meeting.	12/04/2015

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Q 0242 Bldg. 00	<p>infection control practitioner, it was observed that the top of the crash cart had an accumulation of dust behind the AED (automated external defibrillator), and on the lower ledges of the cart, above the wheels.</p> <p>4. On 12/1/15 at 4:00 PM and 4:10 PM, staff member #50 confirmed that dust/debris was present on the vital signs monitor in bay #6 and on the code cart.</p> <p>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.</p> <p>Based on document review and interview, the facility had failed to complete a TB (tuberculosis) risk assessment in 2014, for implementation in 2015, that was approved by the infection control committee, and failed to ensure Hepatitis B documentation for two of two housekeeping staff, N1 and N2.</p> <p>Findings Include:</p>	O 0242	<p>A TB risk assessment was completed by the team leader on 12/1/15. It will be taken to the next QA committee and then to the BOM for approval regarding discontinuation of annual testing. We have requested documentation from the contracted housekeeping staff to obtain the health records regarding Hepatitis B documentation. It was added to the template for Infection Control</p>	12/03/2015

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	<p>1. Review of the policy BloodBorne Pathogens, Exposure Control Plan, no policy number, last reviewed/revised 12/06/07, indicated the scope covered all employees who could be reasonably anticipated as the result of performing their job duties to face contact with blood and other potentially infectious materials and that consent, vaccination record, or declination would be completed on employees in regards to Hepatitis B.</p> <p>2. At 10:30 AM on 12/2/15, interview with staff member #50, the infection preventionist, confirmed that TB testing of employees was not done in 2015 as it was determined that the facility was a "low risk" facility. Staff member #50 confirmed that a TB risk assessment was not completed in 2014 that would confirm a low risk status, and there was no documentation in the quality and infection control committee meeting minutes of 1/16/15, 4/21/15, 7/17/15, and 10/28/15 of approval of a TB risk assessment and a decision, per the committee, to discontinue annual TB testing.</p> <p>3. Review of two contracted housekeeping employee files indicated that housekeepers N1 and N2 had no documentation in their files of Hepatitis B vaccination, immunity, or declination</p>		meeting which takes place during the QA meeting. It will be monitored quarterly by the Director.		

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S 0000 Bldg. 00	of the series. 4. At 3:00 PM on 11/30/15, interview with staff member #50, the infection preventionist, confirmed that staff members N1 and N2 were at risk for potential contact with blood, or other infectious materials, and there was no documentation, related to Hepatitis B, in the employee files for staff members N1 and N2. No further documentation was provided prior to exit.	S 0000		
S 0310 Bldg. 00	This visit was for a State licensure survey. Facility Number: 004174 Survey Date: 11/30-12/02/2015 QA: cjl 12/07/15 410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1) The program shall be ongoing and			

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	<p>have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to ensure a standard for 7 services furnished by a contractor in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings include:</p> <p>1. Review of a QUALITY MANAGEMENT AND IMPROVEMENT PLAN, Reviewed and/or Revised 11/2015, indicated [an objective was] to develop and monitor indicators based on standards of care</p> <p>2. Review of the facility's QAPI program quality committee minutes and reports, indicated the documents did not include a standard for the contracted services of biohazardous waste hauler, maintenance, medical records, pharmacy, security, transcription, and medical transport.</p> <p>3. Interview of employee #A2, Executive Director, on 12-02-15 at 12:30 pm, confirmed the above and no other documentation was provided prior to</p>	S 0310	The quality monitor indicators based on standards of care were added to contracted services for reporting at the quarterly QA meeting. We will be reevaluating the contracted services based on the new template. This will be monitored by the Director.	12/04/2015

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S 0428 Bldg. 00	<p>exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on observation and interview, the infection control committee failed to ensure cleanliness and sanitation in 3 pre/post op bays (#6, #7, and #8), and related to a dusty code/crash cart.</p> <p>Findings Include:</p> <p>1. At 10:25 AM on 12/1/15, while in the company of pre/post op nurse #54, it was observed in bays #7 and #8 that the tops of the sharps containers and wall mounted vital signs monitors had an accumulation of dust present.</p> <p>2. At 4:00 PM on 12/1/15, while in the company of staff member #50, the infection control practitioner, it was</p>	S 0428	We reviewed the cleanliness and sanitation breeches with CDC staff and contracted housekeeping staff. This will be added to the task checklist on the crash cart and added to the daily assignment sheet. A random QA will be done by the team leader and reported at the next QA meeting.	12/04/2015

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S 0440 Bldg. 00	<p>observed that a large accumulation of dust was present on the top/back of the vital signs monitor in bay #6.</p> <p>3. At 4:10 PM on 12/1/15, while in the company of staff member #50, the infection control practitioner, it was observed that the top of the crash cart had an accumulation of dust behind the AED (automated external defibrillator), and on the lower ledges of the cart, above the wheels.</p> <p>4. On 12/1/15 at 4:00 PM and 4:10 PM, staff member #50 confirmed that dust/debris was present on the vital signs monitor in bay #6 and on the code cart.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(vii)</p> <p>The infection control committee responsibilities must include, but not be limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases.</p>			

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	<p>Based on document review and interview, the infection control committee failed to complete a TB (tuberculosis) risk assessment in 2014, for implementation in 2015, that was approved by the infection control committee, and failed to ensure Hepatitis B documentation for two of two housekeeping staff, N1 and N2.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> At 10:30 AM on 12/2/15, interview with staff member #50, the infection preventionist, confirmed that TB testing of employees was not done in 2015 as it was determined that the facility was a "low risk" facility. Staff member #50 confirmed that a TB risk assessment was not completed in 2014 that would confirm a low risk status, and there was no documentation in the quality and infection control committee meeting minutes of 1/16/15, 4/21/15, 7/17/15, and 10/28/15 of approval of a TB risk assessment and a decision, per the committee, to discontinue annual TB testing. Review of the policy BloodBorne Pathogens, Exposure Control Plan, no policy number, last reviewed/revised 12/06/07, indicated the scope covered all employees who could be reasonably anticipated as the result of performing 	S 0440	A TB risk assessment was completed by the team leader on 12/1/15. It will be taken to the next QA committee and then to the BOM for approval regarding discontinuation of annual testing. We are working with the contracted housekeeping staff to obtain the health records regarding Hepatitis B documentation. It was added to the template for Infection Control meeting which takes place during the QA meeting. It will be monitored quarterly by the Director.	12/03/2015			

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S 0466 Bldg. 00	<p>their job duties to face contact with blood and other potentially infectious materials and that consent, vaccination record, or declination would be completed on employees in regards to Hepatitis B.</p> <p>3. Review of two contracted housekeeping employee files indicated that housekeepers N1 and N2 had no documentation in their files of Hepatitis B vaccination, immunity, or declination of the series.</p> <p>4. At 3:00 PM on 11/30/15, interview with staff member #50, the infection preventionist, confirmed that staff members N1 and N2 were at risk for potential contact with blood, or other infectious materials, and there was no documentation, related to Hepatitis B, in the employee files for staff members N1 and N2. No further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(g)(3)</p> <p>Sterilization services must be directed by a qualified person or persons and must provide for the following:</p> <p>(3) Records of results must be maintained and evaluated periodically in accordance with 410 IAC 15-2.4-2 to</p>				

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	<p>include, but not limited to, the following:</p> <p>(A) Records of recording thermometers or a daily record of the sterilizing cycle (date, time, temperature, pressure, and contents) for each sterilizer load.</p> <p>(B) Results of biological indicators used in testing the sterilizing processes.</p> <p>Based on document review and interview, the facility failed to report biological information at the infection control/quality committee meetings for any of the four 2015 meetings that have been held.</p> <p>Findings Include:</p> <p>1. Review of the Quality Assurance and Infection Control meeting minutes for 1/16/15, 4/21/15, 7/17/15, and 10/28/15, indicated nothing was reported related to the Medi-vator machine strip testing of the solution used to clean endoscopy scopes, or regarding the OPA (ortho-phthalaldehyde) solution testing, that is logged by the staff monitoring this in the decontamination room, at any of the 4 meetings held in 2015.</p> <p>2. Interview with staff member #50, the infection preventionist, at 10:30 AM on 12/2/15 confirmed that biological testing was not currently being reported at the</p>	S 0466	<p>Infection prevention officer audits the high level disinfection logs to insure compliance, the potency of the HLD is tested with each load and the HLD is changed every 14 days or sooner as indicated by potency testing. The medivators machine has preventative maintenance as recommended by the manufacturer. This was not reported other than describing it as infection control rounds being completed at the QA meetings. This will be added to the reporting starting the next QA meeting. The team leader will be responsible for this.</p>	12/03/2015

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S 0526 Bldg. 00	<p>combination Quality and Infection committee meetings.</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on document review and interview, the facility failed to ensure that nursing staff performing pregnancy testing on patients, had skills competency demonstrated for 5 of 5 RNs (registered nurses) and LPNs (licensed practical nurses), staff members N3, N4, N6, N7 and N8; and regarding two of 3 RNs who lacked documentation of accu check skills competencies in their files, staff members N6 and N7.</p> <p>Findings Include; 1. Review of personnel files for 3 RNs and 2 LPNs indicated that only an on line urine pregnancy testing course was completed for the five nurses N3, N4, N6, N7, and N8 between 1/2015 and 11/2015 and that RNs N6 and N7 lacked any documentation of skills competency for performing accu checks (blood glucose monitoring).</p>	S 0526	The clinical staff performed skill competencies for pregnancy testing and blood glucose monitoring. These will be assigned at the same time as the electronic in services are due. The team leader will be responsible for making sure these are completed annually. They will be monitored annually by the Director. These will be added to the template for the quarterly QA meeting.	12/04/2015

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S 0736 Bldg. 00	<p>2. Interview with staff member #50, the nursing team leader, at 9:20 AM on 12/1/15, confirmed that the facility no longer completes a skills competency checklist for urine pregnancy tests, as was done previously, and only requires the on line education related to the urine pregnancy tests performed for patients. No other documentation was provided prior to exit</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based on document review and interview, the facility's medical staff failed to meet for 2 of 4 quarters in calendar year 2015.</p> <p>Findings include:</p>	S 0736	Reviewed regulations with medical staff about quarterly medical staff meeting requirements. Medical staff meetings have been scheduled bimonthly with the physicians input on date/time for 2016. If a meeting is cancelled the	12/04/2015			

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S 0860 Bldg. 00	<p>1. Review of the medical staff by laws, last reviewed November 19, 2013, indicated regular Medical Staff meetings will be held quarterly each year.</p> <p>2. Review of the medical staff minutes of calendar year 2015 indicated the medical staff met only in the second quarter (April 27) and the fourth quarter (November 13).</p> <p>3. Interview of employee #A2, Executive Director, on 12-02-2015 at 12:30 pm, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(B)</p> <p>Requirements 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>(B) A requirement that an appropriate history and physical workup must be in the chart of every patient before</p>		physicians have agreed to a phone conference/webinar in the evening as soon as possible after the cancelled meeting. The administrative assistant has coordinated these with the office schedulers. The Director will be responsible for monitoring these quarterly.		

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	<p>surgery. If this has been dictated, but not yet recorded in the patient's chart, there shall be a statement to that effect and an admission note in the chart by the admitting practitioner which includes, but is not limited to, vital signs, allergies, any significant risk factors, and date written.</p> <p>Based on document review and interview, the facility failed to ensure the implementation of its policy related to H & Ps (history and physicals) for 2 of 9 H & Ps by physician #53, patients #4 and #7.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. Review of the policy History and Physical of Patient, no policy number, last reviewed/revised 11/5/12, indicated the H & P assessment must be completed before the endoscopy procedure begins. 2. Review of medical records indicated that patient #4 had documentation of the endoscopy start time of 8:31 AM on 11/3/15, and a finalized time on the H & P of 8:48 AM on 11/3/15. Patient #7 had a procedure start time of 11:39 AM on 11/2/15 and an H & P time of 11:55 AM on 11/2/15. 3. At 11:15 AM on 12/2/15, interview with staff member #51, the surgery center director, confirmed that the H & Ps for patients #4 and #7 were not completed 	S 0860	<p>The team leader reviewed standards and process for documenting H&P in EPIC with the physician. Physician was performing H&P and documenting prior to procedure but not finalizing in EMR until after procedure. This created a time stamp that was after the procedure had started. It has been added to the medical record audit to be completed quarterly by our medical records consultant. The team leader will be responsible for reporting at the next QA meeting.</p>	12/04/2015

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S 0920 Bldg. 00	<p>prior to the beginning of the procedures. No other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following: Based on document review and interview, the facility failed to ensure the implementation of the facility policy related to weekly glucometer quality control checks, and related to checking the expiration date of the glucometer control solutions in the pre/post op area.</p> <p>Findings Include: 1. Review of the policy Blood Glucose Testing, no policy number, last reviewed or revised 11/5/12, indicated under "Procedure", that the nurse will follow the glucometer recommendations in the manual. 2. Review of the manufacturer's booklet for the EvenCare G3 glucometer (by Medline) indicated on page 23 that staff should "perform a control solution test"... "at least once per week to verify that the meter and test strips are working properly together."</p>	S 0920	Control solutions were replaced immediately with new bottles. The team leader reviewed the blood glucose testing policy and the manufacturers recommended use with the clinical staff. This task will be added to the daily assignment sheet. Weekly audits of the glucometer solution and the quality log will be performed by the team leader and reported at the quarterly QA meeting.	12/03/2015			

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	<p>3. Review of the manufacturer's booklet for the EvenCare G3 glucometer (by Medline) indicated on page 24 that control solutions are good three months after the opening date.</p> <p>4. Review of the Quality Control Log for the EvenCare G3 glucometer indicated that the weeks of 8/24/15 to 8/28/15, 11/2/15 to 11/6/15 and 11/16/15 to 11/20/15 lacked documentation of control solution and test strip control checking.</p> <p>5. At 10:20 AM on 12/1/15, while on tour of the pre/post op area in the company of nurse #54, it was observed that the glucometer control solutions, level 1 and level 3 vials, had expired 11/3/15.</p> <p>6. At 10:20 AM on 12/1/15, nurse #54 confirmed that the glucometer control solutions had expired on 11/3/15 and were not replaced, as they should have been.</p> <p>7. At 10:30 AM on 12/2/15, interview with staff member #50, the nursing team leader, confirmed that the quality log for checking the control solution and test strips for the glucometer had 3 weeks that lacked control checks being done, as</p>			

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S 1116 Bldg. 00	<p>required per the manufacturer.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(a)(4)(A)</p> <p>(4) In new construction, renovations, and additions, the center site and facilities, or nonlicensed facilities acquired for the purpose of providing center services shall meet the following:</p> <p>(A) The 2001 edition of the national "Guidelines for Design and Construction of Hospitals and Health Care Facilities" (Guidelines). Based on document review, observation, and interview, the facility did not have a floor receptor or service sink and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite in 1 instance.</p> <p>Findings include:</p> <p>1. Review of the 2001 edition of the national "Guidelines for Design and Construction of Hospital and Health Care Facilities" indicates in section 9.5.F.5.m. indicated space containing a floor receptor or service sink and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite.</p>	S 1116	Housekeeping is contracted by CHA and is included in the facility lease. After the ISDH survey housekeeping has been instructed to use the housekeeping closet in the hall for all areas except for the procedure rooms. The housekeeping closet in the facility will be used for the procedure rooms only. The infection control officer will do quarterly audits to be reported to the QA committee quarterly.	12/04/2015

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	<p>2. On 12-02-2015 at 10:00 am, in the presence of employee #A2, Executive Director, it was observed there was a housekeeping sink and storage closet adjacent to Procedure Room A.</p> <p>3. Interview of employee #A2 indicated the facility began services in calendar year 2005 and this housekeeping area was used for the entire facility, not dedicated to just the procedure rooms.</p>				