

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001051	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER INDIANAPOLIS ENDOSCOPY CENTER LLP			STREET ADDRESS, CITY, STATE, ZIP CODE 8315 E 56TH ST STE 100 INDIANAPOLIS, IN 46216		
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Q000000	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 007886</p> <p>Survey Date: 1-13/16-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 01/24/14</p>	O000000			

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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Q000162	<p>416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ul style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on document review and interview, the facility failed to ensure that when a patient was transferred to a hospital that a copy of the transfer form was in the patient's medical record (MR) for 1 of 2 patient transfer MRs reviewed (Patient #3).</p> <p>Findings include:</p> <p>1. Review of policy / procedure Emergency Transfer of Patient's Records indicated the following: "Procedure</p>	O000162	Q 162 – Plan of Correction and Prevention 1-3. The Emergency Transfer of Patient's Records policy (attached) has been revised to reflect that a "transfer form" (attached) will be sent with the patient if the receiving facility is using paper charting, or in the event the patient should be transferred to a non-network facility. In the event that a patient should be transferred to a network facility using the Electronic Medical Record (EMR), all information will be accessible to receiving hospital through the same EMR. In an effort to prevent	02/19/2014			

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	<p>2. If using paper charting, copy of documents that should accompany patient being transferred are as follows: d. Transfer form." This policy / procedure was last reviewed / revised on 08-22-12.</p> <p>2. Review of patient #3's MR indicated the patient was admitted to the facility on 07-26-13 for surgery. Patient #3's MR indicated that the patient was transferred to facility #2 on 07-26-13 and the MR lacked documentation of a transfer form.</p> <p>3. On 01-15-14 at 0910 hours, staff #41 confirmed that patient #3's MR did not have a copy of the transfer form and facility #2 did not have access to the facility's electronic medical record (EMR). A paper copy of the transfer form should have been completed.</p>		<p>this deficiency from recurring in the future, all transfer records will be audited by the Clinical Team Leader for compliance for a period of one (1) year. In the event of noncompliance, the Corrective Action policy (attached) will be enforced for the employees involved. Staff will be re-educated on this subject matter at the next Staff Meeting scheduled for 2/26/14. The revised policies will go before the Governing Board for approval on 2/19/14.</p>		

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Q000221	<p>416.50(a) NOTICE OF RIGHTS</p> <p>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.</p> <p>Based on document review and interview, the facility failed to have a written policy that they would provide the patient or their representative with verbal notice of the patient rights.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a facility policy and procedure entitled PATIENT RIGHTS AND RESPONSIBILITIES, reviewed 11-16-11, indicated it did not contain any statement to the effect that the facility would provide the patient or their representative with verbal notice of the patient rights. Review of a document entitled PATIENT'S RIGHTS & RESPONSIBILITIES, attached to the above-stated policy, indicated it did not 	0000221	<p>Q 221 – Plan of Correction and Prevention 1-3. The Patient Rights and Responsibilities policy (attached) and the Patient Rights & Responsibilities form (attached) have been revised to reflect that we will provide patients with verbal and written notice of the patient rights. This deficiency will be prevented by the permanent change of these documents and the approval of our Governing Board on 2/19/14. The Executive Director will be responsible for making sure these changes are implemented by the stated date.</p>	02/19/2014	

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Q000224	<p>contain any statement to the effect that the facility would provide the patient or their representative with verbal notice of the patient rights.</p> <p>3. In interview, on 1-16-14 at 10:30 am, employee #A3 confirmed the above and no other documentation was provided prior to exit.</p> <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 provide the patients or their representative,</p>	Q000224	Q 224 – Plan of Correction and Prevention 1-3. The Patient Rights/Advance Directives/Physician Financial	02/19/2014

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	<p>verbally and in writing, official State advance directive forms.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a facility policy and procedure entitled PATIENT RIGHTS AND RESPONSIBILITIES, reviewed 11-16-11, indicated it did not contain any statement to the effect that the facility would provide the patient or their representative, verbally and in writing, the official State advance directive forms. 2. Review of a document entitled PATIENT'S RIGHTS & RESPONSIBILITIES, attached to the above-stated policy, indicated it did not contain any statement to the effect that the facility would provide the patient or their representative, verbally and in writing, the official State advance directive forms 3. In interview, on 1-16-14 at 10:30 am, employee #A3 confirmed the above and no other documentation was provided prior to exit. 		<p>Interest Disclosure Procedure policy (attached), the Patient Rights and Responsibilities policy (attached), and the Patient Rights & Responsibilities form (attached) have been revised to reflect that we will provide the patients with verbal and written notice of the State advance directive forms (attached). This deficiency will be prevented by the permanent changes of said documents and their approval by our Governing Board on 2/19/14. The Executive Director will be responsible for making sure these changes are implemented by the stated date.</p>		

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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 007886</p> <p>Survey Date: 1-13/16-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 01/24/14</p>	S000000		
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S000672	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(13) A copy of the transfer form, if the patient is referred to a hospital or other facility.</p> <p>Based on document review and interview, the facility failed to ensure that when a patient was transferred to a hospital that a copy of the transfer form was in the patient's medical record (MR) for 1 of 2 patient transfer MRs reviewed (Patient #3).</p> <p>Findings include:</p> <p>1. Review of policy / procedure Emergency Transfer of Patient's Records indicated the following: "Procedure 2. If using paper charting, copy of documents that should accompany patient being transferred are as follows: d. Transfer form." This policy / procedure was last reviewed / revised on 08-22-12.</p> <p>2. Review of patient #3's MR indicated the patient was admitted to the facility on 07-26-13 for surgery. Patient #3's</p>	S000672	S 672 – Plan of Correction and Prevention 1-3. The Emergency Transfer of Patient's Records policy (attached) has been revised to reflect that a "transfer form" (attached) will be sent with the patient if the receiving facility is using paper charting, or in the event the patient should be transferred to a non-network facility. In the event that a patient should be transferred to a network facility using the Electronic Medical Record (EMR), all information will be accessible to receiving hospital through the same EMR. In an effort to prevent this deficiency from recurring in the future, all transfer records will be audited by the Clinical Team Leader for compliance for a period of one (1) year. In the event of noncompliance, the Corrective Action policy (attached) will be enforced for the employees involved. Staff will be re-educated on this subject matter at the next Staff Meeting scheduled for 2/26/14. The revised policies will go before the	02/26/2014	

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S000920	<p>MR indicated that the patient was transferred to facility #2 on 07-26-13 and the MR lacked documentation of a transfer form.</p> <p>3. On 01-15-14 at 0910 hours, staff #41 confirmed that patient #3's MR did not have a copy of the transfer form and facility #2 did not have access to the facility's electronic medical record (EMR) a paper copy of the transfer form should have been completed.</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 the facility failed to ensure that nursing staff follow the Recovery and Discharge Criteria policy & procedure for 3 of 28 medical records (MR) reviewed (Patient #4, 14 & 21).</p> <p>Findings include:</p> <p>1. Review of policy & procedure Recovery and Discharge Criteria indicated the following; "Procedure Recovery Care</p>	S000920	<p>Governing Board for approval on 2/19/14.</p> <p>S 920 – Plan of Correction and Prevention1-4. In an effort to correct the deficiency regarding "patient must meet a score of 11 or above on the Aldrete score or with physician order to be discharged" according to the Recovery and Discharge Criteria policy (attached), the Executive Director will be re-educate the staff at the next Staff Meeting scheduled on 2/26/14. In an effort to prevent the deficiency from recurring, the Clinical Coordinators will perform internal daily chart audits (attached) on 10% of our patients for a period of one (1) year to monitor</p>	02/26/2014			

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	<p>Criteria for discharge - Patient must meet a score of 11 or above on the Aldrete score or with physician order to be discharged." This policy / procedure was last reviewed / revised on 08-17-12.</p> <p>2. Review of patient #4's MR indicated the patient had a procedure on 11-01-13. Patient #4's MR indicated the last documented Aldrete score was a 7 on 11-01-13 at 1007 hours. Patient #4's MR lacked documentation of a physician order to be discharged due to the Aldrete score less than 11.</p> <p>3. Review of patient #14's MR indicated the patient had a procedure on 10-01-13. Patient #4's MR indicated the last documented Aldrete score was a 10 on 10-01-13 at 1334 hours. Patient #14's MR lacked documentation of a physician order to be discharged due to the Aldrete score less than 11.</p> <p>4. Review of patient #21's MR indicated the patient had a procedure on 10-25-13. Patient #21's MR indicated the last documented Aldrete score was a 8 on 10-25-13 at 1225 hours. Patient #21's MR lacked documentation of a physician order to be discharged due to the Aldrete score less than 11.</p>		<p>completion of the Aldrete scores. They will report noncompliant employees to the Executive Director and they will be subject to disciplinary action as outlined in the Corrective Action policy (attached). The Executive Director will also request our contracted Medical Record Auditor to perform a quarterly focused audit on the completion of the Aldrete scores for a period of one (1) year. The next scheduled Medical Record audit is 1/31/14. Noncompliant employees discovered from the external Medical Record audit will also be subject to disciplinary action as outline in the Corrective Action policy (attached). The deficiency will be corrected following staff re-education at the next Staff Meeting scheduled for 2/26/14.</p>				

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