

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2011
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NAME OF PROVIDER OR SUPPLIER COMMUNITY CENTER FOR DIGESTIVE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011
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Q0000	<p>The visit was for a re-certification survey.</p> <p>Facility Number: 004174</p> <p>Survey Date: 11-28-11 to 11-30-11</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 12/07/11</p>	O0000		
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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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Q0105	<p>Emergency equipment available to the operating rooms must include at least the following:</p> <ul style="list-style-type: none"> (1) Emergency call system. (2) Oxygen. (3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. (4) Cardiac defibrillator. (5) Cardiac monitoring equipment. (6) Tracheostomy set. (7) Laryngoscopes and endotracheal tubes. (8) Suction equipment. (9) Emergency medical equipment and supplies specified by the medical staff. <p>Based on document review and interview, the facility failed to ensure that required emergency equipment was available for 2 of 9 items of required emergency equipment.</p> <p>Findings:</p> <p>1. The policy/procedure Emergency Crash Cart (reviewed 11-18-10) indicated the following: " A complete list of supplies, medications, and code flow sheet will be available on a clipboard on top of cart." The policy/procedure failed to indicate what emergency equipment was available if needed or otherwise specified by the medical staff.</p>	00105	The equipment was on the cart, Cardiac Monitor and Tracheostomy set, but not on the inventory. We have added this to the inventory sheet and to the policy on 12/1/11. We reviewed immediately with staff, and will review again on the 12/19/11 staff meeting. The Executive Director was responsible for correcting the deficiency.	12/01/2011
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	<p>2. The document Crash Cart Inventory (9/2011) failed to indicate that a cardiac monitor or tracheostomy set (including location of equipment) was available.</p> <p>3. During an interview on 11-29-11 at 1105 hours, staff #A1 confirmed that the policy/procedure and crash cart inventory lacked the required equipment.</p>			

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Q0141	<p>Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC.</p> <p>Based on observation, patient medical record review, policy and procedure review, and staff interview, the registered nurse supervisor failed to ensure that glucometer control solutions were dated, as per the manufacturer's recommendations, and failed to implement facility policy related to blood sugar checks prior to performing endoscopy procedures, for 1 of 1 patients who was insulin dependent diabetic (pt. N1).</p> <p>Findings:</p> <ol style="list-style-type: none"> review of the Accu-Check Advantage manufacturer's information related to "Control Testing" (found on line), indicated "When you first open the bottle, write the date on the label--the control solution is good for three months from that date or until the expiration date on the bottle, whichever comes first" while on tour of the facility on 11/28/11 at 3:55 PM, in the company of staff member NE, indicated: <ol style="list-style-type: none"> the control solutions, with expiration dates of 9/29/12, were not dated when 			Q0141	<p>We disposed of the unlabeled solutions and replaced them with dated bottles. We reviewed with staff and will review again on 12/19/11 in the staff meeting. We reviewed blood glucose policy with staff. The Policy was revised to add dating of the solutions and monitoring them for expiration. The Executive Director was responsible for the correction of the deficiency.</p>		12/01/2011

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	<p>opened, nor were they dated with a 3 month expiration date after they were opened</p> <p>3. interview with staff members NA, NB and NE at 4:00 PM on 11/28/11 indicated:</p> <p>a. it was unknwn by these staff members that an expiration date occurred three months, or 90 days, after opening the solutions</p> <p>b. it was unknown when the current control solutions had been opened, as they were not dated when opened</p> <p>c. the blood glucose testing policy does not address dating the control solutions at the time of openeing, or the three month expiration of solutions after opening</p> <p>4. at 4:00 PM on 11/28/11, review of the policy and procedure "Blood Glucose Testing", indicated:</p> <p>a. under "Policy", it reads: "Patients whose blood glucose levels are in question, or who are insulin controlled diabetics will have blood glucose testing performed."</p> <p>b. under "Procedure", it reads: "...3. The blood sugar level will be noted on the chart, as well as the time it was tested and person performing test..."</p> <p>5. at 12:15 PM on 11/28/11, review of patient medical records indicated pt. N1:</p>						

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	<p>a. was noted in the physician history, in the "health history comments" section, as: "...Endocrine: Diabetes mellitus, insulin dependent"</p> <p>b. listed home medications that included: "+ insulin smart pack flex pen"</p> <p>c. had no blood sugar check documentation found in the patient's medical record prior to the endoscopy procedure of 9/1/11</p> <p>6. interview with staff member NB at 4:00 PM on 11/28/11 indicated:</p> <p>a. there was no documented blood sugar check for pt. N1 prior to their endoscopy procedure of 9/1/11, as is required by facility policy</p>			

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Q0162	<p>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ol style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the accuracy of medical records for 2 of 20 patient records reviewed (pts. N11 and N17).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. at 10:45 AM on 11/28/11, review of the policy and procedure "Medical Records, Completion of Chart", indicated: <ol style="list-style-type: none"> a. under "Policy", it reads: "Per State and Federal regulations, Community Center for Digestive Care must ensure accurate and timely completion of a patient's medical record..." 	00162	The deficiencies on the records were reviewed with staff on the documentation. Policy will be reviewed on 12/19/11 at the staff meeting. The discrepancies on Physician pre op assessment of ASA was reviewed with the Medical Staff along with the policy. Both discrepancies on the medical records were reconciled and resolved. In order to insure adherence to the policy a QA study will be conducted for 6 months on medical records which includes the ASA documentation and med rec conciliation. We will audit 20 charts per month for compliance. On medical records the QA will be done monthly for 3 months and then quarterly if the goal of 90%	12/19/2011	

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	<p>2. review of patient medical records at 12:15 PM on 11/28/11 and 8:30 AM on 11/30/11, indicated:</p> <p>a. pt. N11 had documentation on 9/9/11 of an ASA (American Society of Anesthesiologists) level of II on the "Pre-Endoscopy History and Physical" and an ASA level of III on the "Immediate Pre-Anesthesia Assessment" form</p> <p>b. pt. N17 had physician orders on 9/13/11 for Fentanyl 100 mcg and Versed 10 mg, with the nursing staff only documenting 8 mg of Versed being administered on the "Nursing Procedure Report" form</p> <p>3. interview with staff member NB at 11:25 AM on 11/30/11 indicated:</p> <p>a. the medical record for pt. N11 had inaccurate documentation of the ASA level with the history and physical noting one level and the anesthesia documentation indicating a different level</p> <p>b. the Versed for pt. N17 was documented by nursing with 8 mg administered, but the physician documented 10 mg being given, indicating inaccurate documentation</p>		<p>adherence to the policy is met. The Executive Director was responsible for correcting the deficiency.</p>				

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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 patient medical record review, document review and staff interview, the facility failed to ensure the provision of patient rights information prior to each procedure performed for 1 of 1 patients who had a second procedure at the facility, failed to ensure the verbal notice of patient rights prior to the day of the procedure for 2 of 2 patients observed on 11/29/11 (pt. N4 and pts. N21 and N22) and failed to ensure that the patient rights document given to patients prior to the day of surgery included 6 of 14 required elements.</p> <p>Findings: 1. review of patient medical records at 12:15 PM on 11/28/11, indicated pt. N4 had: a. one endoscopy procedure on 5/13/11 and another on 9/1/11 b. had only one signed form in the medical record, related to the receipt of patient rights information, advance directives information, and physician ownership information, that was signed prior to the 5/13/11 procedure date</p>			O0221	<p>The Pt Rights are mailed out in the patient paperwork before their procedure and they are asked verbally on preop call if they have any questions. We are reviewing and revising policy and scheduling an inservice with the Dr's office staff that do registration and the staff at CCDC to go over the changes. We have updated the policy and reviewed with both the CCDC and the physician office staff to include explanation verbally of the patient rights to the patients. and also to state that a pt rights needs to be signed every time the patient comes in, not just once a year. The Executive Director was responsible for correcting the deficiency.</p>		12/16/2011

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	<p>2. interview of patients N21 and N22, who had endoscopy procedures observed by the surveyor on 11/29/11, indicated:</p> <p>a. neither patient remember receiving, either verbally or in writing, any information related to patient rights, even though they signed a form indicating they had received this information prior to the day of service</p> <p>b. both patients indicated they had received "a lot of paperwork in the mail", but did not read it all</p> <p>3. interview with staff member NA at 3:15 PM on 11/29/11, indicated:</p> <p>a. it was thought by facility staff that patients only needed to be informed of patient rights, advance directives, and physician ownership, once per year</p> <p>b. it was unknown that patient rights needed to be provided to patients prior to each procedure performed</p> <p>c. it cannot be determined that facility staff, or physician office staff, are explaining verbally to patients, their patient rights</p> <p>4. The policy/procedure Patient Rights And Advanced Directives (reviewed 11-18-10) failed to indicate or reference the specific patient rights information to be provided to the patient or the patient's</p>						

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	<p>representative in advance of the date of the procedure.</p> <p>5. Review of the facility document Community Center for Digestive Care Patient Rights & Responsibilities failed to indicate the following:</p> <p>a) The facility must provide the patient <u>or the patient's representative</u> with <u>verbal and written</u> notice of the patient's rights in advance <u>of the date</u> of the procedure.</p> <p>b) a clear statement indicating that their physician may have a financial interest or ownership in the facility.</p> <p>c) <u>the facility must provide the patient and/or their representative</u> in advance of the date of the procedure, with information concerning its policies on advance directives and <u>(upon request) official State advanced directive forms.</u></p> <p>d) all allegations of mistreatment, neglect, verbal, mental, sexual and/or physical abuse or any other serious allegations of harm will be promptly reported to a person in authority and fully documented and investigated. Any substantiated allegation will be reported to the State authority or the local authority, or both.</p> <p>e) the rights of the patient shall be exercised by the person appointed under State law to act on the patient's behalf when a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may</p>			
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	<p>exercise the patient's rights to the extent allowed by State law.</p> <p>f) the patient has the right to <u>receive care in a safe setting.</u></p> <p>6. During an interview on 11-29-11 at 1125 hours, staff #A1 confirmed that the patient rights and responsibilities document lacked the requirements indicated above and that the policy/procedure Patient Rights And Advanced Directives failed to indicate the required patient rights information to be provided to the patient.</p>				

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Q0222	<p>In addition, the ASC must - Post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients (or their representatives, if applicable) waiting for treatment. The ASC's notice of rights must include the name, address, and telephone number of a representative in the State agency to whom patients can report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman.</p> <p>Based on document review and interview, the facility failed to ensure that the posted patient rights document included 8 of 14 required elements.</p> <p>Findings:</p> <p>1. The policy/procedure Patient Rights And Advanced Directives (reviewed 11-18-10) failed to indicate or reference the specific patient rights information to be conspicuously posted in a public area of the center and failed to indicate the requirement that the patient rights would be conspicuously posted in a public area.</p> <p>2. Review of the Patient Rights & Responsibilities on display in the waiting and reception area failed to indicate the following:</p> <p>a) The facility must provide the patient <u>or the patient's representative</u> with <u>verbal and written</u></p>	00222	The Pt Rights are mailed out in the patient paperwork before their procedure and they are asked verbally on preop call if they have any questions. We are reviewing and revising policy and scheduling a inservice with the Dr's office staff that do registration and the staff at CCDC to go over the changes. We have updated the policy to state that a pt rights needs to be signed every time the patient comes in, not just once a year. We ensured that the patient rights included all of the 14 required elements. We reviewed with staff on 12/19/11 in the staff meeting. The corrected copy will be posted in the Lobby. The Executive Director was responsible for correcting the deficiency.	12/16/2011			

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	<p>notice of the patient's rights in advance <u>of the date</u> of the procedure.</p> <p>b) a clear statement indicating that their physician may have a financial interest or ownership in the facility.</p> <p>c) <u>the facility must provide the patient and/or their representative</u> in advance of the date of the procedure, with information concerning its policies on advance directives and <u>(upon request) official State advanced directive forms.</u></p> <p>d) all allegations of mistreatment, neglect, verbal, mental, sexual and/or physical abuse or any other serious allegations of harm will be promptly reported to a person in authority and fully documented and investigated. Any substantiated allegation will be reported to the State authority or the local authority, or both.</p> <p>e) the patient has the right to exercise his or her rights without <u>being subjected to discrimination</u> or reprisal.</p> <p>f) the patient has the right to voice grievances regarding treatment or care that is <u>(or fails to be)</u> furnished.</p> <p>g) the rights of the patient shall be exercised by the person appointed under State law to act on the patient's behalf when a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. 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>h) the patient has the right to <u>receive care in a safe setting.</u></p>			
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	<p>3. During an interview on 11-29-11 at 1125 hours, staff #A1 confirmed that the posted patient rights and responsibilities lacked the requirements indicated above and that the policy/procedure Patient Rights And Advanced Directives failed to indicate the required patient rights information to be conspicuously posted and the requirement that the patient rights would be conspicuously posted.</p>			
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NAME OF PROVIDER OR SUPPLIER COMMUNITY CENTER FOR DIGESTIVE CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011			
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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, the facility failed to follow its policy/procedure and ensure that written notice of physician financial interest or ownership was provided to patients prior to the date of the procedure.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Patient Rights and Advanced Directives (reviewed 11-18-10) indicated the following: " Physician ' s office gives patient information on patient rights, ownership (as applicable) and advanced directives. Physician ' s office faxes confirmation sheet with patient ' s signature and date to Community Center for Digestive Care. " 2. Review of the document Community Center for Digestive Care Patient Rights and Responsibilities failed to indicate a clear statement indicating some physicians may have a financial interest 	Q0223	The Physician ownership was updated to be more easily understandable by the recommendation from the ISDH surveyor. We are providing the updated document prior to the date of the procedure. The Executive Director was responsible for correcting the deficiency.	12/13/2011			

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	<p>or ownership in the center.</p> <p>3. The Patient Rights receipt confirmation indicated the following: " By signing below, I attest that I have received the following <u>prior to my date of surgery</u> ...[and] ... Notice of Legal Disclosure for [3 physicians] ... has a financial interest in ... Community Center for Digestive Care. "</p> <p>4. Review of 13 of 20 medical records (patient #5, 7-9, 11-20) indicated that the Patient Rights receipt confirmation was signed by the patient on the date of the procedure.</p> <p>5. During an interview on 11-30-11 at 0915 hours, staff #A1 confirmed that the Patient Rights and Responsibilities failed to indicate a clear statement indicating some physicians may have a financial interest or ownership in the center and that the Notice of Legal Disclosure failed to be provided in writing prior to the date of surgery for the majority of medical records reviewed.</p>			
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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 interview, the facility lacked a policy/procedure requiring the availability, if requested, of the State of Indiana Advanced Directives brochure for patients who do not have an advanced directive, to ensure the availability at the facility of a copy of the patient's advanced directive for patients who have an advanced directive, and to document prominently in the medical record when a patient has executed an advance directive and when a patient has provided a copy of their Advance Directives for the medical record.</p> <p>Findings:</p> <p>1. The policy/procedures Patient Rights and Responsibilities, Patient Rights and</p>	Q0224	We are updating the brochure for patients to the one that is on the website for the State of Indiana. The Nursing staff was inserviced on 12/19/11 about documenting in the Medical Record on the patient admission that they talked to the patient about Advanced Directives. The documentation of Advance Directives is part of the Medical Record audit. The Executive Director was responsible for correcting the deficiency.	12/19/2011	

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	<p>Advanced Directives, and Advanced Directives (all reviewed 11-18-10) failed to indicate or reference the specific <u>State</u> Advanced Directives information to be provided to the patient or the patient's representative in advance of the date of the procedure (whether requested or provided per policy) and failed to indicate how the facility would document in the medical record whether or not the patient had prepared an Advance Directive and if a copy of the document was received by the facility.</p> <p>2. Review of the facility document Community Center for Digestive Care Patient Rights & Responsibilities failed to indicate the patient right to receive a copy of the State Advanced Directive Brochure if requested.</p> <p>3. During an interview on 11-30-11 at 1150 hours, staff #A1 confirmed that the policy/procedures failed to indicate that State Advanced Directives information would be provided (whether by policy or if requested). Staff #A1 confirmed that the policy/procedures lacked the provisions for documenting in the</p>			

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	<p>medical record whether or not the patient had prepared an Advance Directive, and if a copy of the document was received by the facility. Staff #A1 confirmed that the Patients Rights & Responsibilities document failed to indicate the patient right to receive a copy of the State Advanced Directive Brochure if requested.</p>			
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Q0225	<p>(i) The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC.</p> <p>(v) The grievance process must specify timeframes for review of the grievance and the provisions of a response.</p> <p>(vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished.</p> <p>(vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.</p> <p>Based on document review and interview, the grievance policy/procedure failed to indicate criteria when a complaint must be regarded as a grievance and failed to indicate specific timeframes for grievance investigation, determination, and providing the written notification of determination to the patient.</p> <p>Findings:</p> <p>1. The facility policy/procedure Patient Complaint/Grievance (reviewed 11-18-10) lacked the following:</p> <p>a. criteria indicating when a complaint will be considered a grievance (complaint is submitted in writing, when requested</p>	O0225	We are revising the policy to indicate the difference between a complaint and a grievance, and also to include timeframes for following up with the complaint. The tracking form will be updated to include dates and timeframes of completion. We have added this to our quarterly QA monitoring. The Executive Director was responsible for correcting the deficiency.	12/15/2011			

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	<p>by patient, postponed for later resolution, any complaint requiring an investigation, or includes allegations of abuse or mistreatment).</p> <p>b. specific timeframes for investigation, review of results, and communicating the determination to the complainant.</p> <p>c. flowchart provision for response to allegations involving abuse, neglect or mistreatment.</p> <p>2. The document Patient Grievance Form and Patient Grievance/Complaint Tracking Form failed include a provision for recording a date when the form was initiated, investigation completed, or patient notified of the determination.</p> <p>3. During an interview on 11-29-11 at 1410 hours, staff#A1 confirmed that the policy/procedure failed to clearly identify when a complaint shall be treated as a grievance and failed to indicate specific timeframes for the grievance process.</p>			
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Q0226	<p>(ii) All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented.</p> <p>(iii) All allegations must be immediately reported to a person in authority in the ASC.</p> <p>(iv) Only substantiated allegations must be reported to the State authority or the local authority, or both.</p> <p>Based on document review and interview, the facility failed to ensure that substantiated allegations of abuse, neglect, or mistreatment will be reported to the State and/or the local authority.</p> <p>Findings:</p> <p>1. The policy/procedure Patient Rights And Advanced Directives (reviewed 11-18-10) failed to indicate or reference the specific patient rights information to be provided to the patient or the patient's representative in advance of the date of the procedure.</p> <p>2. Review of the facility document Community Center for Digestive Care Patient Rights & Responsibilities failed to indicate that all allegations of mistreatment, neglect, verbal, mental, sexual and/or physical abuse or any other serious allegations of harm will be promptly reported to a person in authority and fully documented and investigated.</p>			Q0226	<p>We are revising the policy to state all allegations of mistreatment, neglect, verbal, mental, sexual and/or physical abuse or any other serious allegations of harm will be promptly reported to a person in authority and fully documented and investigated. Any substantiated allegation will be reported to the State authority or the local authority, or both. The Executive Director was responsible for correcting the deficiency.</p>		12/15/2011

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	<p>Any substantiated allegation will be reported to the State authority or the local authority, or both.</p> <p>3. The facility policy/procedure Patient Complaint/Grievance (reviewed 11-18-10) failed to clearly indicate that all substantiated allegations of mistreatment, neglect, verbal, mental, sexual and/or physical abuse will be reported to the State authority, local authority, or both.</p> <p>4. During an interview on 11-30-11 at 1130 hours, staff #A1 confirmed that the Patient Rights & Responsibilities document lacked the provision for abuse allegations indicated above and confirmed that the Patient Complaint/Grievance policy/procedure failed to clearly indicate that all substantiated allegations of abuse will be reported.</p>				

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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 Patient Rights and Responsibilities failed to indicate the exercise of patient rights by the legal representative when the patient is determined to be incompetent by a court of law or otherwise where a patient may have designated a legal representative to exercise the patient's rights.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Patient Rights and Responsibilities (reviewed 11-18-10) failed to indicate or reference the specific patient rights information to be provided to the patient or the patient's representative in advance of the date of the procedure. Review of the facility document Community Center for Digestive Care 	O0230	We have revised the policy to include Pt Rights for a patient representative for an incompetent patient or any legal representative in accordance to state law. The Executive Director was responsible for correcting the deficiency.	12/16/2011			

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	<p>Patient Rights & Responsibilities failed to indicate the following: The rights of the patient may be exercised by the person appointed under State law to act on the patient's behalf when a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. 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>3. During an interview on 11-30-11 at 1150 hours, staff #A1 confirmed that the Patient Rights & Responsibilities document lacked the provision for the exercise of patient rights when the patient is not competent.</p>			

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Q0242	<p>The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.</p> <p>Based on facility policy and procedure review, personnel file review, and staff interview, the facility failed to implement its employee health policy related to communicable disease immunity and failed to ensure an effective infection control plan was created related to non immune employees for 3 of 7 employee files reviewed (P1, P3 and P4).</p> <p>Findings:</p> <p>1. at 2:35 PM on 11/29/11, review of the policy and procedure "Employee Statement of Health", indicated:</p> <p>a. under "Procedure", it reads: "...2. Each employee will have documentation of either vaccination or immunity to Rubella, Rubeola and Chicken Pox..."</p> <p>2. review of personnel health files at 1:55 PM on 11/29/11 indicated:</p> <p>a. staff member P1 had verbally attested to having had Chicken Pox as a child, with a Nurse Practitioner signing off on this self reporting</p> <p>b. staff member P3 was lacking documentation of a second Rubella,</p>	O0242	<p>We will be interviewing each employee if they can produce acceptable documentation that shows immunity. If they are not able to, then a titer will be drawn and protocol followed. The protocol for following the CDC guidelines is being followed up by Employee Health. The first group will be done by 12/30/11 and the next group will be done by 1/30/12. The Executive Director was responsible for correcting the deficiency.</p>	12/15/2011			

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	<p>documentation indicated one MMR (measles, mumps, rubella) was administered 4/25/85</p> <p>c. staff member P4 had a non-immune ("less than 5.0 IU/ml") result for Rubella on 10/18/02, but this was blacked out and "Immune in '92" was written in with no indication of who made the notation</p> <p>3. interview with staff members NA, NB and NE at 4:00 PM on 11/29/11, indicated:</p> <p>a. another document for staff member P4 was received by employee health and indicated that on 12/9/04 at 8:50 AM, a Nurse Practitioner wrote "doesn't need Rubella Booster" (on the non-immune Rubella lab form)</p> <p>b. a Nurse Practitioner acceptance of self reported communicable disease history is not addressed in the facility policy related to health history information</p> <p>c. there is nothing in the facility health policy, or infection control plan, that allows a Nurse Practitioner to override policy and determine that employees with non-immune status indicated by lab results, are deferred from receiving a booster</p> <p>d. the facility follows CDC (Centers for Disease Control and Prevention), but it was unknown that two Rubella immunizations are required, not just one,</p>			
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	<p>as was the case for staff member P3, by CDC recommendations</p> <p>e. the infection control plan and facility policy do not address how employees with non-immune communicable disease results will be handled--what recommendations will be made, such as boosters recommended/required, or staff off work during an outbreak, etc.</p>			
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Q0243	<p>The program is - Under the direction of a designated and qualified professional who has training in infection control.</p> <p>Based on employee file review, job description review, and staff interview, the facility failed to ensure the qualification and continuing education of the infection control officer (staff member P7/NB).</p> <p>Findings:</p> <p>1. at 1:55 PM on 11/29/11, review of personnel files indicated:</p> <p>a. staff member P7 was the facility infection control practitioner/officer</p> <p>b. the job description for the "Infection Control Officer" indicated in section: "II. Functions and Duties/Responsibilities", in item H., "Attends ongoing education on infection control."</p> <p>c. had documentation in the file of the last 10 hour infection control education program as 10/09</p> <p>2. interview with staff member NB at 4:00 PM on 11/29/11 indicated:</p> <p>a. a few on line webinars have been viewed by the infection control practitioner, but there is no documentation of this in the personnel file</p> <p>b. no on going education documentation can be provided since the session of October 2009</p> <p>c. the intent of the job description has</p>	Q0243	The infection control officer had been in attendance at the VEI infection control meetings and has completed webinar's but did not print out CE documentation. She has been instructed to print out documentation for her file. She has completed one CE since the surveyor was here. The Executive Director was responsible for correcting the deficiency.	12/12/2011			

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	not been met			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/30/2011
NAME OF PROVIDER OR SUPPLIER COMMUNITY CENTER FOR DIGESTIVE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011		
(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	
Q0261	<p>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.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that a history and physical examination was completed prior to the endoscopy procedure for 20 of 20 records reviewed (N1 through N20).</p> <p>Findings:</p> <ol style="list-style-type: none"> review of the policy and procedure "Medical Record Composition" at 10:45 AM on 11/28/11, indicated: <ol style="list-style-type: none"> under "Procedure", in item 3. "Responsibilities", it reads: "...b. The History & Physical and the Pre-Anesthesia Evaluation will be completed by the physician before the procedure begins." review of patient medical records through out the survey process of 11/28/11 to 11/30/11, indicated: <ol style="list-style-type: none"> the electronic signature by the physician, documenting a pre surgery history and physical for each patient record, had a time that was after the time the procedure had ended for every record, 	00261	The history and physical was completed as is always prior to the procedure as witnessed by the surveyor. The software vendor was contacted the day of survey and corrected the timing of the H&P. A QA study will be initiated during the 1st quarter of 2012 by medical records consultant. The Executive Director will be responsible for correcting the deficiency.	11/30/2011	

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	N1 through N20 3. interview with staff member NB at 4:00 PM on 11/29/11, indicated: a. the physicians are performing the history and physical examinations prior to the endoscopy procedures, but the electronic system does not capture this time accurately, it only shows the time the physician signs off on a chart once the procedure is completed			
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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 policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that the pre surgery/anesthesia assessment was completed prior to the endoscopy procedure for 20 of 20 records reviewed (N1 through N20).</p> <p>Findings:</p> <ol style="list-style-type: none"> review of the policy and procedure "Medical Record Composition" at 10:45 AM on 11/28/11, indicated: <ol style="list-style-type: none"> under "Procedure", in item 3. "Responsibilities", it reads: "...b. The History & Physical and the Pre-Anesthesia Evaluation will be completed by the physician before the procedure begins." review of patient medical records through out the survey process of 11/28/11 to 11/30/11, indicated: <ol style="list-style-type: none"> the electronic signature by the 	00262	The history and pre anesthesia evaluation was completed as is always prior to the procedure as witnessed by the surveyor. The software vendor was contacted the day of survey and corrected the timing of the H&P. A QA study will be initiated during the 1st quarter of 2012 by medical records consultant. The Executive Director will be responsible for correcting the deficiency.	11/30/2011	

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	<p>physician, documenting a pre anesthesia evaluation for each patient record, had a time that was after the time the procedure had started for every record, N1 through N20</p> <p>3. interview with staff member NB at 4:00 PM on 11/29/11, indicated:</p> <p>a. the physicians are performing the pre anesthesia evaluations prior to the endoscopy procedures, but the electronic system does not capture this time accurately, it only shows the time the physician signs off on a chart once the procedure is completed</p>			
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S0148	<p>410 IAC 15-2.4-1 (c) (4)</p> <p>(c) The governing body shall do the following:</p> <p>(4) Require that the chief executive officer designate in writing an administrative officer to serve during his or her absence.</p> <p>Based on document review and interview, the executive director failed to clearly indicate in writing who would be in charge when the chief executive officer was not present.</p> <p>Findings:</p> <p>1. The policy/procedure Absence of Executive Director (reviewed 11-18-10) indicated that a clinical coordinator would be in charge and that there were two clinical coordinators at all times. The policy/procedure failed to indicate a hierarchy or primary and first alternate in command when the administrator was unavailable.</p> <p>2. During an interview on 11-30-11 at 1220 hours, staff #A1 confirmed the policy/procedures failed to indicate which one of two coordinators would serve as the responsible person for the center.</p>	S0148	The policy has been updated to state who will be in charge when the Executive Director is gone. The RN Coordinator will be in charge in the absence of the Executive Director. If both are gone then the Charge Nurse will be in charge. The Executive Director was responsible for correcting the deficiency.	12/05/2011			

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S0162	<p>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 interview, the center failed to ensure that all health care workers maintained Cardiopulmonary Resuscitation (CPR) competency for 4 of 8 credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of physician credential files indicated 4 (P20, P21, P22, and P23) files lacked evidence of current CPR competency. 2. During an interview on 11-30-11) at 1315 hours, staff #A1 confirmed that the facility files lacked documentation of CPR. 	S0162	<p>The deficiencies on the records were reviewed with staff on the documentation. Policy will be reviewed on 12/19/11 at the staff meeting. The discrepancies on Physician pre op assessment of ASA was reviewed with the Medical Staff along with the policy. Both discrepancies on the medical records were reconciled and resolved. In order to insure adherence to the policy a QA study will be conducted for 6 months on medical records which includes the ASA documentation and med rec conciliation. We will audit 20 charts per month for compliance. On medical records the QA will be done monthly for 3 months and then quarterly if the goal of 90% adherence to the policy is met. The Executive Director was responsible for correcting the deficiency.</p>	12/06/2011	

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S0176	<p>410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on policy and procedure review, staff "Meeting/Inservice Attendance Sheet" form review, and staff interview, the facility failed to ensure that skills competencies were performed by nursing staff for the glucometer and the urine pregnancy tests done at the facility.</p> <p>Findings:</p> <p>1. at 4:00 PM on 11/29/11, review of the policy "Blood Glucose Testing", indicated:</p> <p>a. under "Procedure", it reads: "...2. The Nurse will follow the glucometer recommendations in the manual and will be tested annually for competency..."</p> <p>2. at 2:35 PM on 11/29/11, review of the policy and procedure "Employee Orientation and Education", indicated:</p> <p>a. under "Policy", it reads: "...Employees will participate in ongoing assessments and competency reviews to remain current on necessary clinical and administrative skills..."</p>	S0176	The staff will be checked off at the 12/19/11 staff meeting. This will be part of the mandatory inservices that are done annually by the VEI education coordinator. The Executive Director will be responsible for correcting the deficiency.	12/19/2011			

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	<p>3. at 2:40 PM on 11/29/11, review of the staff "Meeting/Inservice Attendance Sheet" where the "Subject" was "Review Accu Check" on 2/11, indicated:</p> <ul style="list-style-type: none"> a. the form listed "Presented By:..." and had a staff RN (registered nurse) listed as the presenter b. the nursing staff signed the form between 2/16/11 and 3/7/11 <p>4. at 2:40 PM on 11/29/11, review of the staff "Meeting/Inservice Attendance Sheet" where the "Subject" was "Pregnancy test" on 4/6/10, indicated:</p> <ul style="list-style-type: none"> a. the form listed "Presented By:..." and had a staff RN listed as the presenter b. the nursing staff signed the form with two signing "reviewed" and the date they had reviewed the instruction related to pregnancy testing <p>5. interview with staff member NB at 4:00 PM on 11/29/11, indicated:</p> <ul style="list-style-type: none"> a. no competency testing was done of the nursing staff for either the pregnancy tests or the glucometer testing during the April 2010 and February 2011 inservices b. the inservices were instructional/informative only c. urine pregnancy test inservices are only done every two years d. the policy related to employee orientation and education does not 			
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	address competency checking for urine pregnancy testing or glucometer checks			

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S0226	<p>410 IAC 15-2.4-1(e)(3)</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>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review, the facility failed to maintain a list of all contracted services, including the scope and nature of services provided, for 4 of 22 services.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a list of contracted services provided by staff #A1 failed to indicate a service provider for the emergency generator, endoscopes, medical record consultant, and patient carts and wheelchairs. Review of facility documentation indicated that emergency generator service was provided by V 1, endoscope support was provided by V 2, medical record consulting was provided by V 3, and cart and wheelchair preventive maintenance was provided by V 4. On 11-30-11 at 1730 hours, staff #A1 confirmed that the center failed to maintain a list of contracted services. 	S0226	<p>We updated the contracted services list and quarterly review sheet. The list of contracted services was immediately updated after the surveyors left to include the Emergency Generator, Endoscopes, Med Rec Consultant, and Patient Carts/Wheelchairs. As a new contracted service is added we will update the lists to provide both the contractor and the nature of services provided. The Executive Director was responsible for correcting the deficiency.</p>	12/12/2011
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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 evaluate 4 contracted services (emergency generator maintenance, endoscope service, medical record consulting, and patient carts and wheelchair maintenance provider) through the Quality Assessment and Performance Improvement (QAPI) program.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The Quality Assurance and Improvement Review Process (reviewed 11-18-10) indicated the following: "The QA review will include review of ... Contractor Services." 2. The document Quality Resources Contracted Service Review 3rd Quarter 2011 lacked evidence of monitoring for the emergency generator provider, endoscope service provider, medical record consultant, and patient carts and wheelchair maintenance provider. 3. Review of facility documentation 	S0310	We updated the contracted services list and quarterly QA review sheet. As a new contracted service is added we will update the lists. The Executive Director was responsible for correcting the deficiency.	12/12/2011	

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	<p>indicated that emergency generator maintenance was performed by V 1, endoscope service and support was provided by V 2, medical record consulting was provided by V 3, and patient cart and wheelchair maintenance was performed by V 4.</p> <p>4. On 11-30-11 at 1255 hours, staff #A1 confirmed that the center failed to follow its policy/procedure for the QA program to document ongoing monitoring of contracted services for 4 vendors.</p>				

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S0408	<p>410 IAC 15-2.5-1(d)</p> <p>(d) The center shall designate a person qualified by training or experience as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on employee file review, job description review, and staff interview, the facility failed to ensure the qualification and continuing education of the infection control officer (staff member P7/NB).</p> <p>Findings:</p> <p>1. at 1:55 PM on 11/29/11, review of personnel files indicated:</p> <p>a. staff member P7 was the facility infection control practitioner/officer</p> <p>b. the job description for the "Infection Control Officer" indicated in section: "II. Functions and Duties/Responsibilities", in item H., "Attends ongoing education on infection control."</p> <p>c. had documentation in the file of the last 10 hour infection control education program as 10/09</p> <p>2. interview with staff member NB at 4:00 PM on 11/29/11 indicated:</p> <p>a. a few on line webinars have been viewed by the infection control practitioner, but there is no documentation of this in the personnel file</p>			S0408	<p>The infection control officer had been in attendance at the VEI infection control meetings and has completed webinar's but did not print out CE documentation. She has been instructed to print out documentation for her file. The Executive Director was responsible for correcting the deficiency.</p>		12/12/2011

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	<p>b. no on going education documentation can be provided since the session of October 2009</p> <p>c. the intent of the job description has not been met</p>			

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S0442	<p>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 facility policy and procedure review, personnel file review, and staff interview, the facility failed to implement its employee health policy related to communicable disease immunity and failed to ensure an effective infection control plan was created related to non immune employees for 3 of 7 employee files reviewed (P1, P3 and P4).</p> <p>Findings:</p> <p>1. at 2:35 PM on 11/29/11, review of the policy and procedure "Employee Statement of Health", indicated:</p> <p>a. under "Procedure", it reads: "...2. Each employee will have documentation of either vaccination or immunity to Rubella, Rubeola and Chicken Pox..."</p>	S0442	We will be interviewing each employee if they can produce acceptable documentation that shows immunity. If they are not able to, then a titer will be drawn and protocol followed. The protocol for following the CDC guidelines is being followed up by Employee Health. The Executive Director was responsible for correcting the deficiency.	12/15/2011			

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	<p>2. review of personnel health files at 1:55 PM on 11/29/11 indicated:</p> <p>a. staff member P1 had verbally attested to having had Chicken Pox as a child, with a Nurse Practitioner signing off on this self reporting</p> <p>b. staff member P3 was lacking documentation of a second Rubella, documentation indicated one MMR (measles, mumps, rubella) was administered 4/25/85</p> <p>c. staff member P4 had a non-immune ("less than 5.0 IU/ml") result for Rubella on 10/18/02, but this was blacked out and "Immune in '92" was written in with no indication of who made the notation</p> <p>3. interview with staff members NA, NB and NE at 4:00 PM on 11/29/11, indicated:</p> <p>a. another document for staff member P4 was received by employee health and indicated that on 12/9/04 at 8:50 AM, a Nurse Practitioner wrote "doesn't need Rubella Booster" (on the non-immune Rubella lab form)</p> <p>b. a Nurse Practitioner acceptance of self reported communicable disease history is not addressed in the facility policy related to health history information</p> <p>c. there is nothing in the facility health policy, or infection control plan, that allows a Nurse Practitioner to override</p>			
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	<p>policy and determine that employees with non-immune status indicated by lab results, are deferred from receiving a booster</p> <p>d. the facility follows CDC (Centers for Disease Control and Prevention), but it was unknown that two Rubella immunizations are required, not just one, as was the case for staff member P3, by CDC recommendations</p> <p>e. the infection control plan and facility policy do not address how employees with non-immune communicable disease results will be handled--what recommendations will be made, such as boosters recommended/required, or staff off work during an outbreak, etc.</p>			
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S0612	<p>410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the accuracy of medical records for 2 of 20 patient records reviewed (pts. N11 and N17).</p> <p>Findings:</p> <p>1. at 10:45 AM on 11/28/11, review of the policy and procedure "Medical Records, Completion of Chart", indicated:</p> <p>a. under "Policy", it reads: "Per State and Federal regulations, Community Center for Digestive Care must ensure accurate and timely completion of a patient's medical record..."</p> <p>2. review of patient medical records at 12:15 PM on 11/28/11 and 8:30 AM on 11/30/11, indicated:</p> <p>a. pt. N11 had documentation on 9/9/11 of an ASA (American Society of Anesthesiologists) level of II on the "Pre-Endoscopy History and Physical" and an ASA level of III on the</p>			S0612	<p>The deficiencies on the records were reviewed with staff on the documentation. Policy will be reviewed on 12/19/11 at the staff meeting. The discrepancies on Physician pre op assessment of ASA was reviewed with the Medical Staff along with the policy. The Executive Director was responsible for correcting the deficiency.</p>		12/19/2011

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	<p>"Immediate Pre-Anesthesia Assessment" form</p> <p>b. pt. N17 had physician orders on 9/13/11 for Fentanyl 100 mcg and Versed 10 mg, with the nursing staff only documenting 8 mg of Versed being administered on the "Nursing Procedure Report" form</p> <p>3. interview with staff member NB at 11:25 AM on 11/30/11 indicated:</p> <p>a. the medical record for pt. N11 had inaccurate documentation of the ASA level with the history and physical noting one level and the anesthesia documentation indicating a different level</p> <p>b. the Versed for pt. N17 was documented by nursing with 8 mg administered, but the physician documented 10 mg being given, indicating inaccurate documentation</p>				

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S0772	<p>410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that a history and physical examination was completed prior to the endoscopy procedure for 20 of 20 records reviewed (N1 through N20).</p> <p>Findings: 1. review of the policy and procedure</p>	S0772	The history and physical was completed as is always prior to the procedure as witnessed by the surveyor. The software vendor was contacted the day of survey and corrected the timing of the H&P. A QA study will be initiated during the 1st quarter of 2012 by medical records consultant. The Executive Director will be responsible for correcting the deficiency.	11/30/2011
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	<p>"Medical Record Composition" at 10:45 AM on 11/28/11, indicated:</p> <p>a. under "Procedure", in item 3. "Responsibilities", it reads: "...b. The History & Physical and the Pre-Anesthesia Evaluation will be completed by the physician before the procedure begins."</p> <p>2. review of patient medical records through out the survey process of 11/28/11 to 11/30/11, indicated:</p> <p>a. the electronic signature by the physician, documenting a pre surgery history and physical for each patient record, had a time that was after the time the procedure had ended for every record, N1 through N20</p> <p>3. interview with staff member NB at 4:00 PM on 11/29/11, indicated:</p> <p>a. the physicians are performing the history and physical examinations prior to the endoscopy procedures, but the electronic system does not capture this time accurately, it only shows the time the physician signs off on a chart once the procedure is completed</p>			
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S0832	<p>410 IAC 15-2.5-4(c)(1)(F)(ii)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and postanesthesia as follows:</p> <p>(ii) The completion by the practitioner administering anesthesia of intra-operative anesthesia monitoring and notations, to include vital signs, on each patient in accordance with the center policy.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that the pre surgery/anesthesia assessment was completed prior to the endoscopy procedure for 20 of 20 records reviewed (N1 through N20).</p> <p>Findings:</p> <p>1. review of the policy and procedure "Medical Record Composition" at 10:45 AM on 11/28/11, indicated:</p> <p>a. under "Procedure", in item 3. "Responsibilities", it reads: "...b. The History & Physical and the Pre-Anesthesia Evaluation will be completed by the physician before the procedure begins."</p>	S0832	The history and pre anesthesia evaluation was completed as is always prior to the procedure as witnessed by the surveyor. The software vendor was contacted the day of survey and corrected the timing of the H&P. A QA study will be initiated during the 1st quarter of 2012 by medical records consultant. The Executive Director will be responsible for correcting the deficiency.	11/30/2011			

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	<p>2. review of patient medical records through out the survey process of 11/28/11 to 11/30/11, indicated:</p> <p>a. the electronic signature by the physician, documenting a pre anesthesia evaluation for each patient record, had a time that was after the time the procedure had started for every record, N1 through N20</p> <p>3. interview with staff member NB at 4:00 PM on 11/29/11, indicated:</p> <p>a. the physicians are performing the pre anesthesia evaluations prior to the endoscopy procedures, but the electronic system does not capture this time accurately, it only shows the time the physician signs off on a chart once the procedure is completed</p>				

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S0862	<p>410 IAC 15-2.5-4(d)(2)(C)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(C) A provision for the following equipment and supplies to be available to the surgical and recovery areas:</p> <p>(i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff.</p> <p>Based on document review, observation and interview, the center failed to ensure that mandatory emergency equipment was available for 3 of 9 items of required emergency equipment and failed to ensure that 4 items indicated on an emergency equipment checklist were available if needed.</p> <p>Findings:</p>	S0862	The equipment was on the cart, Cardiac Monitor and Tracheostomy set, but not on the inventory. We have added this to the inventory sheet and to the policy on 12/1/11. We reviewed immediately with staff, and will review again at the 12/19/11 staff meeting. The missing supplies were restocked immediately. The cart will be inventoried monthly and if anything is used from the cart it is to be replaced immediately. The Executive Director was responsible for correcting the deficiency.	12/01/2011			

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	<p>1. The policy/procedure Emergency Crash Cart (reviewed 11-18-10) indicated the following: " A complete list of supplies, medications, and code flow sheet will be available on a clipboard on top of cart. " The policy/procedure failed to indicate what emergency equipment was available if needed or otherwise specified by the medical staff.</p> <p>2. The document Crash Cart Inventory (9/2011) failed to indicate that a cardiac monitor, tracheostomy set, or oximeter (including location of equipment) was available.</p> <p>3. On 11-29-11 at 1220 hours, during an inventory of the center crash cart contents, the following emergency supplies and equipment were not available as indicated on the Crash Cart Inventory (9/2011):</p> <ul style="list-style-type: none"> a) One of two boxes of gloves b) One 30 French (30F) Nasal Pharyngeal (NP) Airway c) One pair of bandage scissors d) One of two 1000ml bags of 5% Dextrose Water & 0.45% Sodium Chloride 			
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	4. During an interview on 11-29-11 at 1105 hours, staff #A1 confirmed that the policy/procedure and crash cart inventory lacked the required equipment.			
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S0900	<p>410 IAC 15-2.5-5(a)</p> <p>(a) All patient care services must meet the needs of the patient, within the scope of the service offered, in accordance with acceptable standards of practice. Patient care services must be under the direction of a qualified person or persons. Patient care services must require the following:</p> <p>Based on observation, patient medical record review, policy and procedure review, and staff interview, the registered nurse supervisor failed to ensure that glucometer control solutions were dated, as per the manufacturer's recommendations, and failed to implement facility policy related to blood sugar checks prior to performing endoscopy procedures, for 1 of 1 patient who was insulin dependent diabetic (pt. N1).</p> <p>Findings:</p> <ol style="list-style-type: none"> review of the Accu-Check Advantage manufacturer's information related to "Control Testing" (found on line), indicated "When you first open the bottle, write the date on the label--the control solution is good for three months from that date or until the expiration date on the bottle, whichever comes first" while on tour of the facility on 11/28/11 at 3:55 PM, in the company of 			S0900	<p>We disposed of the unlabeled solutions and replaced them with dated bottles. The medication nurse will be monitoring the solution for dating and expiration date. We reviewed with staff and will review again on 12/19/11 in the staff meeting. We reviewed blood glucose policy with staff. We addressed with the staff immediately about the discrepancy of the citation of blood sugar not being documented on an insulin dependent patient. The Executive Director was responsible for the correction of the deficiency.</p>		12/01/2011

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	<p>staff member NE, indicated:</p> <ul style="list-style-type: none"> a. the control solutions, with expiration dates of 9/29/12, were not dated when opened, nor were they dated with a 3 month expiration date after they were opened <p>3. interview with staff members NA, NB and NE at 4:00 PM on 11/28/11 indicated:</p> <ul style="list-style-type: none"> a. it was unknwn by these staff members that an expiration date occurred three months, or 90 days, after opening the solutions b. it was unknown when the current control solutions had been opened, as they were not dated when opened c. the blood glucose testing policy does not address dating the control solutions at the time of openeing, or the three month expiration of solutions after opening <p>4. at 4:00 PM on 11/28/11, review of the policy and procedure "Blood Glucose Testing", indicated:</p> <ul style="list-style-type: none"> a. under "Policy", it reads: "Patients whose blood glucose levels are in question, or who are insulin controlled diabetics will have blood glucose testing performed." b. under "Procedure", it reads: "...3. The blood sugar level will be noted on the chart, as well as the time it was tested and person performing test..." 			
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	<p>5. at 12:15 PM on 11/28/11, review of patient medical records indicated pt. N1:</p> <p>a. was noted in the physician history, in the "health history comments" section, as: "...Endocrine: Diabetes mellitus, insulin dependent"</p> <p>b. listed home medications that included: "+ insulin smart pack flex pen"</p> <p>c. had no blood sugar check documentation found in the patient's medical record prior to the endoscopy procedure of 9/1/11</p> <p>6. interview with staff member NB at 4:00 PM on 11/28/11 indicated:</p> <p>a. there was no documented blood sugar check for pt. N1 prior to their endoscopy procedure of 9/1/11, as is required by facility policy</p>			
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NAME OF PROVIDER OR SUPPLIER COMMUNITY CENTER FOR DIGESTIVE CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011			
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S1166	<p>410 IAC 15-2.5-7(b)(4)(B)(ii)</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>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on document review and interview, the center failed to ensure that preventive maintenance (PM) was performed in accordance with the manufacturer ' s recommendations for its Automatic External Defibrillator (AED).</p> <p>Findings:</p> <p>1. The policy/procedure Defibrillation (reviewed 11-18-10) indicated the following: "The AED ...will be checked and preventive maintenance performed according to the manufacturer's recommendations."</p> <p>2. The Operations and Service Manual for the center AED indicated that annual</p>			S1166	<p>The documentation was completed by the Biomedical Engineers but neglected to enter it into the database. It has been reprinted to show the PM completion. The Executive Director was responsible for correcting the deficiency.</p>		12/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2011
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	<p>maintenance tests are required to confirm that the equipment is functioning properly.</p> <p>3. Documentation titled Preventive Maintenance Work Order (Mandatory) dated 07-12-2011 for the center AED failed to indicate the following:</p> <p>a) an entry in the section Completed By: _____ [and] Date: _____</p> <p>b) an entry in the section Time Charges [and] Total Time: 0.000</p> <p>c) an entry in the section Problem Code indicating that PM was performed</p> <p>d) an entry in the section Action Code indicating that PM was completed</p> <p>4. During an interview on 11-30-11 at 1030 hours, staff #A10 (the biomedical engineering supervisor) confirmed that the documentation failed to indicate that PM for the AED was performed by the contracted service.</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/30/2011	
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S1168	<p>410 IAC 15-2.5-7(b)(4)(B)(iii)</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>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the center lacked documentation of electrical current leakage testing or triennial analysis of preventive maintenance (PM) records on all patient care equipment in use at the center.</p> <p>Findings:</p> <p>1. PM records lacked evidence of electrical current leakage testing and triennial analysis by either the center or the biomedical engineering services provider for patient care equipment.</p>	S1168	The Biomedical Engineers will start documenting this on the PM's starting in January 2012. The Executive Director was responsible for correcting the deficiency.	12/01/2011			

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	<p>2. Documentation titled Preventive Maintenance Work Order(s) dated 02-10-2011, 02-17-2011 and 07-18-2011 for the center failed to indicate that ground current leakage testing was performed and recorded as either pass/fail or otherwise indicate the test measurements on the documentation.</p> <p>3. During an interview on 11-30-11 at 1030 hours, staff #A10 confirmed that PM records lacked documentation of electrical current leakage testing and staff #A1 confirmed that triennial analysis of the patient care equipment PM was not being performed for the center.</p>			
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