

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001028	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/29/2013
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NAME OF PROVIDER OR SUPPLIER GASTROINTESTINAL ENDOSCOPY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 ST MARYS DR, STE 110 W EVANSVILLE, IN 47714
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Q000000	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 005820</p> <p>Survey Date: 10/28/2013 through 10/29/2013</p> <p>Surveyors: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 11/04/13</p>	Q000000		
Q000043	<p>416.41(c) DISASTER PREPAREDNESS PLAN (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or</p>			

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

TITLE

(X6) DATE

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

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	<p>circumstances that are likely to threaten the health and safety of those in the ASC.</p> <p>(2) The ASC coordinates the plan with State and local authorities, as appropriate.</p> <p>(3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.</p> <p>Based on documentation review and staff interview, the facility failed to provide evidence of any emergency disaster drills that were coordinated with appropriate community, state or federal agencies.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The 2013 Digestive Care Center Emergency Operation Plan specifies the center will conduct routine disaster drills to ensure all staff are familiarized with the evacuation plans. At 1:45 PM on 10/29/2013, staff member A2 indicated the only disaster drill the staff member knew the facility conducted was a tornado drill in May 2013. However, the staff member could 	O000043	<p>Responsible Party: Surgery Center Director/Safety Officer</p> <p>Action Plan: The Emergency Operations Plan has been revised to indicate that in addition to or coincidentally with the quarterly fire drills that are required according to the Life Safety Code at least one Emergency Disaster Drill will be completed per year. These will be documented in the Disaster Drill Report. We intend to complete these drills twice yearly in order to ensure they are completed at least annually.</p> <p>Estimated Completion Date: 12/4/2013 Actual Completion Date: pending</p>	12/04/2013

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Q000061	<p>not provide documented evidence of the tornado drill. Staff member A2 indicated he/she did not have any documented evidence of any emergency disaster drills the facility ever held.</p> <p>416.42(a)(1) ANESTHETIC RISK AND EVALUATION A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. Based on observation, staff interview and document review, the facility failed to ensure the physician examined the patient prior to procedure for 1 patient observation (patient #28).</p> <p>Findings include:</p> <p>1. During observation of patient #28 throughout his/her preop phase and procedure beginning at 10:45 a.m. on 10/29/13, the following was observed: (A) At no time did the physician do a physical assessment of the patient including, but not limited to, listening to the patients lungs sounds and heart.</p> <p>2. M.D. #1 indicated in interview at</p>	O000061	<p>Responsible Party: Charge Nurse, Anesthesia Manager, Quality and Safety Improvement Committee Action Plan: Each physician and nurse anesthetist will be traced and audited on a quarterly basis by the charge nurse using the "PROCEDURAL COMPLIANCE TRACER" form. The Quality Coordinator will ensure that all providers are observed. The results of these audits will be reported at the Governing Body and Medical Staff meeting, and the results for the anesthesia provider will be reported at the Anesthesia Care Associates board meeting. Additionally, the Medical Staff and CRNA staff were re-educated at their meetings on November 11th and 14th respectively. Estimated</p>	11/19/2013

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	<p>12:00 p.m. on 10/29/13 that the history and physical (H&P) is completed the day of the procedure and listening to the patients lungs is a shared responsibility between the physician and anesthesia.</p> <p>3. Anesthesia provider #1 indicated in interview at 12:05 p.m. on 10/29/13 that listening to the patients lungs is a shared responsibility between the physician and anesthesia.</p> <p>4. Review of patient #28 medical record stated the following: (A) "Physical exam was performed prior to anesthesia", cardiovascular: Auscultation: regular rate and rhythm. No murmur or gallop rub. ...Respiratory: Auscultation: clear to auscultation bilaterally."</p> <p>5. Facility policy titled "MEDIAL RECORDS" last reviewed/revised 5/10/12 states: "2. The patient's medical record must contain patient identification data.....history and physical,.... pre-operative physical exams....."</p> <p>6. Anesthesia policy titled "RECORD KEEPING" last reviewed/revised 10/16/13 states on page 28: "B. Appropriate physical examination, including vital signs and documentation of airway assessment."</p>		<p>Completion Date: The tracer forms will be completed prior to December 6th.. The audits will begin for the 4th quarter of 2013 and will be completed in December. Results will be presented at the Governing Body and Medical Staff meeting and Anesthesia Care Associates meeting scheduled in January of 2014. Actual Completion Date: Re-education completed 11/11/2013 and 11/14/2013.</p>				

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Q000081	<p>416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES</p> <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 staff interview, the facility failed to ensure the contracted service that provides for medical records review was included in its comprehensive quality assessment and</p>	Q000081	Responsible Party: Surgery Center Director Action Plan: Medical Records Consultant will be evaluated with the other Indirect Care Vendors and has been added to the list for the Quality and Safety Improvement Committee. We will evaluate the proper completion of the reviews for each quarter as well as ensure that our reviewer has a current	12/19/2013

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	<p>improvement (QA&I) program.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Digestive Care Center Quality and Safety Improvement Program (last approved 11/2012) states, "Direct Care Vendors, such as medical record reviews, will be reviewed by the committee monthly or quarterly, as appropriate." 2. The Gastrointestinal Endoscopy Center entered into a Medical Record Consulting Agreement starting October 1, 2012 through December 31, 2014. The Indirect Patient Care Vendors Quality Review Contracted Vendor/Service evaluation form for Medical Record Review was not completed for the first 12 months starting October 1, 2012. 3. At 10:30 AM on 10/29/2013, staff member A2 indicated the Medical Records Consultant was not monitored by the Quality 		<p>license. Estimated Completion Date: Added to list for December 2013 evaluation. Actual Completion Date: 12/19/13</p>				

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Q000101	<p>Assurance Committee for the service they were providing the center.</p> <p>416.44(a)(1) PHYSICAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on observation, the facility failed to ensure the surgery center janitor's closet was maintained cleaned and organized.</p> <p>Findings included:</p> <p>At 2:25 PM on 10/29/2013, the surgery center janitor's closet was observed storing assorted chemicals, a container of cat litter, and assorted cleaning supplies directly on the floor and not on the shelves within the room. The floor was observed with soil residue and</p>	0000101	Responsible Party: Infection Control Nurse, Infection Control Committee Action Plan: The janitor's closet was cleaned and all unapproved items were discarded. The Infection Control policy titled "HOUSEKEEPING" was revised to read "No personal items or unapproved cleaners or chemicals may be stored in the janitor's closet. No items can be stored on floor; they must be stored on shelves." All employees will be made aware of the policy revision during the staff meeting scheduled for November 26th. Estimated Completion Date: The policy was revised on November 19, 2013. It will be shared with the Infection Control Committee at a meeting on	11/26/2013

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Q000105	<p>pieces of paper on the janitor closet's floor.</p> <p>416.44(c) EMERGENCY EQUIPMENT The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC' s operating room. The equipment must meet the following requirements:</p> <p>(1) Be immediately available for use during emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel.</p> <p>Based on documentation review and staff interview, the facility failed to perform daily maintenance checks on the defibrillator as required by the manufacturer's recommendations.</p> <p>Findings included:</p> <p>1. The Lifepak 20 Defibrillator/Monitor Operating Instructions daily recommended Maintenance Schedule states, "Complete Operator's Checklist</p>	0000105	<p>November 20, 2013 and shared with remaining staff members at a staff meeting on November 26th. Actual Completion Date: 11/26/2013</p> <p>Responsible Party: Charge Nurse Action Plan: The policy "LifePAK and Crash Cart Maintenance" has been revised to read "An RN will be assigned to complete the LIFEPAK 20e Defibrillator Checklist daily, in accordance with Appendix D of the LIFEPAK 20e Defibrillator/Monitor Operator's Checklist". An in-service was held on November 20, 2013 to make all RN staff aware of the policy revisions. The Charge Nurse will keep completed checklists and will do monthly audits to verify compliance. Estimated Completion Date: The policy was revised on November 19, 2013. The checklist will become</p>	11/21/2013

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	<p>(refer to Appendix D)." The Operator's daily checklist includes: Check printed results of daily auto tests, inspect physical condition, inspect power source, examine accessory cables, check ECG printer, perform Manual User Test if the daily auto test was interrupted.</p> <p>2. The Monthly Crash Cart Checks evidenced that manual defibrillator checks are completed once a month. The logs did not evidence the results from the daily auto tests nor any of the manufacturer's recommended operators daily maintenance checks.</p> <p>3. At 2:00 PM on 10/29/2013, staff member A2 confirmed the facility was not performing daily maintenance inspections of the Lifepak defibrillator as required by the manufacturer.</p>		<p>mandatory on November 21, 2013. Actual Completion Date: 11/21/2013</p>	

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Q000181	<p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on documentation review, staff interview and observation, the facility failed to ensure the consulting Pharmacist will conduct monthly compliance reviews as per ASC policy and procedure and failed to ensure staff cleansed the I.V. ports prior to medication administration for 1 patient observation (patient #28).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Pharmacist Consultant Services policy (last approved November, 2012) states, "Monthly compliance review will be completed by the pharmacist or his/her designee (pharmacy tech)." 2. The facility provided 4 monthly 	O000181	<p>Responsible Party: Charge Nurse, Surgery Center Director, Manager of Anesthesia Services, Quality and Safety Improvement Committee Action Plan: The policy "Pharmacist Consultant Services" was revised to read "A compliance review will be completed monthly by the pharmacist or his/her designee (pharmacy tech). The pharmacist will complete the review at least annually." In addition, the Charge Nurse and Endoscopy Center Director are meeting with the contracted pharmacist on November 20th to discuss the non-compliant issues and, based on outcome of the meeting, possibly contracting a different pharmacy consultant. This is the second such meeting and other options for reviewers are being investigated. Each nurse anesthetist will be traced and audited on a quarterly basis by the Charge Nurse using the "PROCEDURAL COMPLIANCE TRACER" form. Included on this tracer is verification that alcohol pads are used on the IV port</p>	11/20/2013

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Q000221	<p>inspections since December 10, 2012: 12/10/12, 6/3/13, 7/1/13, and 8/26/13. The facility did not provide 6 monthly inspections for the first 9 months of 2013: January, February, March, April, May, and September.</p> <p>3. At 12:30 PM on 10/29/2013, staff member A2 confirmed the contracted consultant was not conducting monthly inspections for 2013 as per ASC policy.</p> <p>4. Anesthesia provider #1 was observed administering I.V. medication x 3 beginning at 11:00 a.m. on 10/29/13. He/she did not cleanse the I.V. port with alcohol prior to medication administration.</p> <p>416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this</p>		<p>before administering medications. The results of the tracer will be reported at the Anesthesia Care Associates board meeting. Any provider not in compliance with this requirement will also be reported at the next Infection Control Committee meeting. Estimated Completion Date: The tracer forms will be completed prior to December 6th.. The audits will begin for the 4th quarter of 2013 and will be completed in December. Results will be presented at the Anesthesia Care Associates meeting scheduled in January of 2014. Actual Completion Date: Re-education completed 11/14/2013.</p>				

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Q000241	<p>section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.</p> <p>Based on document review and staff interview, the facility failed to provide evidence that patients received patient rights information for 30 of 30 patient records (patients #1-30).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Patients #1-30 medical records lacked evidence that the patient received patient rights information prior to their procedure. 2. Staff member #2 verified in interview at 3:30 p.m. on 10/29/13 that there was no evidence that patients received the patient rights information. <p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.</p> <p>Based on document review, observation, and staff interview, the facility failed to adhere to hand hygiene policy, failed to ensure all areas of patient stretchers were disinfected, failed to</p>	0000221	<p>Responsible Party: Surgery Center Director Action Plan: The Gastrointestinal Endoscopy Center's Consents and Notifications (form GA279) has been revised. The section that read "I have been given the opportunity to review Gastrointestinal Endoscopy Center's Notice of Privacy Practices" has been amended to read "I have been given the opportunity to review Gastrointestinal Endoscopy Center's Notice of Privacy Practices and the Gastrointestinal Endoscopy Center Patient Rights and Responsibilities prior to my procedure." Estimated Completion Date: 11/20/13 Actual Completion Date: 11/20/13</p>	11/20/2013			
		0000241	<p>Responsible Party: Infection Control Nurse, Infection Control Committee Action Plan: The Infection Control Quarterly Review worksheet has been created by the Infection Control</p>	11/26/2013			

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	<p>adhere to thermometer cleaning policy, failed to use single patient use items for only one patient, and failed to test the high level disinfectant prior to each use.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "HAND HYGIENE" last reviewed/revised 12/5/12 states on page 2: "C. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient." 2. Facility policy titled "DAILY CLEANING PROTOCOL" last reviewed/revised 11/27/12 states on page 2 under Admission/Recovery Bays: "3. Stretchers will be sprayed and wiped with disinfectant solution per manufacturer's directions. 3. Facility policy titled "USE OF THERMOMETERS" last reviewed/revised 11/30/12 states "...The thermometer should be cleaned with alcohol wipes in between patient use....." 4. The package for the suction connecting tubing states on package: "Sterile Single use only". 5. Facility policy titled 		<p>Nurse and will be completed at least quarterly to ensure that staff is adhering to several infection control policies, including "HAND HYGIENE". The Infection Control Nurse will randomly audit two staff members in each category quarterly. If a staff member is not compliant with the Center's policy, the Infection Control Nurse will re-educate that employee and perform a second audit on them the following quarter to ensure that they have corrected their practices. Any staff member who fails this second audit will be presented to the Infection Control Committee and further action will be taken. The Infection Control Nurse will also perform a hand hygiene review with all staff, during the annual Skills Assessment Period, utilizing Glo-Germ to demonstrate the effectiveness of each employee's hand washing technique. The Infection Control policy "DAILY CLEANING PROTOCOL" was revised to read "Stretchers will be wiped with disinfectant solution per manufacturer's directions." Staff will be made aware of the change at a mandatory staff meeting scheduled for 11/26. In addition to explaining the policy revision, the Infection Control Nurse will demonstrate the proper way to clean a stretcher after patient use. The policy "USE OF THERMOMETERS" was revised to read "The thermometer should</p>				

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	<p>"ORTHO-PHTHALADEHYDE (OPA) MONITORING" last reviewed/ revised 12/5/12 states under policy: "Testing of ortho-phthalaldehyde solution efficacy before each run cycle....."</p> <p>6. Review of facility log for OPA use in "bucket" indicated that the solution is not checked prior to each use. Per log, the solution is checked daily.</p> <p>7. During observations beginning at 10:45 a.m. on 10/29/13, the following was observed:</p> <p>(A) The O2 connecting tubing was not changed after a procedure. The room was cleaned and utilized for another procedure.</p> <p>(B) Anesthesia provider #1 came from the procedure room with gloves on after a procedure was complete, assisted with placing the patient in a recovery bay, went to the nurses station and checked through the schedule, touched the counter, picked up the thermometer and used it for patient #28, brought the thermometer back to the nurses station and set it down. He/she did not clean the thermometer after use.</p> <p>(C) All of the above was with the soiled gloves he/she had on when exiting the procedure room.</p> <p>(D) Two (2) staff members were observed cleaning soiled stretchers in the</p>		<p>be cleaned with alcohol wipes before patient use."Staff will be made aware of the change at the mandatory staff meeting scheduled for 11/26. Alcohol wipes will be made readily available at all thermometer storage locations. We have found replacement tubing that is not labeled for single patient use that will take the place of the suction connection tubing we currently use. Until that tubing arrives, we are discarding the tubing after each use. 5-8. A new Ortho-Phthalaldehyde (OPA) Monitor Log has been created and used with the OPA "bucket". This monitor log will be used to verify that the OPA is being tested at the beginning of each work day and before each run cycle. This revised log will be added to the existing policy. Staff members will be made aware of the change at the staff meeting scheduled for 11/26. Estimated Completion Date: 11/26/2013 for policy revision and review. December tracers will be completed for the Infection Control Quarterly Review. Actual Completion Date: pending</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001028		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/29/2013	
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Q000261	<p>recovery area. Both failed to wipe the small projections on the siderail.</p> <p>8. Staff member #N5 indicated the following in interview beginning at 3:00 p.m. on 10/29/13: (A) The suction connecting tubing is changed daily and not in between each patient. (B) The "bucket" of OPA is checked daily.</p> <p>416.52(a)(1) ADMISSION ASSESSMENT Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. Based on observation, staff interview and document review, the facility failed to ensure a comprehensive physical assessment was conducted for 1 patient observation (patient #28).</p> <p>Findings include:</p> <p>1. During observation of patient #28 throughout his/her preop phase and procedure beginning at 10:45 a.m. on 10/29/13, the following was observed:</p>	O000261	<p>Responsible Party: Charge Nurse, Anesthesia Manager, Quality and Safety Improvement Committee Action Plan: Each physician and nurse anesthetist will be traced and audited on a quarterly basis by the charge nurse using the "PROCEDURAL COMPLIANCE TRACER" form. The Quality Coordinator will ensure that all providers are observed. The results of these audits will be reported at the Governing Body and Medical Staff meeting, and the results for</p>	11/19/2013			

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	<p>(A) At no time did a physician or anesthesia provider do a physical assessment of the patient including, but not limited to, listening to the patients lungs sounds and heart.</p> <p>2. M.D. #1 indicated in interview at 12:00 p.m. on 10/29/13 that the history and physical (H&P) is completed the day of the procedure and listening to the patients lungs is a shared responsibility between the physician and anesthesia.</p> <p>3. Anesthesia provider #1 indicated in interview at 12:05 p.m. on 10/29/13 that listening to the patients lungs is a shared responsibility between the physician and anesthesia.</p> <p>4. Review of patient #28 medical record stated the following: (A) "Physical exam was performed prior to anesthesia", cardiovascular: Auscultation: regular rate and rhythm. No murmur or gallop rub. ...Respiratory: Auscultation: clear to auscultation bilaterally."</p> <p>5. Facility policy titled "MEDIAL RECORDS" last reviewed/revised 5/10/12 states: "2. The patient's medical record must contain patient identification data.....history and physical,.... pre-operative physical exams....."</p>		<p>the anesthesia provider will be reported at the Anesthesia Care Associates board meeting. Additionally, the Medical Staff and CRNA staff were re-educated at their meetings on November 11th and 14th respectively. Estimated Completion Date: The tracer forms will be completed prior to December 6th.. The audits will begin for the 4th quarter of 2013 and will be completed in December. Results will be presented at the Governing Body and Medical Staff meeting and Anesthesia Care Associates meeting scheduled in January of 2014. Actual Completion Date: Re-education completed 11/11/2013 and 11/14/2013.</p>		

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S000000	<p>6. Anesthesia policy titled "RECORD KEEPING" last reviewed/revised 10/16/13 states on page 28: "B. Appropriate physical examination, including vital signs and documentation of airway assessment."</p> <p>This visit was for a State licensure survey.</p> <p>Facility Number: 005820</p> <p>Survey Date: 10/28/2013 through 10/29/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 11/04/13</p>	S000000		

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S000162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on document review and staff interview, the facility failed to ensure staff completed ACLS certification per policy for 2 (#N3 and N4) of 4 Registered Nurses.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "ADVANCED CARDIAC LIFE SUPPORT (ACLS) last reviewed/revised 5/31/12 states under guidelines: "All Physicians, Registered Nurses (RN's), and Certified Registered Nurse Anesthetist's (CRNA's) who work in center will be required to be certified in Advanced Cardiovascular Life Support and maintain certification." 2. Staff members #N3 and N4 personnel files lacked evidence of ACLS certification. 	S000162	<p>Responsible Party: Charge Nurse, Endoscopy Center Director Action Plan: The job description for Registered Nurses the endoscopy center was changed to require Advanced Cardiac Life Support within six (6) months of employment. The policy "ADVANCED CARDIAC LIFE SUPPORT (ACLS)" was revised to require ACLS within six (6) months of employment for registered nurses, certified registered nurse anesthetists, and physicians. In addition, all files for employees listed above will be reviewed to ensure they contain a valid ACLS card. Arrangements will be made for any employees without proof of certification. This could be obtaining a copy of a missing card or enrolling in class to meet Digestive Care Center endoscopy center guidelines. Estimated Completion Date: The job description and policy were</p>	11/19/2013			

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S000310	<p>3. Staff member #2 verified the above at 3:00 p.m. on 10/29/13.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 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 staff interview, the facility failed to ensure the contracted service that provides for medical records review was included in its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p> <p>1. Digestive Care Center Quality and Safety Improvement Program (last approved 11/2012) states, "Direct Care Vendors, such as</p>	S000310	<p>revised on November 19, 2013. All employee files will be reviewed and action plans carried out by January 1, 2014. Actual Completion Date: Job Description and Policy Revisions completed 11/19/2013</p> <p>Responsible Party: Surgery Center Director Action Plan: Medical Records Consultant will be evaluated with the other Indirect Care Vendors and has been added to the list for the Quality and Safety Improvement Committee. We will evaluate the proper completion of the reviews for each quarter as well as ensure that our reviewer has a current license. Estimated Completion Date: Added to list for December 2013 evaluation. Actual Completion Date: pending</p>	12/19/2013	

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	<p>medical record reviews, will be reviewed by the committee monthly or quarterly, as appropriate."</p> <p>2. The Gastrointestinal Endoscopy Center entered into a Medical Record Consulting Agreement starting October 1, 2012 through December 31, 2014. The Indirect Patient Care Vendors Quality Review Contracted Vendor/Service evaluation form for Medical Record Review was not completed for the first 12 months starting October 1, 2012.</p> <p>3. At 10:30 AM on 10/29/2013, staff member A2 indicated the Medical Records Consultant was not monitored by the Quality Assurance Committee for the service they were providing the center.</p>				

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S000400	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation and document review, the facility failed to provide an environment that minimized risk to patients by failing to cleanse the I.V. ports prior to medication administration for 1 patient observation and failing to adhere to facility policy related to hand hygiene.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "HAND HYGIENE" last reviewed/revised 12/5/12 states on page 2: "C. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient." 2. During observations beginning at 10:45 a.m. on 10/29/13, the following was observed: (A) Anesthesia provider #1 came from the procedure room with gloves on after a procedure was complete, assisted with placing the patient in a recovery bay, 	S000400	<p>Responsible Party: Charge Nurse, Surgery Center Director, Manager of Anesthesia Services, Quality and Safety Improvement Committee Action Plan: The policy "Pharmacist Consultant Services" was revised to read "A compliance review will be completed monthly by the pharmacist or his/her designee (pharmacy tech). The pharmacist will complete the review at least annually." In addition, the Charge Nurse and Endoscopy Center Director are meeting with the contracted pharmacist on November 20th to discuss the non-compliant issues and, based on outcome of the meeting, possibly contracting a different pharmacy consultant. This is the second such meeting and other options for reviewers are being investigated. Each nurse anesthetist will be traced and audited on a quarterly basis by the Charge Nurse using the "PROCEDURAL COMPLIANCE TRACER" form. Included on this tracer is verification that alcohol pads are used on the IV port before administering medications. The results of the tracer will be</p>	11/20/2013

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S000428	<p>went to the nurses station and checked through the schedule, touched the counter, picked up the thermometer and used it for patient #28, brought the thermometer back to the nurses station and set it down.</p> <p>(B) All of the above was with the soiled gloves he/she had on when exiting the procedure room.</p> <p>3. Anesthesia provider #1 was observed administering I.V. medication x 3 beginning at 11:00 a.m. on 10/29/13. He/she did not cleanse the I.V. port with alcohol prior to medication administration.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation.</p>		<p>reported at the Anesthesia Care Associates board meeting. Any provider not in compliance with this requirement will also be reported at the next Infection Control Committee meeting. Estimated Completion Date: The policy was revised on November 19, 2013. The meeting is scheduled for November 20, 2013 at 12:30 pm. Actual Completion Date: 11/20/13 for the pharmacy reviews issues. For #4, tracers will be completed in December.</p>	

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	<p>Based on document review and observation, the facility failed to ensure all areas of patient stretchers were disinfected between patient use and failed to adhere to facility thermometer cleaning policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "DAILY CLEANING PROTOCOL" last reviewed/revised 11/27/12 states on page 2 under Admission/Recovery Bays: "3. Stretchers will be sprayed and wiped with disinfectant solution per manufacturer's directions. 2. Facility policy titled "USE OF THERMOMETERS" last reviewed/revised 11/30/12 states "...The thermometer should be cleaned with alcohol wipes in between patient use....." 3. During observations beginning at 10:45 a.m. on 10/29/13, the following was observed: <ul style="list-style-type: none"> (A) Two (2) staff members were observed cleaning soiled stretchers in the recovery area. Both failed to wipe the small projections on the siderail. (B) Anesthesia provider #1 was observed using the thermometer on a patient, brought the thermometer back to the nurses station and set it down. He/she 	S000428	<p>Responsible Party: Infection Control Nurse, Infection Control Committee Action Plan: The Infection Control policy "DAILY CLEANING PROTOCOL" was revised to read "Stretchers will be wiped with disinfectant solution per manufacturer's directions."Staff will be made aware of the change at a mandatory staff meeting scheduled for 11/26. In addition to explaining the policy revision, the Infection Control Nurse will demonstrate the proper way to clean a stretcher after patient use. The policy "USE OF THERMOMETERS" was revised to read "The thermometer should be cleaned with alcohol wipes before patient use."Staff will be made aware of the change at the mandatory staff meeting scheduled for 11/26. Alcohol wipes will be made readily available at all thermometer storage locations. Estimated Completion Date: Both policies were revised on November 19, 2013. The mandatory staff meeting will be held on November 26, 2013. Actual Completion Date: pending</p>	11/26/2013			

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S000432	<p>did not clean the thermometer after use.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and staff interview, the facility failed to test the high level disinfectant prior to each use for one (1) container of solution used.</p> <p>Findings include:</p> <p>1. Facility policy titled "ORTHO-PHTHALALDEHYDE (OPA) MONITORING" last reviewed/revised 12/5/12 states under policy: "Testing of ortho-phthalaldehyde solution efficacy before each run cycle....."</p> <p>2. Review of facility log for OPA use in "bucket" indicated that the solution is not</p>	S000432	<p>Responsible Party: Infection Control Nurse, Infection Control Committee Action Plan: A new Ortho-Phthalaldehyde (OPA) Monitor Log has been created and used with the OPA "bucket". This monitor log will be used to verify that the OPA is being tested at the beginning of each work day and before each run cycle. This revised log will be added to the existing policy. Staff members will be made aware of the change at the staff meeting scheduled for 11/26. Estimated Completion Date: The OPA policy was revised on November 19, 2013. The staff meeting to make employees aware of the change will be held on November 16,</p>	11/19/2013

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S000436	<p>checked prior to each use. Per log, the solution is checked daily.</p> <p>3. Staff member #N5 indicated the following in interview beginning at 3:00 p.m. on 10/29/13: (A) The "bucket" of OPA is checked daily.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(v)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(v) Reuse of disposables. Based on observation, document review, and staff interview, the infection control committee failed to ensure the facility did not use single use items on more than one patient.</p> <p>Findings include:</p> <p>1. During observations beginning at 10:45 a.m. on 10/29/13, the following was observed:</p>	S000436	<p>2013. Actual Completion Date: pending</p> <p>Responsible Party: Infection Control Committee Action Plan: We have found replacement tubing that is not labeled for single patient use that will take the place of the suction connection tubing we currently use. Until that tubing arrives, we are discarding the tubing after each use. Estimated Completion Date: December 2, 2013 Actual Completion Date: pending</p>	12/02/2013

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S000650	<p>(A) The O2 connecting tubing was not changed after a procedure. The room was cleaned and utilized for another procedure.</p> <p>2. The package for the suction connecting tubing states on package: "Sterile Single use only".</p> <p>3. Staff member #N5 indicated the following in interview beginning at 3:00 p.m. on 10/29/13: (A) The suction connecting tubing is changed daily and not in between each patient.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(2)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(2) Appropriate medical history and results of a physical examination completed within the time frames in section 4(b)(3)(M) of this rule.</p> <p>Based on observation, staff interview and document review, the facility failed to ensure a history and physical exam was performed for 1 patient observation (patient #28).</p>	S000650	Responsible Party: Charge Nurse, Anesthesia Manager, Quality and Safety Improvement Committee Action Plan: Each physician and nurse anesthetist will be traced and audited on a quarterly basis by the charge	12/31/2013

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	<p>Findings include:</p> <ol style="list-style-type: none"> 1. During observation of patient #28 throughout his/her preop phase and procedure beginning at 10:45 a.m. on 10/29/13, the following was observed: (A) At no time did a physician or anesthesia provider do a physical assessment of the patient including, but not limited to, listening to the patients lungs sounds and heart. 2. M.D. #1 indicated in interview at 12:00 p.m. on 10/29/13 that the history and physical (H&P) is completed the day of the procedure and listening to the patients lungs is a shared responsibility between the physician and anesthesia. 3. Anesthesia provider #1 indicated in interview at 12:05 p.m. on 10/29/13 that listening to the patients lungs is a shared responsibility between the physician and anesthesia. 4. Review of patient #28 medical record stated the following: (A) "Physical exam was performed prior to anesthesia", cardiovascular: Auscultation: regular rate and rhythm. No murmur or gallop rub. ...Respiratory: Auscultation: clear to auscultation bilaterally." 		<p>nurse using the "PROCEDURAL COMPLIANCE TRACER" form. The Quality Coordinator will ensure that all providers are observed. The results of the physician's audits will be reported at the Governing Body and Medical Staff meeting, and the results of the anesthesia provider tracer will be reported at the Anesthesia Care Associates board meeting. . Estimated Completion Date: The tracer forms will be completed prior to December 6th.. The audits will begin for the 4th quarter of 2013 and will be completed in December. Results will be presented at the Governing Body and Medical Staff meeting and Anesthesia Care Associates meeting scheduled in January of 2014. Actual Completion Date: Re-education completed 11/11/2013 and 11/14/2013.</p>		

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S001008	<p>5. Facility policy titled "MEDIAL RECORDS" last reviewed/revised 5/10/12 states: "2. The patient's medical record must contain patient identification data.....history and physical,.... pre-operative physical exams....."</p> <p>6. Anesthesia policy titled "RECORD KEEPING" last reviewed/revised 10/16/13 states on page 28: "B. Appropriate physical examination, including vital signs and documentation of airway assessment."</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)</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>Based on documentation review and staff interview, the facility failed to ensure the consulting Pharmacist will conduct monthly compliance reviews as per ASC policy and procedure.</p>	S001008	Responsible Party: Charge Nurse, Surgery Center Director, Manager of Anesthesia Services, Quality and Safety Improvement Committee Action Plan: The policy "Pharmacist Consultant Services" was revised to read "A compliance review will be completed monthly by the	11/20/2013

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	<p>Findings included:</p> <ol style="list-style-type: none"> 1. Pharmacist Consultant Services policy (last approved November, 2012) states, "Monthly compliance review will be completed by the pharmacist or his/her designee (pharmacy tech)." 2. The facility provided 4 monthly inspections since December 10, 2012: 12/10/12, 6/3/13, 7/1/13, and 8/26/13. The facility did not provide 6 monthly inspections for the first 9 months of 2013: January, February, March, April, May, and September. 3. At 12:30 PM on 10/29/2013, staff member A2 confirmed the contracted consultant was not conducting monthly inspections for 2013 as per ASC policy. 		<p>pharmacist or his/her designee (pharmacy tech). The pharmacist will complete the review at least annually." In addition, the Charge Nurse and Endoscopy Center Director are meeting with the contracted pharmacist on November 20th to discuss the non-compliant issues and, based on outcome of the meeting, possibly contracting a different pharmacy consultant. This is the second such meeting and other options for reviewers are being investigated. Estimated Completion Date: The policy was revised on November 19, 2013. The meeting is scheduled for November 20, 2013 at 12:30 pm.</p>				

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S001164	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on documentation review and staff interview, the facility failed to perform daily maintenance checks on the defibrillator as required by the manufacturer's recommendations.</p> <p>Findings included:</p> <p>1. The Lifepak 20 Defibrillator/Monitor Operating</p>	S001164	<p>Responsible Party: Charge Nurse Action Plan: The policy "LifePAK and Crash Cart Maintenance" has been revised to read "An RN will be assigned to complete the LIFEPAK 20e Defibrillator Checklist daily, in accordance with Appendix D of the LIFEPAK 20e Defibrillator/Monitor Operator's Checklist". An in-service was held on November 20, 2013 to make all RN staff aware of the policy revisions. The Charge Nurse will keep completed checklists and will do monthly audits to verify compliance. Estimated</p>	11/21/2013

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	<p>Instructions daily recommended Maintenance Schedule states, "Complete Operator's Checklist (refer to Appendix D)." The Operator's daily checklist includes: Check printed results of daily auto tests, inspect physical condition, inspect power source, examine accessory cables, check ECG printer, perform Manual User Test if the daily auto test was interrupted.</p> <p>2. The Monthly Crash Cart Checks evidenced that manual defibrillator checks are completed once a month. The logs did not evidence the results from the daily auto tests nor any of the manufacturer's recommended operators daily maintenance checks.</p> <p>3. At 2:00 PM on 10/29/2013, staff member A2 confirmed the facility was not performing daily maintenance inspections of the Lifepak defibrillator as required by the manufacturer.</p>		<p>Completion Date: The policy was revised on November 19, 2013. The checklist will become mandatory on November 21, 2013. Actual Completion Date: 11/21/2013</p>	

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S001172	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: Based on observation, the facility failed to ensure the surgery center janitor's closet was maintained cleaned and organized.</p> <p>Findings included: At 2:25 PM on 10/29/2013, the surgery center janitor's closet was observed storing assorted</p>	S001172	<p>Responsible Party: Infection Control Nurse, Infection Control Committee Action Plan: The janitor's closet was cleaned and all unapproved items were discarded. The Infection Control policy titled "HOUSEKEEPING" was revised to read "No personal items or unapproved cleaners or chemicals may be stored in the janitor's closet. No items can be stored on floor; they must be stored on shelves." All employees will be made aware of the policy revision during the staff</p>	11/26/2013

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S001198	<p>chemicals, a container of cat litter, and assorted cleaning supplies directly on the floor and not on the shelves within the room. The floor was observed with soil residue and pieces of paper on the janitor closet's floor.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on documentation review and staff interview, the facility failed to provide evidence of any emergency disaster drills that were coordinated with appropriate community, state or federal agencies.</p> <p>Findings included:</p>	S001198	<p>meeting scheduled for November 26th. Estimated Completion Date: The policy was revised on November 19, 2013. It will be shared with the Infection Control Committee at a meeting on November 20, 2013 and shared with remaining staff members at a staff meeting on November 26th. Actual Completion Date: pending</p> <p>Responsible Party: Surgery Center Director/Safety Officer Action Plan: The Emergency Operations Plan has been revised to indicate that in addition to or coincidentally with the quarterly fire drills that are required according to the Life Safety Code at least one Emergency Disaster Drill will be completed per year. These will be documented in the Disaster Drill Report. We intend to complete these drills twice yearly in order to ensure they are completed at least annually.</p>	12/04/2013

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	<p>1. The 2013 Digestive Care Center Emergency Operation Plan specifies the center will conduct routine disaster drills to ensure all staff are familiarized with the evacuation plans.</p> <p>2. At 1:45 PM on 10/29/2013, staff member A2 indicated the only disaster drill the staff member knew the facility conducted was a tornado drill in May 2013. However, the staff member could not provide documented evidence of the tornado drill. Staff member A2 indicated he/she did not have any documented evidence of any emergency disaster drills the facility ever held.</p>		<p>Estimated Completion Date: 12/4/2013 Actual Completion Date: pending</p>	