

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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	
S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 003498</p> <p>Survey Date: 1/30/2013 through 1/31/2013</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 02/05/13</p>	S0000			

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: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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 QUALITY ASSESSMENT AND IMPROVEMENT 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 staff interview, the facility failed to ensure a process for monitoring 14 contracted services: Anesthesia, Biohazard Waste, Biomedical PM, Housekeeping, HVAC/Heating, Lab, Laundry, Maintenance, Medical Records, Pathology, Pest Control, Pharmacist, Radiology and Transcription.</p> <p>Findings included:</p> <p>1. The Endoscopy Center Quality Assurance Plan (approved 7/17/12) notes the Quality Assurance Committee shall be responsible for conducting, coordinating, and evaluating quality of care in the</p>	S0300	The Evaluation on Contracted Services has been changed to a numbered system instead of checkmarks indicating the parameters were reviewed. There were no issues to the contracted services in the year of minutes reviewed. The Executive Director will be responsible for the evaluation of the contracted services.	02/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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>center on an ongoing basis, including contracted services.</p> <p>2. The Quality Assurance Committee minutes were reviewed for 2012. In all four quarters of 2012, an Endoscopy Center Evaluation of Contract Services computer generated reports were presented to the committee each quarter. The report identifies 14 contracted services: Anesthesia, Biohazard Waste, Biomedical PM, Housekeeping, HVAC/Heating, Lab, Laundry, Maintenance, Medical Records, Pathology, Pest Control, Pharmacist, Radiology and Transcription, however, the reports lacked documentation on how each contracted service was reviewed in meeting its goals and criteria.</p> <p>3. At 10:00 AM on 1/31/2013, staff member #1 indicated the staff would provide information to him/her if one of the contracted services was not performing to par. The staff member indicated he/she does not have documentation or</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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	
	reports on how each contracted service is effective.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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			
S0432	<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 observation, policy and procedure review, manufacturer's directions, and interview, the infection control committee failed to ensure the appropriate rinsing procedures for high level disinfection were followed and failed to ensure chemicals were labeled appropriately.</p> <p>Findings included:</p> <p>1. During the tour of the facility on 01/30/13, beginning at 10:35 AM and accompanied by staff member #A5, the following observations were made:</p> <p>A. Two spray bottles containing a clear solution, with the labels shredding off and illegible, in the nurse station.</p> <p>B. One spray bottle containing a clear solution, with the label shredding off and illegible, in the cabinet in procedure room</p>	S0432	<p>1. New bottles have been purchased with legible labels of cleaning solutions. Endoscopy Charge Nurse is responsible to make sure legible labels are on bottles at all times. 2-5. Both policies have been changed to 3 separate rinses to reflect manufacturer's guidelines. Staff has been inserviced on new policy. Endoscopy Charge Nurse is responsible for compliance.</p>	02/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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>#1.</p> <p>C. One spray bottle containing a clear solution, with the label shredding off and illegible, in the Scope Processing Room.</p> <p>D. Two large, blue plastic basins on the counter in the Scope Processing Room, one labeled to soak instruments in Cidex OPA and the other labeled for rinsing the instruments.</p> <p>2. The facility policy "Cold Sterilization", last reviewed 03/20/12, indicated, "High level disinfection of instruments can be achieved by using cold sterilization methods according to manufacturer's recommendations. The [facility] utilizes Cidex OPA sterilant.</p> <p>...B. Rinse water: 1. Fill Rinse pan with filtered water daily. 2. Rinse instruments thoroughly."</p> <p>3. The facility policy "Reprocessing Savary Dilators", last reviewed 03/20/12, indicated, "6. Place dilator into OPA soak pan and use 10 cc syringe with metal attachment to instill OPA into internal channel. ...11. After soaking dilator in OPA use clean gloves to take dilator to rinse pan on clean side and place in water. 12. Use 10 cc syringe with metal attachment to squirt water through internal channel to rinse. 13. Take dilator out of water and squirt alcohol through internal channel. 14. Dry</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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>exterior of dilator with towels and blow dry interior channel with forced air. ...16. After each use of the savary cleaning brush, place brush in OPA for 12 minutes, rinse in water, dry and package for storage."</p> <p>4. The manufacturer's directions for Cidex OPA indicated, "B. Rinsing Procedure: Following removal from Cidex OPA Solution, thoroughly rinse the medical device by immersing it completely in a large volume (e.g. 2 gallons) of water. Use sterile water unless potable water is acceptable. Keep the device totally immersed for a minimum of 1 minute in duration, unless a longer time is specified by the reusable device manufacturer. Manually flush all lumens with large volumes (not less than 100 milliliters) of rinse water unless otherwise noted by the device manufacturer. Remove the device and discard the rinse water. Always use fresh volumes of water for each rinse. Do not reuse the water for rinsing or any other purpose. Repeat the procedure TWO (2) additional times, for a total of THREE (3) RINSES, with large volumes of fresh water to remove Cidex OPA Solution residues. Residues may cause serious side effects. SEE WARNINGS. THREE (3) SEPARATE, LARGE VOLUME WATER IMMERSION RINSES ARE</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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>REQUIRED."</p> <p>5. At 12:05 PM on 01/30/13, staff member #A6 indicated the lumens of the devices were handled 3 times, rinsing with water, squirting alcohol, and blowing air, but confirmed the process of 3 separate rinses was not followed. He/she also confirmed some of the instruments did not have lumens and just soaked once in the rinse basin.</p> <p>6. At 12:30 PM on 01/30/13, staff member #A5 confirmed the illegible labels on the spray bottles that he/she indicated was Cavicide. He/she indicated the bottles were refilled from a larger container of the chemical.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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			
S0442	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on policy review, employee medical file review, and interview, the facility failed to ensure all of their employees had reliable documentation of immunization status in 7 of 12 employee medical files reviewed (P1, P2, P5, P7, P9, P11, and P12).</p> <p>Findings included:</p> <p>1. The facility policy "Employee Physical Examination & Ongoing Health Assessment", last reviewed 03/20/12, indicated, "Health evaluations assure that employees' health is maintained in a manner that reduces the possibility of transmitting disease or infection to Center patients or other employees. A. All</p>	S0442	All employees will have blood drawn and immunization status documented. The Infection Control Preventionist is responsible for assuring compliance.	02/20/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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>employees shall undergo a pre-employment physical examination. 1. A complete medical history, including communicable diseases, i.e. Rubella, measles, mumps, tuberculosis, hepatitis, shigella, multi-drug resistant organisms, chronic skin lesions, will be completed by a physician. See attached 'Employee Communicable Disease History' example 'A'. 2. A pre-employment physical examination is performed by a physician of the Center's choice. See attached 'Employee Health Examination'."</p> <p>2. The medical files for staff members #P1, P2, P7, and P11 indicated the "Employee Communicable Disease History" filled out and signed by the employee (not the physician). The "Employee Health Examination" form was divided into 2 sections with the employee completing the top portion and a physician signing the bottom portion, "Physical Exam: To Be Completed By The Physician". Each employee self-attested to a history of Rubella, Rubeola, and Chicken Pox, but the files lacked any reliable verification of immunization.</p> <p>3. The medical file for staff member #P5 indicated the "Employee Communicable Disease History" filled out and signed by the employee (not the physician). The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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>"Employee Health Examination" form was divided into 2 sections with the employee completing the top portion and a physician signing the bottom portion, "Physical Exam: To Be Completed By The Physician". The employee self-attested to a history of Chicken Pox, but not Rubella or Rubeola. The file contained a copy of a titer that indicated nonimmune status to Rubeola.</p> <p>4. The medical file for staff member #P9 indicated the "Employee Communicable Disease History" filled out and signed by the employee (not the physician). The "Employee Health Examination" form was divided into 2 sections with the employee completing the top portion and a physician signing the bottom portion, "Physical Exam: To Be Completed By The Physician". The employee self-attested to a history of Chicken Pox and Rubeola, but not Rubella. The file lacked any reliable verification of immunization.</p> <p>5. The medical file for staff member #P12 indicated the "Employee Communicable Disease History" filled out and signed by the employee (not the physician). The "Employee Health Examination" form was divided into 2 sections with the employee completing the top portion and a physician signing</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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 bottom portion, "Physical Exam: To Be Completed By The Physician". The employee self-attested to a history of Rubella, Rubeola, and Chicken Pox and also indicated he/she had titers that demonstrated positive antibodies, but the file lacked any documentation of this.</p> <p>6. At 1:20 PM on 01/31/13, staff member #A1 indicated this practice had always been acceptable in the past, but acknowledged the physician signing the paperwork was a Center physician who did not really know the past history of the employees. Staff member #A1 confirmed the lack of reliable documentation of immunization status in the employee medical files.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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 PHARMACEUTICAL SERVICES 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 policy review, observation, and interview, the facility failed to follow their policies regarding multi-dose vials for 2 of 2 open vials observed and for removal of expired medication.</p> <p>Findings included:</p> <p>1. The facility policy "Pharmacy Services", last reviewed, 03/20/12, indicated, "No outdated or otherwise unusable drugs are stored in the Center."</p> <p>2. The facility policy "Medication Administration", last reviewed, 03/20/12, indicated, "1. After opening a multidose vial, always initial bottle. Always date bottle with date opened. Multidose vials will be good for 28 days after opening unless otherwise stated by manufacturer or becoming inadvertently contaminated."</p>	S1010	<p>Outdates will be checked on a monthly basis and removed as outdated. The Endoscopy Charge Nurse is responsible for overseeing this task. Policy and Procedures have been changed to state that multidose vials will be dated and initialed when opened and destroyed in 28 days. Staff has been inserved for clarification. Endoscopy Charge Nurse is responsible for overseeing this procedure.</p>	01/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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>3. During the tour of the center beginning at 11:00 AM on 01/30/13, accompanied by staff member #A5, the following observations were made:</p> <p>A. An open 20 milliliter vial of Ondansetron dated as opened on 12/18/12 at 1400 in the medication cabinet.</p> <p>B. Two of two 20 milliliter vials of 1% Lidocaine with a manufacturer's expiration date of 1 Jan. 2013 in the medication cabinet.</p> <p>C. One opened, but not dated, 20 milliliter vial of 1% Lidocaine with a manufacturer's expiration date of 1 Jan. 2013 in the drawer of the Mayo stand in the clean utility room.</p> <p>4. At 11:00 AM on 01/30/13, staff member #A5 confirmed the medications had expired and should have been removed, but indicated the pharmacist had indicated the opened multidose vials could be used until the manufacturer's expiration date.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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
S1146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</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>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, manufacturer's literature, and interview, the facility failed to maintain a safe environment for patients and staff in the Scope Processing Room and Procedure Rooms 1 and 2.</p> <p>Findings included:</p> <p>1. During the tour of the facility on 01/30/13, beginning at 11:00 AM and accompanied by staff member #A5, the following observations were made:</p> <p>A. A container of antiseptic handrub in a wall mounted holder without a spill tray, installed approximately 8-10 inches above a red electrical switch in Procedure Room #1.</p> <p>B. A container of antiseptic handrub in a wall mounted holder without a spill tray, installed approximately 7-8 inches above a red electrical switch in Procedure Room</p>			S1146	<p>The antiseptic handrub will be moved away from electrical switches. The Endoscopy Charge Nurse will be responsible for the completion of the change. On 2/4/13, the bottles were removed and an eye washing station was installed at the handwashing sink in the scope processing room. The Endoscopy Charge Nurse will be responsible to ensure it is checked regularly and documented.</p>		02/20/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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>#2. C. A wall mounted eye wash station containing two empty plastic bottles in the Scope Processing Room.</p> <p>2. The label on the Steris Alcare Plus antiseptic handrub indicated it contained 62% ethyl alcohol and a warning that the product was flammable, keep away from fire or flame.</p> <p>3. The instruction sheet for the Bel-Art Eye Wash Bottles indicated, "3. Under clean conditions, fill bottle completely. We recommend sterile eyewash solution refill... 6. Check and refill with new solution as outlined in steps 1-5 once every month."</p> <p>4. The manufacturer's literature for Cidex OPA, one of the chemicals used in the Scope Processing Room, indicated, "In case of eye contact, immediately flush eyes with large quantities of water for at least 15 minutes."</p> <p>5. At 12:05 PM on 01/30/13, staff member #A6 indicated the closest actual eye wash station was in the medication room, further than 50 feet away and through two doorways. Staff member #A5 indicated the bottles in the wall mounted unit weren't kept filled because they were unsure about expiration dates</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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	
	and what solution to use. Both staff confirmed a method for flushing the eyes was not immediately accessible.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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			
S1170	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on policy & procedure review, document review, manufacturer's recommendations, and interview, the facility failed to ensure defibrillator checks were done according to manufacturer's recommendations.</p> <p>Findings included:</p> <p>1. The facility policy "Daily Checklist-Crash Cart & Critical Equipment", last reviewed 03/20/12, indicated, "2. Check and/or test the functionality of the following equipment daily: a. Defibrillator/Monitor ...3. Record results</p>	S1170	The defibrillator will be discharged every patient care day. The Endoscopy Charge Nurse is responsible for assuring the defibrillator is discharged and documented every patient care day.	01/31/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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>of inspection on checklist." Attached to the policy were several pages from an Operator's Guide (no name identified) which indicated, "Delivered energy and discharge buttons check: Perform this check once a week."</p> <p>2. The facility "Daily Emergency Equipment Checklist" form indicated the defibrillator was to be charged once a month and the check marks on the forms from Oct. through Dec. 2012 indicated that was what was done.</p> <p>3. The 1990 Service Manual for the Zoll PD 1200 Pacemaker/Defibrillator for the defibrillator used in the facility, indicated part of the daily test routine was to ensure the Delivered Energy display on the monitor registered 200 joules and to press the Discharge button.</p> <p>4. During the tour of the facility at 11:40 AM on 01/30/13, staff member #A5 indicated the emergency equipment and crash cart were checked daily, the defibrillator was turned to 200 joules, but it was only discharged monthly according to the log.</p> <p>5. At 2:15 PM on 01/30/13, staff member #A6 indicated the nurses did discharge the defibrillator and run the strips during the daily checks, but could not provide</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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	
	any of the strips to verify this. Staff members #A5 and A6 confirmed the checks could not be verified since the logs indicated monthly discharging.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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			
S1182	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the Safety Inspection Forms are documented as required by the Center.</p> <p>Findings included:</p> <p>1. The Endoscopy Center meeting minutes were reviewed for the previous 4 quarters. The facility documents safety rounds on Safety Inspection Forms. The direction on the form states, "All areas reviewed must be rated using the following scale; 1. Acceptable safety level; 2. Needs Correction; 3. Not Applicable."</p> <p>2. Six Safety Inspection Forms</p>	S1182	The Safety Inspection forms will be completed as the scale indicates. The Endoscopy Charge Nurse is responsible for assuring the document is completed appropriately.	02/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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>were reviewed for 2012: 1/24/12, 2/5/12, 3/19/12, 7/3/12, 8/28/12, and 9/26/12. All 6 forms evidenced the facility was not adhering to the Safety Inspection Form directions. The facility was inserting a check-mark on each criteria the form identified. The facility was not identifying if the facility was or was not in compliance with the facility's Safety Program.</p> <p>3. At 11:30 AM on 1/31/2013, staff member #1 confirmed the safety inspection forms were not correctly filled out by staff.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032			
(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			
S1188	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on documentation review and staff interview, the facility failed to evaluate fire drills as defined in the facility's Fire Safety Plan.</p> <p>Findings included:</p> <p>1. Fire Safety Management Plan (approved 3/20/2012) states, "All fire drills will evaluated and critiqued for purpose of identifying deficiencies and opportunities for improvement. A written report documenting the evaluation of each</p>	S1188	The fire drills will be evaluated after each drill and documented. The Endoscopy Charge Nurse is responsible to assure the evaluation occurs with each drill.	02/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2013
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
(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>drill and the corrective actions recommended or taken for any deficiencies found will be completed by the Safety Officer and filed with the Safety Officer."</p> <p>2. The fire drills for 2012 were reviewed and documentation lacked evidence each fire drill being evaluated for purpose of identifying deficiencies and opportunities for improvement.</p> <p>3. At 12:30 PM on 1/30/2013, staff member #1 confirmed the fire drills were not being evaluated.</p>				