

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Q0000	<p>This visit was for a recertification survey.</p> <p>Facility #: 004546</p> <p>Survey Dates: 1-17/18-12</p> <p>Surveyors:</p> <p>Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>Jennifer Hembree RN Public Health Nurse Surveyor</p> <p>QA: claughlin 01/25/12</p>	O0000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Q0002	<p>As used in this part: Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of this part. The ambulatory surgical center must comply with state licensure requirements.</p> <p>Based on observation and staff interview, the facility failed to prevent other entities from utilizing non-clinical spaces for one (1) waiting area, reception area, and bathroom area observed.</p> <p>Findings include:</p> <p>1. Observation of the non-clinical areas beginning at 10:30 on 1/17/12, the following was observed: (A) The facility utilizes one (1) waiting room, reception area, and bathroom area for both the ambulatory surgery center (ASC) and the office practice. (B) The ASC and office practice were both in operation during the survey of 1/17/12 and 1/18/12.</p> <p>2. Staff member #1 indicated in interview at 11:30 a.m. on 1/17/12 that the office practice and ASC both are open 8:30 a.m. - 4:30 p.m. on Mondays and Tuesdays</p>	00002	The practice manager will apply for a waiver from the Indiana State Department of Health to be exempt from the hardship of constructing a seperate waiting room, bathroom area, and reception area. Sheryl Robertson has gone to the ISDH site and email corresponded with Randy Snyder as to the direction of applying for a waiver. Per Ref: S&C-10-20-ASC, the waiver process was located and the application will be sent to the ISDH per instruction by 02/17/2012. Within the following 30 days, the ASC will apply for signage for the Center. Person Responsible - Practice Manager	02/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>and the physicians alternate where they are working.</p> <p>3. Staff member #3 verified in exit at 3:00 p.m. on 1/18/12 that he/she is aware that the two (2) practices are sharing common space.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Q0041	<p>When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.</p> <p>Based on document review and interview, the facility failed to include all services, including those services furnished by a contractor, in the facility Quality Assurance and Performance Improvement (QAPI) program to ensure they are provided in a safe and effective manner.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 1-17-12 and 1-18-12 lacked evidence that the contracted services of laboratory and radiology services were included in the facility's QAPI program to ensure they are provided in a safe and effective manner. 2. Interview with B#1 and B#3 on 1-18-12 at 1010 hours confirmed the contracted services of laboratory and radiology were not included in the facility's QAPI program to ensure they are provided in a safe and effective manner. 	Q0041	<p>A staff meeting was held on 1/25/2012 and the Quality Assurance committee was given instruction on including laboratory and radiology services to the program to ensure they are providing services in a safe and effective manner. A checklist will be developed and monitored indicating if the lab and/or xray was on the patient's chart after ordering by the MD and before the next patient visit. The QAPI will report on this quarterly and make any necessary recommendations to the Center and to the Board of Directors. Person Responsible - Clinical Manager</p>	01/25/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Q0081	<p>(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.</p> <p>(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.</p> <p>(c)(1) The ASC must set priorities for its performance improvement activities that -</p> <ul style="list-style-type: none"> (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care. <p>Based on document review and interview, the facility Quality Assurance and Performance Improvement (QAPI) program failed to develop a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 1-17-12 and 1-18-12 lacked evidence that the facility Quality Assurance and Performance Improvement (QAPI) 	O0081	A staff meeting was held 1/25/2012 and the Quality Assurance committee was instructed on including reportable events quarterly as evidenced by the creation of a reportable event spreadsheet monitored monthly. ADDENDUM: A checklist was developed and approved by the Board of Directors for use in reporting these events. This checklist will be monitored by the QA committee on a monthly basis. Person Responsible - Clinical Manager	01/25/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>program developed a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH) or that these events were included in the facility QAPI program.</p> <p>2. Interview with B#1 and B#3 on 1-18-12 at 1010 hours confirmed the facility Quality Assurance and Performance Improvement (QAPI) program failed to develop a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH) or that these events were included in the facility QAPI program.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Q0103	<p>[The ASC must provide a functional and sanitary environment for the provision of surgical services.] The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.</p> <p>Based on document review and staff interview, the facility failed to have a plan in place to capture infections for all patients presenting to the center for surgery and failed to have policy in place for State notifiable disease reporting requirements.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of infection control meeting minutes for the previous year indicated there was no system in place to capture infections of patients having surgery at the facility. 2. The facility failed to provide policy for state notifiable disease reporting requirements at the time of exit despite numerous request. 3. Staff member #1 indicated the following in interview at 11:00 a.m. on 1/17/12: (A) The facility relies on the patient to report at a post operative visit if there are problems, however there is no tracking of 	00103	<ol style="list-style-type: none"> 1. A staff meeting was held 1/25/2012 and the Infection Control Committee was instructed on the use of the infection control log.2. The Board of Directors met 1/19/2012 and developed a policy and procedure for the reporting of diseases to the Indiana State Department of Health. Staff was instructed on this new policy and procedure at the staff meeting 1/25/2012. The Infection Control log will be monitored monthly and it will be a part of the Infection Control plan. The Infection Control committee and Quality Assurance committee will review these records at least quarterly and make reports and recommendations to the Center and the Board of Directors. Person Responsible - Clinical Manager 	01/25/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	post operative visits to ensure 100% of patients are monitored.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Q0181	<p>Drugs must be prepared and administered according to established policies and acceptable standards of practice.</p> <p>Based on document review, observation and staff interview, the facility failed to implement policy for disposal of medications.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "PHARMACY SERVICES" last reviewed/revised 9/29/11 states on page 1 under "Disposal of Outdated/Unwanted Drugs": "The procedure for disposing of outdated or unwanted drugs is as follows:.....2. If the drugs cannot be returned to the vendor; a. Non-narcotic drugs shall be disposed of in the clinical sink." 2. During observation of a procedure at 1:40 p.m. on 1/17/12 the following was observed: <ul style="list-style-type: none"> (A) Four (4) cc of Marcaine was drawn out of a 30 ml. vial and tech #1 threw the remainder of the vial in the trash. (B) Two (2) cc of Omnipaque was drawn out of a 20 ml. vial and tech #1 threw the remainder of the vial in the trash. 3. Tech #1 indicated in interview at 1:50 p.m. that staff have been instructed they could throw medication vials in the trash as long as the vial is not broken. 	O0181	<p>The Board of Directors met on 1/19/2012 and reviewed the policy and procedure on Administration of medications in the center. Staff was given a copy of the policy and procedure for disposal on non-narcotic drugs at the staff meeting 1/25/2012. The Quality Assurance committee will include in their reports if there were any medication errors. The Clinical Manager will do random unannounced spot checks for compliance and report to the Quality Assurance Committee. Person Responsible - Clinical Manager</p>	01/25/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Q0221	<p>The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands.</p> <p>Based on document review and staff interview, the facility failed to ensure patients were provided with written notice of patient rights in advance of the date of the procedure for 22 of 30 patients (Patients #N1, N2, N5-N7, N10, N11, N13, N14, N16-N18, N20, N21, and N23-N30).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Patient #N1 had a procedure on 12/12/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 5/2/11. 2. Patient #N2 had a procedure on 5/31/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The 	O0221	<p>At the staff meeting 1/25/2012, Administration Assistants were instructed on the policy and procedure of disclosing patients' rights and responsibilities to all patients in advance of the day of surgery for every procedure at the center. The Quality Assurance Committee will monitor this at least quarterly and make this part the QA plan. They will report and make recommendations to the Center and to the Board of Directors at least quarterly. Person Responsible - Clinical Manager</p>	01/25/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>record contained an advance directive document from a previous procedure dated 2/4/10.</p> <p>3. Patient #N5 had a procedure on 6/14/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 1/18/10.</p> <p>4. Patient #N6 had a procedure on 5/17/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 5/11/10.</p> <p>5. Patient #N7 had a procedure on 11/7/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>document from a previous procedure dated 6/4/10.</p> <p>6. Patient #N10 had a procedure on 10/18/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 11/8/10.</p> <p>7. Patient #N11 had a procedure on 8/19/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/3/11.</p> <p>8. Patient #N13 had a procedure on 12/6/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>dated 12/8/10.</p> <p>9. Patient #N4 had a procedure on 11/2/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 1/27/11.</p> <p>10. Patient #N16 had a procedure on 9/19/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/22/11.</p> <p>11. Patient #N17 had a procedure on 8/24/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 2/19/11.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>12. Patient #N18 had a procedure on 10/12/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 6/28/11.</p> <p>13. Patient #N20 had a procedure on 9/8/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure.</p> <p>14. Patient #N21 had a procedure on 11/22/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/11/11.</p> <p>15. Patient #N23 had a procedure on 12/5/11. His/her medical record lacked documentation that the patient received</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 12/3/10.</p> <p>16. Patient #N24 had a procedure on 12/5/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 10/7/11.</p> <p>17. Patient #N25 had a procedure on 9/14/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 7/1/11.</p> <p>18. Patient #N26 had a procedure on 12/19/11. His/her medical record lacked documentation that the patient received information on advance directives and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 10/27/11.</p> <p>19. Patient #N27 had a procedure on 11/28/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 6/11/10.</p> <p>20. Patient #N28 had a procedure on 10/25/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 12/9/10.</p> <p>21. Patient #N29 had a procedure on 11/7/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/24/11.</p> <p>22. Patient #N30 had a procedure on 1/17/12. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 9/29/10.</p> <p>23. Staff member #3 indicated in interview at 11:40 a.m. on 1/18/12 that patient rights information is completed one time and not for each procedure the patient has at the facility.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Q0223	<p>The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure.</p> <p>Based on document review and staff interview, the facility failed to ensure patients were provided with physician financial interests or ownership in advance of the date of the procedure for 22 of 30 patients (Patients #N1, N2, N5-N7, N10, N11, N13, N14, N16-N18, N20, N21, and N23-N30).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Patient #N1 had a procedure on 12/12/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 5/2/11. 2. Patient #N2 had a procedure on 5/31/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance 	Q0223	<p>At the staff meeting 1/25/2012, Administrative Assistants instructed on the policy and procedure of disclosing physician ownership in advance of the Day of procedure to all patients for every procedure at the center. The Policy and Procedure will be updated by 2/3/12 to reflect this. This will on the patient's chart with the Informed consent which is in advance of the day of the procedure for all procedures. This will be monitored by the Quality Assurance committee quarterly. Person Responsible - Clinical Manager</p>	01/25/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 2/4/10.</p> <p>3. Patient #N5 had a procedure on 6/14/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 1/18/10.</p> <p>4. Patient #N6 had a procedure on 5/17/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 5/11/10.</p> <p>5. Patient #N7 had a procedure on 11/7/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>record contained an advance directive document from a previous procedure dated 6/4/10.</p> <p>6. Patient #N10 had a procedure on 10/18/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 11/8/10.</p> <p>7. Patient #N11 had a procedure on 8/19/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/3/11.</p> <p>8. Patient #N13 had a procedure on 12/6/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>document from a previous procedure dated 12/8/10.</p> <p>9. Patient #N4 had a procedure on 11/2/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 1/27/11.</p> <p>10. Patient #N16 had a procedure on 9/19/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/22/11.</p> <p>11. Patient #N17 had a procedure on 8/24/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>dated 2/19/11.</p> <p>12. Patient #N18 had a procedure on 10/12/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 6/28/11.</p> <p>13. Patient #N20 had a procedure on 9/8/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure.</p> <p>14. Patient #N21 had a procedure on 11/22/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/11/11.</p> <p>15. Patient #N23 had a procedure on 12/5/11. His/her medical record lacked</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 12/3/10.</p> <p>16. Patient #N24 had a procedure on 12/5/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 10/7/11.</p> <p>17. Patient #N25 had a procedure on 9/14/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 7/1/11.</p> <p>18. Patient #N26 had a procedure on 12/19/11. His/her medical record lacked documentation that the patient received</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 10/27/11.</p> <p>19. Patient #N27 had a procedure on 11/28/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 6/11/10.</p> <p>20. Patient #N28 had a procedure on 10/25/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 12/9/10.</p> <p>21. Patient #N29 had a procedure on 11/7/11. His/her medical record lacked documentation that the patient received information on advance directives and</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/24/11.</p> <p>22. Patient #N30 had a procedure on 1/17/12. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 9/29/10.</p> <p>23. Staff member #3 indicated in interview at 11:40 a.m. on 1/18/12 that physician ownership is completed one time and not for each procedure the patient has at the facility.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
Q0224	<p>The ASC must comply with the following requirements:</p> <p>(i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with 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>(ii) 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>(iii) 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 staff interview, the facility failed to ensure patients were provided with information concerning policies on advance directives and failed to determine whether the patient had executed an advance directive in advance of the date of the procedure for 22 of 30 patients (Patients #N1, N2, N5-N7, N10, N11, N13, N14, N16-N18, N20, N21, and N23-N30).</p> <p>Findings include:</p> <p>1. Patient #N1 had a procedure on 12/12/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The</p>	Q0224	On 1/19/2012 the Board of Directors met. The Advanced Directive Policy and Procedure was reviewed and revised indicating an Advanced Directive for every procedure at the center will be completed in advance of the day of the procedure. The staff was informed on 1/25/2012 at the staff meeting. The Informed Consent will be revised by 2/17/12 to include indication the the Advance Directive was addressed with the patient and signed appropriately in advance of the day of surgery. The Quality Assurance Committee will monitor compliance and report, make recommendations to the Board of Directors at least quarterly. Person Responsible - Clinical Manager	01/25/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>record contained an advance directive document from a previous procedure dated 5/2/11.</p> <p>2. Patient #N2 had a procedure on 5/31/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 2/4/10.</p> <p>3. Patient #N5 had a procedure on 6/14/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 1/18/10.</p> <p>4. Patient #N6 had a procedure on 5/17/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>document from a previous procedure dated 5/11/10.</p> <p>5. Patient #N7 had a procedure on 11/7/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 6/4/10.</p> <p>6. Patient #N10 had a procedure on 10/18/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 11/8/10.</p> <p>7. Patient #N11 had a procedure on 8/19/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dated 3/3/11.</p> <p>8. Patient #N13 had a procedure on 12/6/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 12/8/10.</p> <p>9. Patient #N4 had a procedure on 11/2/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 1/27/11.</p> <p>10. Patient #N16 had a procedure on 9/19/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/22/11.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>11. Patient #N17 had a procedure on 8/24/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 2/19/11.</p> <p>12. Patient #N18 had a procedure on 10/12/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 6/28/11.</p> <p>13. Patient #N20 had a procedure on 9/8/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure.</p> <p>14. Patient #N21 had a procedure on 11/22/11. His/her medical record lacked documentation that the patient received</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/11/11.</p> <p>15. Patient #N23 had a procedure on 12/5/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 12/3/10.</p> <p>16. Patient #N24 had a procedure on 12/5/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 10/7/11.</p> <p>17. Patient #N25 had a procedure on 9/14/11. His/her medical record lacked documentation that the patient received information on advance directives and</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 7/1/11.</p> <p>18. Patient #N26 had a procedure on 12/19/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 10/27/11.</p> <p>19. Patient #N27 had a procedure on 11/28/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 6/11/10.</p> <p>20. Patient #N28 had a procedure on 10/25/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 12/9/10.</p> <p>21. Patient #N29 had a procedure on 11/7/11. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 3/24/11.</p> <p>22. Patient #N30 had a procedure on 1/17/12. His/her medical record lacked documentation that the patient received information on advance directives and failed to document in the medical record whether the patient had an advance directive prior to the procedure. The record contained an advance directive document from a previous procedure dated 9/29/10.</p> <p>23. Staff member #3 indicated in interview at 11:40 a.m. on 1/18/12 that advance directives information is completed one time and not for each procedure the patient has at the facility.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Q0230	<p>(2) If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.</p> <p>(3) If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>Based on document review and interview, the facility failed to develop a policy/procedure to protect the rights of a patient adjudged incompetent by a court of law.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of facility documents on 1-17-12 and 1-18-12 lacked evidence that the facility had developed a policy/procedure to protect the rights of patients adjudged incompetent by a court of law. Interview with B#1 on 1-18-12 at 1310 hours confirms the facility has not developed a policy/procedure to protect the rights of patients adjudged incompetent by a court of law. 	00230	The Practice Manager will enlist two additional licensed physicians for Utilization Review Committee, and the quarterly reports will reflect this. By 2/18/2012 3 physicians who hold no interest in the Center will be appointed to the Utilization Review committee by the Board of Directors. The 1st quarter UR committee meeting will reflect the appointment and the completion of the medical record review for the 4th qtr of 2011. The Quality Assurance will report on the appointment and the completion of the medical record review for the 4th qtr 2011. Person Responsible - Practice Manager	02/17/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

Q0245	<p>The program is - Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement.</p> <p>Based on document review and staff interview, the facility failed to have a plan in place to capture infections for all patients presenting to the center for surgery.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of infection control meeting minutes for the previous year indicated there was no system in place to capture infections of patients having surgery at the facility. 2. Staff member #1 indicated in interview at 11:00 a.m. on 1/17/12 that the facility relies on the patient to report at a post operative visit if there are problems, however there is no tracking of post operative visits to ensure 100% of patients are monitored. 	Q0245	<p>A staff meeting was held 1/25/2012 and the Infection Control Committee was instructed on the use of the infection control log. The Infection Control log will be monitored monthly and it will be a part of the Infection Control plan. The Infection Control committee and Quality Assurance committee will review these records at least quarterly and make reports and recommendations to the Center and the Board of Directors. Person Responsible - Clinical Manager</p>	01/25/2012
-------	---	-------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Q0262	<p>Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals.</p> <p>Based on document review and staff interview, the facility failed to ensure a pre-surgical assessment was conducted prior to surgery for 29 of 30 patients (patients #N1-N29).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Patients #N1-N29 medical records lacked evidence of a pre-surgical assessment upon admission. 2. Staff member #1 verified the above at 2:20 p.m. on 1/18/12. 	00262	<p>The Board of Directors met 1/19/2012 and the policy and procedure for Medical Records PreAssessment Physical was reviewed with the Medical Staff. History and Physicals will be updated on the day of each procedure. The Quality Assurance Committee will make this part of their plan and will report and make any recommendations to the Center and to the Board of Directors at least quarterly. The surgical pre-assessments will be monitored monthly and data will be gathered for a quarterly report by the QA committee. Person Responsible - Clinical Manager and Medical Staff QA committee</p>	01/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S0230	<p>410 IAC 15-2.4-1(e)(5)</p> <p>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:</p> <p>(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.</p> <p>Based on document review and interview, the governing body failed to provide for a periodic review of the center and its operation by a utilization review committee comprised of three or more duly licensed physicians who have no financial interest in the facility.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of facility documents on 1-17-12 indicated two physicians (MD#3 and MD#4) conducted reviews of the center and its operations as a utilization review committee during the 1st and 2nd quarters of 2011. Review of facility documents titled policy # 2.01 under Section D: UTILIZATION REVIEW COMMITTEE indicates the following: The utilization review Committee shall consist of a chairperson and at least two (2) members, none of whom have a financial interest in 	S0230	<p>The Practice Manager will enlist two additional licensed physicians for Utilization Review Committee, and the quarterly reports will reflect this. By 2/18/2012 3 physicians who hold no interest in the Center will be appointed to the Utilization Review committee by the Board of Directors. The 1st quarter UR committee meeting will reflect the appointment and the completion of the medical record review for the 4th qtr of 2011. The Quality Assurance will report on the appointment and the completion of the medical record review for the 4th qtr 2011. Person Responsible - Practice Manager</p>	02/17/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the Center as well as the following ex officio members: The Executive Director and Director. The committee shall meet quarterly.</p> <p>3. Review of facility documents on 1-17-12 indicated "The board voted to leave MD#3 as the sole physician on the panel for record review".</p> <p>4. Interview with B#3 on 1-18-12 at 1205 hours confirmed the utilization review (UR) committee did not meet quarterly in 2011 as required by facility policy; confirmed the UR Committee reviews were completed in the 1st and 2nd quarters of 2011 by 2 physicians and 3 members are required by facility policy; B#3 confirmed the board voted to leave MD#3 as the sole physician on the panel for record review.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0300	<p>410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>Based on document review and interview, the facility failed to follow the facility's approved Quality Assurance Plan.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 1-17-12 and 1-18-12 indicated the Quality Assurance (QA) Committee was comprised of an Operating Room (OR) Registered Nurse (RN) (B#4) and a Post Anesthesia Care Unit (PACU) RN (B#5). 2. Review of the facility Quality Assurance Plan, approved 9-29-11, indicated the following on page 2 under Quality Assurance Committee: This committee shall have representations from the medical staff, nursing services, and administration. 3. Interview with B#1 on 1-18-12 at 1020 hours confirmed B#4 is an RN in the OR and B#5 is an RN in the PACU; B#1 confirmed the QA Plan was approved on 9-29-11 and requires representatives from medical staff, nursing services, and 	S0300	On 1/19/2012 the Board of Directors met and approved appointment of Dr. Borhan and Sarah Ramey RN to the Quality Assurance Committee. Sarah Ramey, RN is the Administrative component of the committee. Person Responsible - Board of Directors	01/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	administration in the committee composition; B#1 confirmed the committee does not have representatives from the medical staff or administration.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S0310	<p>410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and 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.</p> <p>Based on document review and interview, the facility failed to include all services, including those services furnished by a contractor, in the facility Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <p>1. Review of facility documents on 1-17-12 and 1-18-12 lacked evidence that the internal laboratory services, contracted laboratory services, internal radiology services, and contracted radiology services were included in the facility's QAPI program.</p> <p>2. Interview with B#1 and B#3 on 1-18-12 at 1010 hours confirmed the internal laboratory services, contracted laboratory services, internal radiology services, and contracted radiology services were not included in the facility's QAPI program.</p>	S0310	<p>A staff meeting was held on 1/25/2012 and the Quality Assurance committee was given instruction on including laboratory and radiology services to the program to ensure they are providing services in a safe and effectice manner. A checklist will be developed and monitored indicating if the lab and/or xray was on the patient's chart after ordering by the MD and before the next patient visit. The QAPI will report on this quarterly and make any necessary recommendations to the Center and to the Board of Directors. Person Responsible - Clinical Manager</p>	01/25/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0320	<p>410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the facility failed to include medication errors in the facility Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings included:</p> <p>1. Review of facility documents on 1-17-12 and 1-18-12 lacked evidence that medication errors were included in the facility's QAPI program.</p> <p>2. Interview with B#1 and B#3 on 1-18-12 at 1010 hours confirmed that medication errors were not included in the facility's QAPI program.</p>	S0320	<p>A staff meeting was held on 1/25/2012 and the Quality Assurance committee was given instruction on including medication errors to their quarterly reports. If no medication errors are made, the QAPI will reflect this and be reported as such. Person Responsible - Clinical Manager</p>	01/25/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0332	<p>410 IAC 15-2.4-2.2(a)(1)</p> <p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the center:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded:</p> <p>(AA) Objects intentionally implanted as part of a planned intervention.</p> <p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>removal exceeds the risk of retention, such as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries that were the</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>reason for admission to the center.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is progression from Stage 2 or Stage 3 if the</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the center.</p> <p>Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or</p> <p>(BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the center.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p> <p>Based on document review and interview,</p>	S0332	A staff meeting was held	01/25/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the facility Quality Assurance and Performance Improvement (QAPI) program failed to develop a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 1-17-12 and 1-18-12 lacked evidence that the facility Quality Assurance and Performance Improvement (QAPI) program developed a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH). 2. Interview with B#1 and B#3 on 1-18-12 at 1010 hours confirmed the facility Quality Assurance and Performance Improvement (QAPI) program failed to develop a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH). 		<p>1/25/2012 and the Quality Assurance committee was instructed on including reportable events quarterly as evidenced by the creation of a reportable event spreadsheet monitored monthly. ADDENDUM: A checklist was developed and approved by the Board of Directors for use in reporting these events. This checklist will be monitored by the QA committee on a monthly basis. Person Responsible - Clinical Manager</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

S0334	<p>410 IAC 15-2.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) center employee involved;</p> <p>or any other information.</p> <p>(2) A potential reportable event may be identified by a center that:</p> <p>(A) receives a patient as a transfer; or</p> <p>(b) admits a patient subsequent to discharge; from another health care facility subject to a</p>			
-------	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>reportable event requirement. In the event that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually.</p> <p>(e) Any serious reportable listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the center between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)</p> <p>Based on document review and interview, the facility failed to include adverse events, reportable to the Indiana State</p>	S0334	A staff meeting was held 1/25/2012 and the Quality Assurance committee was instructed on including reportable	02/17/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Department of Health (ISDH), in the facility Quality Assurance and Performance Improvement (QAPI) program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of facility QAPI documents on 1-17-12 and 1-18-12 lacked evidence that adverse events, reportable to the ISDH, were included in the facility QAPI program. 2. Interview with B#1 and B#3 on 1-18-12 at 1010 hours confirmed adverse events, reportable to the ISDH, are not included in the facility QAPI program. 		<p>events quarterly as evidenced by the creation of a reportable event spreadsheet monitored monthly. The reportable event checklist will be created as a spreadsheet and will be added to the Policy and Procedure and will be used monthly. The Quality Assurance committee will report on and make any recommendations to the Center and to the Board of Directors at least quarterly. Person Responsible - Clinical Manager</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

S0414	<p>410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on document review, the facility failed to ensure the infection control committee had membership that included a representative from the medical staff.</p> <p>Findings include:</p> <p>1. Review of the infection control meeting minutes for the previous year indicated the facility held a quarterly infection control meeting with two (2) nurses only. There was no representative from the medical staff on the committee.</p>	S0414	The Board of Directors met 1/19/012 and approved the appointment of Dr. Robertson to the Infection Control Committee. Person Responsible - Board of Directors	01/19/2012
-------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0418	<p>410 IAC 15-2.5-1(f)(2)(A)</p> <p>(2) The infection control committee responsibilities must include, but are not limited to the following:</p> <p>(A) Establishing techniques and systems for identifying, reviewing, and reporting infections in the center.</p> <p>Based on document review and staff interview, the facility failed to have a plan in place to capture infections for all patients presenting to the center for surgery.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of infection control meeting minutes for the previous year indicated there was no system in place to capture infections of patients having surgery at the facility. Staff member #1 indicated in interview at 11:00 a.m. on 1/17/12 that the facility relies on the patient to report at a post operative visit if there are problems, however there is no tracking of post operative visits to ensure 100% of patients are monitored. 	S0418	<p>A staff meeting was held 1/25/2012 and the Infection Control Committee was instructed on the use of the infection control log. The Infection control log will be a part of the Infection control plan and will be monitored by the Infection Control committee and the QAPI at least quarterly. Any reports and recommendations will be given to the Center and to the Board of Directors. The Infection Control nurse will be received certification by APIC. She will start the training certification program within the following 30 days. Person Responsible - Clinical Manager</p>	02/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S0422	<p>410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.</p> <p>Based on document review, the infection control committee failed to review employee exposure incidents for one (1) exposure.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Incident report review indicated that RN #1 had a needlestick injury on 8/19/11. 2. The infection control meeting minutes dated 11/21/11 (first meeting after incident) failed to address the previous needlestick injury. 	S0422	<p>A staff meeting was held 1/25/2012 and the Infection Control Committee Members were instructed on the importance of documenting any and all needle sticks. An addendum will be made to reflect that a report from the first needle stick was indeed done, indicating that the Infection control committee failed to document it as such. A late report will be an addendum in the Infection control meeting minutes and will be brought to the Infection control committee as well as the Quality Assurance committee. Person Responsible - Clinical Manager</p>	02/17/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S0622	<p>410 IAC 15-2.5-3(c)(6)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(6) The center shall have a system of coding and indexing medical records which allows for timely retrieval of records by diagnosis and procedure, physician, and condition on discharge, in order to support continuous quality assessment and improvement activities.</p> <p>Based on document review and interview, the facility failed to have a system of coding and indexing of medical records that allows for timely retrieval of records by diagnosis, physician, and condition on discharge.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of facility documents on 1-18-12 lacked evidence that the facility's system for coding and indexing of medical records allowed for the timely retrieval of records by diagnosis, physician, or condition on discharge. 2. Interview with staff member B#3 on 1-18-12 at 0850 hours confirmed the facility's system for coding and indexing of medical records does not allow for the timely retrieval of records by diagnosis, physician, or condition on discharge. 	S0622	<p>The Practice Manager will begin work with software system to develop a timely retrieval of medical records based on physician, diagnosis, and condition on discharge. Within the following 30 days, the PM will instruct the Clinical Manager on the retrieval of this information. The Quality Assurance committee will report on the completion of this task by 3/17/2012. Person Responsible - Practice Manager</p>	02/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/18/2012	
NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S1010	<p>410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on document review, observation and staff interview, the facility failed to implement policy for disposal of medications.</p> <p>Findings include;</p> <p>1. Facility policy titled "PHARMACY SERVICES" last reviewed/ revised 9/29/11 states on page 1 under "Disposal of Outdated/Unwanted Drugs": "The procedure for disposing of outdated or unwanted drugs is as follows:.....2. If the drugs cannot be returned to the vendor; a. Non-narcotic drugs shall be disposed of in the clinical sink."</p> <p>2. During observation of a procedure at 1:40 p.m. on 1/17/12 the following was observed:</p> <p>(A) Four (4) cc of Marcaine was drawn out of a 30 ml. vial and tech #1 threw the remainder of the vial in the trash.</p>	S1010	<p>The Board of Directors met on 1/19/2012 and reviewed the policy and procedure on Administration of medications in the center. Staff was given a copy of the policy and procedure for disposal on non-narcotic drugs at the staff meeting 1/25/2012. The Quality Assurance committee will include in their reports if there were any medication errors. The Clinical Manager will do random unannounced spot checks for compliance and report to the Quality Assurance Committee. Person Responsible - Clinical Manager</p>	01/25/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>(B) Two (2) cc of Omnipaque was drawn out of a 20 ml. vial and tech #1 threw the remainder of the vial in the trash.</p> <p>3. Tech #1 indicated in interview at 1:50 p.m. that staff have been instructed they could throw medication vials in the trash as long as the vial is not broken.</p>			
--	---	--	--	--