STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15C0001028		04/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GASTROINTESTINAL ENDOSCOPY CENTER	801 ST MARYS DR, STE 110 W EVANSVILLE, IN 47714

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S 000 Bldg. 00	This visit was for a State licensure survey. Dates of survey: 04/15/15 to 04/17/15 Facility number: 005820 QA: cjl 05/06/15	S 000		
S 153 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review and interview, the chief executive officer (CEO) failed to ensure orientation of of contract personnel to center policies for 3 of 3 contracted employees. Findings: 1. Review of personnel files (P1 - P11) indicated lack of documentation of records or orientation to the center for P9, P10, & P11.	S 153	Responsible Party: Surgery Center Director Description of Plan of Correction: Surgery Center Director will ensure that all contracted employees and non-employees have the "GEC Contracted Personnel Orientation Checklist" completed and in their files This will be required for the three Contracted Personnel listed in the findings, and also for our janitorial services provider and our Equipment Representative from Medtronic. The checklist will include general orientation	05/31/2015

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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	2. On 4/17/15 at 12:30pm, A1, Director, confirmed files were not kept for contracted personnel and the center did not have documentation of orientation to center personnel policies for any of the 3 above personnel.		information as well as specific role orientation. The checklist will be created and completed for each of the named Contracted Personnel prior to May 31st, 2015	
S 646 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(3) All entries in the medical record must be as follows: (3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule. Based on document review and interview, the center failed to ensure medical record (MR) entries were authenticated and dated in accordance with their policy/procedure (P&P) for 26 of 26 MRs (#s 1-26). Findings: 1. Review of the P&P titled Medical Records indicated all documentation by clinical staff must be dated and time stamped. The P&P was last reviewed 10/14/14. 2. Review of physician orders for MRs #1-26 indicated the following: MR#'s	S 646	Responsible Party: Quality Assurance and Improvement Committee Description of Plan of Action: The presence of Signature, Date and Time from MD and RN staff has been added as an item for review in three places: Medical Record Review, Physician Peer Review, and Utilization Review. These reviews and there results are monitored by the QAIC and then reported to the Governing Body monthly or quarterly as per the nature of the frequency of the review. At the Medical Staff meeting on May 11th, the Medical Staff was reminded of this requirement and re-education with each provider has already been completed. The review line items have	06/08/2015

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NAME OF PROVIDER OR SUPPLIER GASTROINTESTINAL ENDOSCOPY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 ST MARYS DR, STE 110 W EVANSVILLE, IN 47714	

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	1-4, 6-10, & 12-25 lacked date and time. MR#'s 5, 11, & 26 included a date, but lacked evidence of a time stamp. 3. On 4/16/15 at 1:00pm, A1, Director, indicated physician orders are required to be signed, dated, and timed.		already been added pending approval of the Governing Body at the next meeting on June 8, 2015.	
S 668 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(11) All patient records must document and contain, at a minimum, the following: (11) Condition on discharge, disposition of the patient, and time of dismissal. Based on document review and interview, the medical record service of the center failed to assure all patient records contained condition on discharge and disposition of the patient for 12 of 28 medical records (MR) (MR#s 3, 4, 5, 7, 10, 13, 14, 16, 17, 18, 22, & 26). Findings: 1. Review of Medical Staff (MS) Rules Section E Medical Records indicated the following: The patient's MR must contain ...conditions of discharge. MS Rules were last reviewed 11/14.	S 668	Responsible Party: Quality Assurance and Improvement Committee Description of Plan of Action: An email to all providers was sent describing the correct way to document these requirements and they were reminded of this requirement at the Medical Staff meeting on May 10th. The presence of condition on discharge and disposition of the patient have been added as items for review in two places: Physician Peer Review and Utilization Review. These reviews and their results are monitored by the QAIC and then reported to the Governing Body	06/08/2015

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	2. On 4/16/15 at 1:00pm A1, Director, indicated discharge condition and status is included as an addendum in the physician procedure report. 3. Review of 28 MRs lacked addendum discharge condition and status documentation for following 12 MRs: MR#'s 3, 4, 5, 7, 10, 13, 14, 16, 17, 18, 22, & 26. 4. On 4/16/15 at 2:00pm, A1 confirmed the above MRs lacked discharge condition and status documentation.		monthly or quarterly as per the nature of the frequency of the review. The review line items have already been added pending approval of the Governing Body at the next meeting on June 8, 2015.	
S 672 Bldg. 00	410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13) All patient records must document and contain, at a minimum, the following: (13) A copy of the transfer form, if the patient is referred to a hospital or other facility. Based on document review and interview, the medical record (MR) service of the center failed to ensure the MR contained a copy of a transfer form for 1 of 1 transfer MR (MR #28). Findings:	S 672	Responsible Party: Quality Assurance and Improvement Committee Description of Plan of Action: A new transfer form has been created that includes all items required per policy Transfer to Hospital: Emergency Admission.	05/01/2015

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	1. Review of the policy/procedure (P&P) titled Transfer to Hospital: Emergency Admission indicated the following: A copy of the patient transfer form and a complete copy of the patient's medical record will accompany the patient. An addendum may be made to the electronic record...or the physician may hand write the addendum in the medical record to document the change in the patient's condition. Refer to Patient Transfer Form for patient transfer summary. The P&P was last revised 1/23/13. 2. Review of 1 transfer medical record (MR#28) lacked evidence of a transfer report, the physician's electronic note lacked an addendum with transfer information and the record lacked evidence of a hand written addendum. 3. On 4/17/15 at 2:40pm Al, Director, confirmed MR#28 lacked a transfer order/transfer report.		This form has already been implemented and will be reviewed by the QAIC for every patient that is transferred beginning in May of 2015.	
S 146 Bldg. 00	410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2) (b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the			

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	safety and well-being of patients are assured as follows: (2) No condition may be created or maintained which may result in a hazard to patients, public, or employees. Based on document review and observation, the center failed to store and maintain drugs and biologicals in accordance to their policy/procedure (P&P) for 2 intravenous solutions. Findings: 1. Review of the P&P titled Medication Expiration indicated under #2. Stock medications are checked once a month for expiration dates... and under #4. Disposal of Expired Medications: This will be handled through contract Pharmacy Services. The P&P was last revised 11/13. 2. Review of the document titled Pharmacy Department - Off Campus Floor Inspection dated 3/2/15 indicated the following: #3. All outdated medications &/or outdated samples have been removed. The "Yes" column was checked. 3. On 4/17/15 at 3:00pm, in the presence of A1, Administrator, in the patient care area the following was observed inside the crash cart: 2, 250 ml bags 0.9% sodium chloride, with expiration date indicated as Exp. 1 Mar 2015.	S 146	Responsible Party: Surgery Center Director, Pharmacy Consultant Description of Plan of Action: We will be meeting with Robert Murphy (Pharmacy Consultant) on 5/26/15 to discuss a couple of changes to the agreement as well as to complete his GEC Contracted Personnel Orientation Checklist. The changes we are requesting are: 1. Move the timing of his inspection from the end of each month to the beginning of each month. 2. Treat any medication which will expire between the dates of his current visit and his next visit as expired then. This will prevent the timing of his visit to lead to expired medication or fluids to be in the center. The Surgery Center Director will propose the changes in writing which must be approved by a Vice President at St Mary's Medical Center (Robert's place of work) which often takes weeks, thus the extended completion date.	06/30/2015