

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Q 0000 Bldg. 00	This visit was for a re-certification survey. Facility Number: 008902 Survey Date: 02-01/03-2016 QA: cjl 03/01/16	Q 0000		
Q 0043 Bldg. 00	416.41(c) DISASTER PREPAREDNESS PLAN (1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC. (2) The ASC coordinates the plan with State and local authorities, as appropriate. (3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan. Based on interview, the facility failed to document current coordination of emergency disaster and preparedness with an appropriate governmental agency.	Q 0043	416.41(c) Disaster Preparedness Plan PLAN OF CORRECTION: The Center will coordinate emergency preparedness with the appropriate government agency. SYSTEMIC CHANGES: The	03/18/2016

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: 15C0001062		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016	
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L				STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260			
(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
Q 0081 Bldg. 00	<p>Findings include:</p> <ol style="list-style-type: none"> On 02-01-2016 at 10:15 am, employee #A1, Nurse Manager, was requested to provide documentation of the coordination of current emergency disaster and preparedness with an appropriate governmental agency In interview, on 02-03-2106 at 2:45 pm, employee #A1 confirmed the facility did not provide documentation of current coordination of emergency disaster and preparedness with an appropriate governmental agency and no other documentation was provided prior to exit. <p>416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES (a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors.</p>				<p>Center will contact the state and local emergency management agency to discuss what the Center's role will be in a community disaster. Communications with the agencies will be documented and maintained for reference at the Center. See Attachment A: Disaster Preparedness Documentation RESPONSIBILITY AND MONITORING: The Center Leader is responsible for contacting the local and state emergency management agencies to identify the Center's role in a community emergency situation. Education will be provided to Center staff on their role in a community disaster. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>(a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC.</p> <p>(c)(1) The ASC must set priorities for its performance improvement activities that -</p> <ul style="list-style-type: none"> (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care. <p>Based on document review and interview, the facility failed to include a monitor and standard for 1 directly-provided service in its quality assessment and performance improvement (QAPI) program for calendar year 2015.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's QAPI program for calendar year 2015 indicated it did not include a monitor and standard for the housekeeping service provided by the nursing staff. 2. Interview of employee #A1, Nurse Manager, on 02-03-2106 at 11:55 am, confirmed the above and no other documentation was provided prior to exit. 	Q 0081	<p>416.43(a) Program Scope and Program Activities, Quality PLAN of CORRECTION: The Center will monitor the performance of the housekeeping service provided by the in-house nursing staff. SYSTEMIC CHANGES: The Center Leader will perform weekly housekeeping inspections of the Center for one quarter, if standard continues to be met for this quarter, future inspections will be done quarterly using a monitoring tool. See Attachment Q: Housekeeping Monitoring Tool. Center Leader will provide a quarterly summary to the QAPI Committee and to the governing board. RESPONSIBILITY AND MONITORING: The Center Leader will review the results of the housekeeping monitoring tools to ensure the Center is being maintained in a safe and sanitary manner. Any variances noted, will be addressed and</p>	03/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Q 0101 Bldg. 00	<p>416.44(a)(1) PHYSICAL ENVIRONMENT</p> <p>The ASC must provide a functional and sanitary environment for the provision of surgical services.</p> <p>Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on interview, the facility failed to document an electrical check for 2 of 5 pieces of patient care equipment (cardiac monitor and emergency call code system).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 02-01-2016 at 10:15 am, employee #A1, Nurse Manager, was requested to provide documentation of electrical current leakage checks for 5 pieces of patient care equipment. 2. Review of facility documentation provided indicated there was no documentation of current electrical leakage checks for a cardiac monitor and 	Q 0101	<p>corrected in a timely manner. The results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>416.44(a) (1) Physical Environment PLAN OF CORRECTION: The Center will provide a functional and sanitary environment for the provision of surgical services. SYSTEMIC CHANGES: Electrical leakage check on all the cardiac monitors (Mindray & Datascope) was performed. See Attachment P: TriMedx Biomed Report. All monitors are given a "pass" rating & have an acceptable leakage current listed. The Code Call System is to be modified. The system is fixed plant equipment that is completely insulated from any conductive surface except the two metal face plate screws. Non-conductive nylon screws will replace the metal screws, eliminating all conductive</p>	03/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Q 0121 Bldg. 00	<p>emergency call code system.</p> <p>3. Interview of employee #A1 on 02-03-2016 at 1:30 pm confirmed there was no documentation of current electrical leakage checks for the cardiac monitor and emergency call code system.</p> <p>416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel. Based on document review and interview, the facility failed to follow the medical staff by laws for Allied Health Professionals (AHP) AH#1, Certified Registered Nurse Anesthetist (CRNA) and AH#2, CRNA, in 1 instance each.</p> <p>Findings include:</p> <p>1. Review of the medical staff bylaws, reviewed by the medical staff on 02-23-2015 and approved by the</p>	Q 0121	<p>surfaces. RESPONSIBILITY AND MONITORING: The Center Leader is responsible for contracting with a bio-medical vendor to perform equipment checks on patient care equipment per the manufacturer's instructions for use. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>416.45(a) Membership and Clinical Privileges PLAN OF CORRECTION: The Center grants privileges in accordance with recommendations from qualified medical personnel. SYSTEMIC CHANGES: The Center Leader obtained the sponsoring physician signatures to the credentialing file for the AHP#1 CRNA and AHP#2 CRNA, See Attachment D: Signed CRNA Supervision Forms. These documents were approved through a Board</p>	03/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016	
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L				STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260			
(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			
Q 0141	<p>governing board on 02-24-2015, indicated if the AHP's license requires supervision or direction by a physician, a signed written agreement between the AHP and the physician, who is a member in good standing of the Medical Staff, in which the physician agrees to provide such supervision or direction whenever the AHP exercises AHP Prerogatives."</p> <p>2. Review of a document entitled ALLIED HEALTH PROFESSIONAL APPLICATION, Statement of Employing/Supervising Physician (if applicable) indicated there were appropriate spaces for entry of information by the AHP, to be signed and dated by the physician and to be initialed and dated by the AHP.</p> <p>3. Review of the credential file of AHP#1, CRNA, indicated there was an above-described form in the file, initialed and dated by AHP#1, but not signed and dated by the supervising physician.</p> <p>4. Review of the credential file of AHP#2, CRNA, indicated there was an above-described form in the file, initialed and dated by AHP#2, but not signed and dated by the supervising physician.</p> <p>416.46(a) ORGANIZATION AND STAFFING</p>		Resolution, See Attachment K: Board Resolution and added to AHP 1 and AHP2's credentialing files. The Center Leader is responsible for the review of each AHP credentialing file and for ensuring all required documentation is present at the time the AHP is presented to the Medical Executive Committee and the Governing Board for credentialing and re-credentialing. The Center Leader has reviewed the files and determined they are current. RESPONSIBILITY AND MONITORING: The Center Leader will ensure all required documents are present in the AHP credentialing files at the time of initial appointment and reappointment to the medical staff of the Center. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Bldg. 00	<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 document review, observation, and interview, the Nurse Manager failed to ensure that nursing staff properly labeled glucometer test strips.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> Review of policy/procedure BLOOD GLUCOSE MONITORS Competency in the use-Quality Control-Cleaning on page 1 indicated the following: POLICY: The blood glucose monitor is properly cleaned and maintained according to manufacturer guidelines. This policy/ procedure was last reviewed/revised on 12/1/2015. Review of the One touch Ultra 2 Blood Glucose Monitoring System USER GUIDE indicated the following: 6 Control solution testing When to test with control solutions NOTE: Write the discard date (3 months after first opening the vial) on the vial label when you first open it. While on tour 2/2/16 at 1012 hours 	O 0141	<p>416.46(a) Organization and Staffing PLAN OF CORRECTION:Nursing services will be provided in accordance with recognized standards of practice. SYSTEMIC CHANGES: The glucose control solution vial will be labeled with the discard date upon being opened. The Center Leader will ensure that the Nurse Manager/Infection Control Nurse of the Center provides the nursing staff with re-training on the blood glucose monitoring policy and procedure which was revised on 12/1/2015. See Attachment E: In-Service Sign-in Sheet and Revised Blood Glucose Policy and Procedure and the manufactures instructions for blood glucose monitor use. RESPONSIBILITY AND MONITORING: The Center Leader will monitor the daily blood glucose check form for compliance with the Blood Glucose Monitoring Policy weekly for 3 months if standard of 100% is met then it will be monitored quarterly in the QAPI minuetts See Attachment R: Daily Blood Glucose Check and Audit form The Center Leader is responsible for oversight of policies and procedures for the Center.</p>	03/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Q 0184 Bldg. 00	<p>with RN (Registered Nurse) N1, Nurse Manager/ Infection Control Coordinator, the control solution bottle was observed to not be labeled with discard date.</p> <p>4. Interview on 2/2/16 at 1012 hours with RN N1, confirmed that the control solution vial was not labeled with a discard date.</p> <p>416.48(a)(3) VERBAL ORDERS Orders given orally for drugs and biologicals must be followed by a written order signed by the prescribing physician. Based on document review and interview, the facility failed to ensure a verbal order policy with a requirement the prescriber indicate the time when the order was signed.</p> <p>Findings include:</p> <p>1. On 02-01-2016 at 10:15 am, employee #A1, Nurse Manager, was requested to provide documentation of a verbal order policy with a requirement the prescriber indicate the time when the order was signed.</p> <p>2. Review of a policy entitled</p>	Q 0184	<p>Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>416.48(a)(3) Verbal Orders PLAN OF CORRECTION: Orders given orally for drugs and biologicals will be followed by a written order signed by the prescribing physician. SYSTEMIC CHANGES: The Center has revised the verbal order policy to include language which requires the physician to indicate the time in which the order was signed. See Attachment F: Revised Physician Order Policy & Procedure and Sign in Sheet. Attachment K: Board Resolution. The Center Leader and the Nurse Manger will provide Center nursing staff with education on the revised Physician Order Policy. RESPONSIBILITY AND</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016	
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L				STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260			
(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
Q 0221 Bldg. 00	<p>PHYSICIAN ORDERS, approved 3/11/2014, indicated it did not indicate the time when the order was signed.</p> <p>3. Interview of employee #A2, AmSurg Clinical Director, on 02-02-2016 at 10:55 am, confirmed all the above and no other documentation was provided prior to exit.</p> <p>416.50(a) NOTICE OF RIGHTS An ASC must, prior to the start of the surgical procedure, provide the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the address and telephone number of the State agency to which patients may report complaints, as well as the Web site for the Office of the Medicare Beneficiary Ombudsman. Based on document review and</p>			O 0221	<p>MONITORING: The Center Leader will monitor the medical records weekly at least twice per week for four weeks, See Attachment T: Medical Record Audit for Orders Timed Correctly and if all orders are in compliance then the Medical Record Consultants Report will be monitored in an ongoing basis to verify compliance with orders being timed See attachment U: Data Collection Worksheet. The Center Leader is responsible for the policies and procedures and for reporting the results of this survey, actions taken; monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>416.50(a) Notice of Rights PLAN</p>		03/28/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L			STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260		
(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>interview, the facility failed to provide to the patient written and verbal notice of the facility's policy of patient rights if the patient was incompetent, whether adjudged by a court or not, and who could exercise the patient's rights.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a facility document entitled PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP, approved 03-11-2016, given both verbally and in writing to patients, indicated it did not include those rights if the patient was incompetent, whether adjudged by a court or not, and who could exercise the patient's rights. 2. Interview of employee #A2, AmSurg Clinical Director, on 02-02-2016 at 11:15 am, confirmed the above and no other documentation was provided prior to exit. 		<p>OF CORRECTION: The Center will provide prior to the start of the surgical procedure, the patient, or the patient's representative, or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that ensures the patient, the representative, or the surrogate understand all of the patient's rights as set forth by CMS.</p> <p>SYSTEMIC CHANGES: The Center Leader will ensure the patient rights and responsibilities given to patients will be the revised documents which include information on the exercise of patient's rights when the patient is incompetent, whether adjudged by a court or not. The Center Leader is responsible for providing education to the Center staff on the revised policy and procedure on Patient Rights and Responsibilities. See Attachment C: Revised Patient and Responsibilities and Sign-in Sheet.</p> <p>RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring the patient's rights and responsibilities remain current, each year at the Annual Board Meeting. The Rights and Responsibilities form will be revised and amended as needed to include State and/or Federal updates. When updates are received, they will be completed and documented quarterly in QAPI minutes. An audit that the patients receive the current</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Q 0222 Bldg. 00	<p>416.50(a)(1)(i) NOTICE OF RIGHTS - POSTING (1)[...] In addition, the ASC must -</p> <p>(i) Post 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 post the facility's policy of patient rights if the patient was incompetent, whether adjudged by a court or not, and who could exercise the patient's rights.</p>	O 0222	<p>"Patient Rights "will be conducted weekly for three weeks or until 100% is reached for three consecutive weeks then when the standard is met the audit will be completed by the medical record consultant and documented in the QAPI minutes See Audit Form S: Daily Audit Patient Rights Received and Attachment U: Data Collection Worksheet. Results of the actions taken, taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>416.50(a)(1)(i) Notice of Rights-Posting PLAN OF CORRECTION: The Center has posted the revised Patient's Rights and Responsibilities in a place within the Center likely to be noticed by the patients or their representatives waiting for their</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Q 0226 Bldg. 00	<p>Findings:</p> <ol style="list-style-type: none"> Review of a facility document entitled PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP, approved 03-11-2016, posted in the facility's reception area, indicated it did not include those rights if the patient was incompetent, whether adjudged by a court or not, and who could exercise the patient's rights. Interview of employee #A2, AmSurg Clinical Director, on 02-02-2016 at 11:15 am, confirmed the above and no other documentation was provided prior to exit. <p>416.50(d)(1), (2), & (3) GRIEVANCES - MISTREATMENT, ABUSE The following criteria must be met:</p> <ol style="list-style-type: none"> All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented. All allegations must be immediately reported to a person in authority in the ASC. <p>Only substantiated allegations must be reported to the State authority or the local</p>		<p>treatment. SYSTEMIC CHANGES: The Center Leader will ensure the current patient rights and responsibilities document is posted. See Attachment G: Revised Patient Rights and Responsibilities. These documents were approved through a Board Resolution, See Attachment K: Board Resolution RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring the patient's rights and responsibilities are posted and that they remain current and are updated as needed to include all required data. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>authority, or both.</p> <p>Based on document review and interview, the facility failed to ensure a policy to document alleged violations/grievances relating, but not limited to mistreatment, verbal, and sexual abuse, to immediately report these allegations to a person in authority at the facility, and to report substantiated allegations to the State authority or the local authority, or both.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 02-01-2016 at 10:15 am, employee #A1, Nurse Manager, was requested to provide the facility's patient rights policy. 2. Review of a policy entitled PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP, approved 03-11-2014, indicated it did not include to document alleged violations/grievances relating, but not limited to mistreatment, verbal, and sexual abuse, to immediately report these allegations to a person in authority at the facility, and to report substantiated allegations to the State authority or the local authority, or both. 3. Interview of employee #A2, AmSurg Clinical Director, confirmed the above-requested policy did not include the above-stated requirements and no 	O 0226	<p>416.50(d)(1),(2)&(3) Grievances-Mistreatment, Abuse PLAN OF CORRECTION: The Center will fully document all alleged violations/grievances related, but not limited to, mistreatment, neglect, verbal, mental, sexual or physical abuse, and all allegations will be immediately reported to a person in authority at the Center. Substantiated allegations will be reported to the State authority, local authority or both. SYSTEMIC CHANGES: The Center has revised the Patient Rights and Responsibilities policy and procedure to include documentation of alleged violations/grievances relating, but not limited to mistreatment, verbal and sexual abuse, to immediately report these allegations to a person in authority in the facility and to report substantiated allegations to the State authority, or the local authority or both. See Attachment G: Revised Patient Rights and Responsibilities. Documents were approved through a Board Resolution See Attachment K: Board Resolution. The Center Leader will ensure the Patient Rights and Responsibilities given to patients will be the revised documents which include information on the exercise of patient's rights when the patient is incompetent, whether adjudged by a court or not. The Center Leader is</p>	03/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Q 0230 Bldg. 00	<p>other documentation was provided by exit.</p> <p>416.50(e)(2)& (3) EXERCISE OF RIGHTS BY OTHERS (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 or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>Based on document review and interview, the facility failed to ensure a policy of patient rights if the patient was incompetent, whether adjudged by a</p>	Q 0230	<p>responsible for providing education to the Center staff on the revised policy and procedure on Patient Rights and Responsibilities.</p> <p>RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring the patient's rights and responsibilities are posted and that they remain current and are updated as needed to include all required data. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>416.50(e)(2)&(3)Exercise of Rights by Others PLAN OF CORRECTION: The Center will ensure that patients adjudged incompetent under applicable</p>	03/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>court or not, and who could exercise the patient's rights.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of a facility document entitled PATIENT RIGHTS & NOTIFICATION OF OWNERSHIP, approved 03-11-2016, indicated it did not include those rights if the patient was incompetent, whether adjudged by a court or not, and who could exercise the patient's rights. 2. In interview, on 3-17-15 at 10:10 am, employee #A2, AmSurg Clinical Director, confirmed the above and no other documentation was provided prior to exit. 		<p>State health and safety laws or by a court of proper jurisdiction, will have their rights exercised by the person appointed under State law to act on the patient's behalf. For patient's that have not been adjudged incompetent by a State court, the legal representative or surrogate designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. SYSTEMIC CHANGES: The Center has revised the Patient's Rights and Responsibilities to include verbiage for patients who are adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the person are exercised by the person appointed under State law to act on the patient's behalf. And, if a State court has not adjudged a patient incompetent, any legal representative or surrogate designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by State law. See Attachment G: Revised Patient Rights and Responsibilities. Approved through Board Resolution See Attachment K: Board Resolution The Center Leader will ensure the revised Patient Rights and Responsibilities is posted and provided to patients. The Center Leader is responsible for providing education to the Center</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Q 0241 Bldg. 00	<p>416.51(a) SANITARY ENVIRONMENT</p> <p>The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.</p> <p>Based on document review, observation and interview, the facility failed to ensure a sanitary environment for the provision of surgical services as related to dust in the vent of procedure room #4 and scope storage.</p> <p>Findings include:</p> <p>1. Review of policy/procedure</p>	Q 0241	<p>staff on the revised policy and procedure on Patient Rights and Responsibilities. Attachment C: In-service Sign in Sheet and Revised Patient Rights and Responsibilities.</p> <p>RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring the patient's rights and responsibilities are posted and that they remain current and are updated as needed to include all required data. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>416.51(a) Sanitary Environment PLAN OF CORRECTION: The Center will provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. SYSTEMIC CHANGES: 1.Dust has been removed from the ceiling and the ceiling vent in Procedure Room #4. 2. The Scope Storage Cabinet has been</p>	03/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>CLEANING Procedure Room indicated on page 1 the following: POLICY: Each procedure room is cleaned and/or disinfected appropriately between patients. This policy/ procedure was last reviewed/revised on 3/11/2014.</p> <p>2. While on tour on 2/2/16 at 1240 hours, dust was observed on the ceiling and in the ceiling vent in procedure room #4.</p> <p>3. Interview on 2/2/16 at 1240 hours with RN (Registered Nurse) N1, Nursing Manager/Infection Control Coordinator, confirmed that dust was on the ceiling and ceiling vent. RN N1 confirmed that the procedure room should have been cleaned.</p> <p>4. Review of policy/ procedure DISINFECTION High-Level on page 2 indicated the following: Final Rinse/Drying/Storage High-level disinfectants have the potential to injure mucous membranes if not thoroughly rinsed from instruments. After high-level disinfection, instruments are rinsed and any channels flushed with water to remove the disinfectant, thoroughly dried, and stored in a well-ventilated environment in accordance with the instrument</p>		<p>modified to allow the scopes to hang vertically without curling on the distal ends. The Center Leader or designee will perform weekly housekeeping inspections of the Center for one quarter, if standard continues to be met for this quarter, future inspections will be done quarterly using a monitoring tool. See Attachment B: Housekeeping Monitoring Tool and will provide a quarterly summary to the QAPI Committee and to the governing board. Any variances will be addressed in a timely manner. The Center Leader has obtained quotes, and approval for modifications to the scope cabinets. The work was completed on 3/18/2016 RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring the patients receive care in a safe and sanitary environment. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>manufacturers' guidelines. This policy/ procedure was last reviewed/revised on 3/11/2014.</p> <p>5. Review of the Olympus Reprocessing/Manual Instructions indicated the following: 5.1 Storage of the endoscope NOTE Prior to storage, uncap the auxiliary water inlet. Doing so will allow air to circulate through the internal lumen of the endoscope and will assist drying (for endoscopes with auxiliary water feeding only). 5. Hang the endoscope in the storage cabinet with the distal end hanging freely. Make sure that the insertion tube hangs vertically and as straight as possible.</p> <p>6. While on tour on 2/2/16 at 1203 hours, it was observed that the endoscopes were hanging in the storage cabinet with the distal ends curled and laying on the base of the cabinet.</p> <p>7. Interview on 2/2/16 at 1203 hours with RN N1, Nursing Manager/Infection Control Coordinator, confirmed that the scopes were in fact curled at the distal end and laying on the base of the cabinet.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Q 0242 Bldg. 00	<p>416.51(b) INFECTION CONTROL PROGRAM</p> <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 document review, observation and interview, the facility failed to maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases in relation to: hand hygiene for 1 of 1 CRNAs (Certified Registered Nurse Anesthetists), #53, TST test (Tuberculosis Skin test) for 1 of 4 RNs, Registered Nurses, N5, and verification of communicable diseases for 1 of 4 RNs, N6.</p> <p>Findings Include:</p> <p>1. Review of policy/ procedure HAND HYGIENE indicated on page 1 the following: Indications for Handwashing Handwashing may also be used for routinely decontaminating hands in the following clinical</p>	O 0242	<p>416.51(b) Infection Control Program PLAN OF CORRECTION: The Center will maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases.</p> <p>SYSTEMIC CHANGES: 1. Hand washing education will be provided to all Center employee staff and Medical Staff and weekly hand hygiene audits will be performed. 2. Employees RN5 will receive a 2-step TST immediately and will be placed in the employee's Health file. 3. RN6 will produced documentation of immunity to varicella via titer. See Attachment I: Revised Hiring and Pre- Employment Policy and Procedure to include immunization requirements. Approved through Board resolution See Attachment K: Board Resolution 1. The Center Leader and/or the Nurse</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>situations: After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) This policy/ procedure was last reviewed/revised on 11/1/2011.</p> <p>2. While on facility tour on 2/2/16 at 1115 hours, CRNA #53 was observed not washing hands following direct patient contact prior to going to nurses station to chart.</p> <p>3. Interview on 2/2/16 at 1115 hours with RN N1, Nurse Manager/Infection Control Coordinator, confirmed the fact that CRNA #53 did not wash hands per policy following direct patient contact.</p> <p>4. Review of policy and procedure Tuberculosis Exposure Control Plan, indicated on page 2 the following: C. Prospective Employees</p> <p>1. All new employees are screened for the presence of infection with M. tuberculosis using the Mantoux TST and</p> <p>2. Skin testing employs the two step procedure. (If the reaction to the first test is less than 10 mm, a second test is given in 1-3 weeks). This policy/procedure was last</p>		<p>Manager/Infection Control Nurse will provide education on hand washing to all center staff and Medical staff. The NM/IC Nurse will perform weekly hand washing audits of at least 10 audits per week until improvement of up to 90% is achieved. Following achievement of this goal, quarterly hand hygiene audits will be performed ongoing as part of the IC program for the Center. See Attachment L: Hand Hygiene Audit Tool and Attachment J: Hand Hygiene In-Service Sign-in Sheet. See Attachment N: Hand Hygiene Policy. 2.The Two-step TST for RN5 and the results of the varicella immunity for RN6 have been documented, those documents are documented in the respective employee's health file. The Nurse Manager/IC Nurse will ensure all new hires receive a two-step TST. 3. The Nurse Manager/IC Nurse will ensure all new hires show proof of varicella immunization, or receive the varicella immunization series. See Attachment H: New Hire Checklist.</p> <p>RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring the the infection control program is compliant to include hand hygiene and immunizations and TB tracking takes place per policy. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>reviewed/ revised on 12/1/2015.</p> <p>5. Review of personnel files, indicated the RN N5, registered nurse, lacked the documentation of a two step TST upon hire.</p> <p>6. Interview on 2/3/16 at 1345 hours with RN N1, Nursing Manager/Infection Control Coordinator, confirmed that RN N5 did not have a two step TST upon hire and that RN N5 only had one TST completed.</p> <p>7. Review of policy/procedure Infection Control Program indicated the following on page 1: COMPONENTS OF THE INFECTION CONTROL PROGRAM: <u>RESPONSIBILITY:</u> The governing board has approved the adherence to nationally recognized infection control guidelines as outlined by i.e. CDC (Centers for Disease Control). This policy/ procedure last reviewed/ revised on 11/1/2011.</p> <p>8. Review of CDC Immunization of Health- Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), Recommendations and Reports,</p>		the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>November 25, 2011/60(RR07): 1-45, Section Varicella Recommendations vaccination, indicated the following; Health-care institutions should ensure that all HCP (health care personnel) have evidence of immunity to Varicella. This information should be documented and readily available at the work location. HCP without evidence of immunity to varicella should receive 2 doses of Varicella vaccine administered 4-8 weeks apart. If >8 weeks elapse after the first dose, the second dose may be administered without restarting the schedule. Recently vaccinated HCP do not require any restriction in their work activities; however, HCP who develop a vaccine-related rash after vaccination should avoid contact with persons without evidence of immunity to varicella who are at risk for severe disease and complications until all lesions resolve (i.e., are crusted over) or, if they develop lesions that do not crust (macules and papules only), until no new lesions appear within a 24-hour period.</p> <p>9. Review of personnel files showed a lack of documentation of immunity to Varicella for RN N6.</p> <p>10. Interview on 2/3/16 at 1345 hours with RN N1, Nurse Manager/Infection</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 0000 Bldg. 00	Control Coordinator, confirmed the file for RN N6 lacked documentation for Varicella immunity. This visit was for a State licensure survey. Facility Number: 008902 Survey Date: 02-01/03-2016 QA: cjl 03/01/16	S 0000		
S 0056 Bldg. 00	410 IAC 15-2.3-2 POSTING OF LICENSE 410 IAC 15-2.3-2 (a) Sec.2.(a) The license must be conspicuously posted on the premises. Based on observation and document review, the facility failed to post the current Indiana State Department of Health license. Findings include:	S 0056	410IAC 15-2.3-2 Posting of the Indiana State License PLAN of CORRECTION: The Center has posted the current Indiana State Department of Health License on the wall in the reception area. SYSTEMIC CHANGES: The Center Leader or Designee will contact the licensing department	02/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 0110 Bldg. 00	<p>1. On 02-02-2106 at 4:10 pm in the presence of employee #A3, Executive Director, the facility's Indiana State Department of Health license was observed to be posted on a wall in the reception area.</p> <p>2. Review of the license indicated it expired 06-30-2015.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the facility's governing board failed to review reports of the quality assessment performance improvement (QAPI) program of 1</p>	S 0110	<p>annually to receive the updated license for file and will post the current license in the reception area. Attachment M: Current Indiana ASC License MONITORING & RESPONSIBILITY: The Center Leader or designee is responsible for contacting the licensing department annually prior to expiration of the original license and posting within the Center. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>410 IAC 15-2.4-1 Governing Body; Powers and Duties 410 IAC15-2.4-1 (a) (5) PLAN of CORRECTION: The Governing Body of the Center will review at least quarterly, reports of</p>	03/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L			STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260		
(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	
S 0172 Bldg. 00	<p>directly-provided service during calendar year 2015, as part of the facility's QAPI program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the governing board meeting minutes for calendar year 2015 indicated the governing board failed to review QAPI activities of the directly-provided service of housekeeping by facility nursing staff. Interview of employee #A1, Nurse Manager, on 02-03-2016 at 11:55 am, confirmed the above and no other documentation was provided prior to exit. <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p>		<p>management operations, including but not limited to quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken and follow-up. SYSTEMIC CHANGES: The Center Leader will perform weekly housekeeping inspections of the Center for one quarter, if standard continues to be met for this quarter, future inspections will be done quarterly using a monitoring tool See Attachment B: Housekeeping Monitoring Tool and Center Leader will provide a quarterly summary to the QAPI Committee and to the governing board. MONITORING & RESPONSIBILITY: The Center Leader will review the results of the housekeeping monitoring tools to ensure the Center is being maintained in a safe and sanitary manner. Any variances noted, will be addressed and corrected in a timely manner. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and in put prior to reporting to the governing body for review and final approval.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review, observation and interview, the Chief Executive Officer failed to maintain personnel records in relation to TST tests (Tuberculosis Skin Test) for 1 of 5 RNs (Registered Nurses), N5, and post offer physical for 1 of 5 RNs, N6.</p> <p>Findings Include:</p> <p>1. Review of policy and procedure Tuberculosis Exposure Control Plan, indicated on page 2 the following: C. Prospective Employees</p> <p>1. All new employees are screened for the presence of infection with M. tuberculosis using the Mantoux TST and</p> <p>2. Skin testing employs the two step procedure. (If the reaction to the first test is less than 10 mm, a second test is given in 1 - 3 weeks).</p> <p>This policy/procedure was last</p>	S 0172	<p>410IAC 15-2.4-1 Governing Body/ Powers and Duties 410 IAC 15-2.4-1 (c) (5) (L) PLAN of CORRECTION: The Center Leader, along with the Center Administrator who functions as the CEO will maintain personnel files in relation to TST testing and post-offer physical in addition to all requirements for pre-hire and testing and post-offer subsequent physical examinations, immunization and tuberculin tests or chest x-rays, as applicable. SYSTEMIC CHANGES: 1. Employee RN N5 will receive a 2-step TST immediately and results will be placed in the employee's health file. 2. The post-offer physical examination documentation was obtained from RN N6 and placed in this employee's Health file. MONITORING&RESPONSIBILIT Y: The results of the 2-step TST for RN N5 and the RN N6 pre-employment health screening have been placed in file. The</p>	03/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>reviewed/revise on 12/1/2015.</p> <p>2. Review of personnel files, indicated the RN N5, registered nurse, lacked the documentation of a two step TST upon hire.</p> <p>3. Interview on 2/3/16 at 1345 hours with RN N1, Nursing Manager/Infection Control Coordinator, confirmed that RN N5 did not have a two step TST upon hire and that RN N5 only had one TST completed.</p> <p>4. Review of policy and procedure Hiring and pre-employment indicated the following: Pre-Employment Health Screening All Employees undergo a medical examination after receiving an offer of employment, but before commencing work, in order to ensure that each employee is physically capable of performing job-related duties. Employees are required to have had a physical examination within six months prior to their employment, or have one within fifteen (15) days after they are initially employed. This policy/procedure was last review/revise on 7/1/2015.</p> <p>5. Review of personnel files indicated lack of documentation of a post offer</p>		Center Leader is responsible for ensuring the Personnel files are maintained to Center policy and state regulations. Audits will be completed at the time of hire using the New Hire Checklist, See Attachment H: New Hire Checklist Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 0310 Bldg. 00	<p>physical for RN N6, Registered Nurse.</p> <p>6. Interview on 2/3/16 at 1345 hours with RN N1, Nursing Manager/Infection Control Coordinator, confirmed that there was no documentation of a physical for RN N6 in the personnel file.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include a monitor and standard for 1 directly-provided service in its quality assessment and performance improvement (QAPI) program for calendar year 2015.</p> <p>Findings include:</p> <p>1. Review of the facility's QAPI program for calendar year 2015 indicated it did not include a monitor and standard for the housekeeping service provided by the nursing staff.</p>	S 0310	<p>410 IAC 15-2.4-2 Quality Assessment and Improvement PLAN of CORRECTION: The Center Quality Assessment and Improvement program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, all services, including services furnished by a contractor. SYSTEMIC CHANGES: The Center Leader will perform weekly housekeeping inspections of the Center for one quarter, if standard continues to be met for this quarter, future inspections will be done quarterly using a monitoring tool. See Attachment</p>	03/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 0432 Bldg. 00	<p>2. Interview of employee #A1, Nurse Manager, on 02-03-2106 at 11:55 am, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p>		<p>Q: Housekeeping Monitoring Tool. Center Leader will provide a quarterly summary to the QAPI Committee and to the governing board. MONITORING & RESPONSIBILITY: The Center Leader or designee will evaluate the house keeping services provided by in-house staff. The Center Leader will review the results of the housekeeping monitoring tools to ensure the Center is being maintained in a safe and sanitary manner. Any variances noted, will be addressed and corrected in a timely manner. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>Based on document review, observation and interview, the infection control committee failed to ensure appropriate cleaning of the ceiling vents in procedure room #4.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> Review of policy/procedure CLEANING Procedure Room indicated on page 1 the following: POLICY: Each procedure room is cleaned and/or disinfected appropriately between patients. This policy/procedure was last reviewed/revise on 3/11/2014. While on tour on 2/2/16 at 1240 hours, dust was observed on the ceiling and in the ceiling vent in procedure room #4. Interview on 2/2/16 at 1240 hours with RN N1, Nursing Manager/Infection Control Coordinator, confirmed that dust was on the ceiling and ceiling vent. RN N1 confirmed that should have been cleaned. 	S 0432	<p>410 IAC 15-2.5-1 Infection Control Program 410 IAC 15-2.5-1 (f)(2)(E)(iii) PLAN of CORRECTION: The infection control committee responsibilities include review and recommendation of changes to procedures, policies and programs which are pertinent to infection control to include, but not be limited to cleaning, disinfection and sterilization. The Center will ensure the IC Committee requirements for cleaning, disinfection and sterilization are followed. The QAPI committee functions as the IC committee. SYSTEMIC CHANGES: 1.Dust has been removed from the ceiling and the ceiling vent in Procedure Room #4. 2. The Scope Storage Cabinet has been modified to allow the scopes to hang vertically without curling on the distal ends. The Center Leader or designee will perform weekly housekeeping inspections of the Center for one quarter, if standard continues to be met for this quarter, future inspections will be done quarterly using a monitoring tool. See Attachment B: Housekeeping Monitoring Tool. Center Leader will provide a quarterly summary to the QAPI Committee and to the governing board. Any variances will be addressed in a timely manner. The Center Leader has obtained quotes and approval for modifications to the scope</p>	03/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 0442 Bldg. 00	<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 document review, observation and interview, the Infection Control Committee failed to determine the communicable disease history of new hire personnel for 1 of 4 RNs (Registered</p>	S 0442	<p>cabinets. The work was completed on 3/18/2016 MONITORING & RESPONSIBILITY: The Center Leader is responsible for ensuring the patients receive care in a safe and sanitary environment. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>410 IAC 15-2.5-1 Infection Control Program 410 IAC 15-2.5-1 (f)(2)(E)(viii) PLAN of CORRECTION: The Center Infection Control Program will ensure a communicable disease</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016	
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L				STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260			
(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>Nurses), N6.</p> <p>Findings Include:</p> <p>1. Review of policy/procedure Infection Control Program indicated the following on page 1: COMPONENTS OF THE INFECTION CONTROL PROGRAM: <u>RESPONSIBILITY:</u> The governing board has approved the adherence to nationally recognized infection control guidelines as outlined by i.e. CDC (Centers for Disease Control). This policy/procedure last reviewed/ revised on 11/1/2011.</p> <p>2. Review of CDC Immunization of Health- Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), Recommendations and Reports, November 25, 2011/60(RR07); 1-45, Section Varicella Recommendations vaccination, indicated the following: Health-care institutions should ensure that all HCP (health care personnel) have evidence of immunity to varicella. This information should be documented and readily available at the work location. HCP without evidence of immunity to varicella should receive 2 doses of Varicella vaccine administered 4-8 weeks apart. If >8 weeks elapse after the first</p>		<p>history is obtained and documented for new personnel as well as an ensuring an ongoing program for current personnel as required by state and federal agencies. SYSTEMIC CHANGES: RN6 produced documentation of immunity to varicella via titer. See Attachment I: Revised Hiring and Pre-Employment Policy and Procedure to include immunization requirements, Approved by Board Resolution. See Attachment K: Board Resolution. See Attachment H: New Hire Checklist. RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring the the infection control program is compliant to include immunizations and verified immunity to communicable diseases. Results of this survey, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 0444 Bldg. 00	<p>dose, the second dose may be administered without restarting the schedule. Recently vaccinated HCP do not require any restriction in their work activities; however, HCP who develop a vaccine-related rash after vaccination should avoid contact with persons without evidence of immunity to varicella who are at risk for severe disease and complications until all lesions resolve (i.e., are crusted over) or, if they develop lesions that do not crust (macules and papules only), until no new lesions appear within a 24-hour period.</p> <p>3. Review of personnel files showed a lack of documentation of immunity to Varicella for RN N6.</p> <p>4. Interview on 2/3/16 at 1345 hours with RN N1, Nurse Manager/Infection Control Coordinator, confirmed the file for RN N6 lacked documentation for Varicella immunity.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>(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>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on document review, observation and interview, the Infection Control Committee failed to ensure proper implementation of personal hygiene practices, that meets acceptable standards of practice for 1 of 1 CRNAs (Certified Nurse Anesthetists), CRNA #53.</p> <p>Finding Include:</p> <p>1. Review of policy/procedure HAND HYGIENE indicated on page 1 the following: Indications for Handwashing Handwashing may also be used for routinely decontaminating hands in the following clinical situations: After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) This policy/procedure was last reviewed/revised on 11/1/2011.</p> <p>2. While on facility tour on 2/2/16 at 1115 hours, CRNA #53 was observed not washing hands following direct patient</p>	S 0444	<p>410IAC 15-2.5-1 Infection Control Program 410 IAC 15-2.5-1(f)(2) (E)(ix) PLAN OF CORRECTION: The Center will maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. SYSTEMIC CHANGES: Hand washing education will be provided to all Center employees and Medical Staff. The NM/IC Nurse will perform weekly hand washing audits of at least 10 audits per week until improvement of up to 90% is achieved. Following achievement of this goal, quarterly hand hygiene audits will be performed ongoing as part of the IC program for the Center. See Attachment L: Hand Hygiene Audit Tool, See Attachment N: Hand Hygiene Policy and Attachment J: In-service Sign-in Sheet. MONITORING & RESPONSIBILITY: The Center Leader is responsible for ensuring that the Infection Control Program is followed to include hand hygiene compliance with monitoring and reporting the results of the hand hygiene audits to the QAPI committee. Results</p>	03/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 0454 Bldg. 00	<p>contact prior to going to nurse station to chart.</p> <p>3. Interview on 2/2/16 at 1115 hours with RN N1, Nurse Manager/Infection Control Coordinator, confirmed the fact that CRNA #53 did not wash hands per policy following direct patient contact.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(g)(2)</p> <p>Sterilization services must be directed by a qualified person or persons and must provide for the following:</p> <p>(2) Written policies and procedures must be available and followed by personnel responsible for sterilizing equipment and supplies, including, but not limited to, the following:</p> <p>(A) Minimum time and temperature for processing various size bundles and packs.</p> <p>(B) Instructions for loading, operating, cleaning, and maintaining sterilizers.</p> <p>(C) Instructions for cleaning packaging, storing, labeling, and dispensing of sterile supplies.</p> <p>(D) Procedure for maintaining and recording the particular sterilizing</p>		<p>of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>cycle.</p> <p>(E) Sterilization of heat labile reusable equipment. Based on document review, observation and interview, the facility failed to ensure proper storage of Olympus endoscopes following cleaning.</p> <p>Findings Include:</p> <p>1. Review of policy/procedure DISINFECTION High-Level on page 2 indicated the following: Final Rinse/Drying/Storage High-level disinfectants have the potential to injure mucous membranes if not thoroughly rinsed from instruments. After high-level disinfection, instruments are rinsed and any channels flushed with water to remove the disinfectant, thoroughly dried, and stored in a well-ventilated environment in accordance with the instrument manufacturers' guidelines. This policy/ procedure was last reviewed/ revised on 3/11/2014.</p> <p>2. Review of the Olympus Reprocessing/Manual Instructions indicated the following: 5.1 Storage of the endoscope NOTE Prior to storage, uncap the auxiliary water inlet. Doing so will allow air to circulate through the internal lumen</p>	S 0454	<p>410 IAC 15-2.5-1 Infection Control Program 410 IAC 15-2.5-1(g)(2) PLAN of CORRECTION: Sterilization services are directed by the Center Infection Control Nurse and written policies and procedures are available and followed by personnel responsible for sterilizing equipment and supplies, including, but not limited to, instructions for cleaning, packaging, storing, labeling and dispensing sterile supplies. The Center will ensure sterilization and high level disinfection services are performed per manufacturers and SGNA standards. SYSTEMIC CHANGES: The scope storage cabinet has been modified to allow the scopes to hang vertically without curling on the distal ends. The Center Leader obtained quotes for the modification for scope cabinets and received approval for these changes. MONITORING & RESPONSIBILITY: The Infection Control Nurse/Center Leader are responsible for ensuring that the Infection Control Program is compliant with scope manufacturing guidelines for processing and storage. Modifications to the scope storage cabinet ensure the distal ends of the scopes will</p>	03/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 0526 Bldg. 00	<p>of the endoscope and will assist drying (for endoscopes with auxiliary water feeding only).</p> <p>5. Hang the endoscope in the storage cabinet with the distal end hanging freely. Make sure that the insertion tube hangs vertically and as straight as possible.</p> <p>3. While on tour on 2/2/16 at 1203 hours, it was observed that the endoscopes were hanging in the storage cabinet with the distal ends curled and laying on the base of the cabinet.</p> <p>4. Interview on 2/2/16 at 1203 hours with RN N1, Nursing Manager/Infection Control Coordinator, confirmed that the scopes were in fact curled at the distal end and laying on the base of the cabinet.</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Based on document review, observation and interview, the facility failed to ensure that 1 of 4 RNs (Registered Nurses), N1</p>	S 0526	<p>hang freely. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>410 IAC 15-2.5-2 Laboratory Services 410 IAC15-2.5-2 (h) PLAN of CORRECTION: All nursing and other center</p>	03/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016	
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L				STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260			
(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
S 0728 Bldg. 00	<p>and 1 of 1 LPNs (Licensed Practical Nurses), N4 were proficient as related to blood glucose monitoring.</p> <p>Findings Include:</p> <ol style="list-style-type: none"> 1. Review of policy/procedure BLOOD GLUCOSE MONITORS Competency in Use- Quality Control- Cleaning on page 1 indicated the following: Competency All RNs, LPNs, and medical assistants providing direct patient care are proficient in the use of the peripheral blood glucose monitor. This policy/procedure was least reviewed/revised on 12/1/2015. 2. Review of personnel files showed no documentation of annual blood glucose monitoring competency for RN N1, Nurse Manager/Infection Control Coordinator and LPN N4, Licensed Practical Nurse. 3. Interview on 2/3/16 at 1345 hours with RN N1 confirmed that there was no documentation of the competencies for RN N1 or LPN N4 as related to blood glucose monitoring. 				<p>personnel performing laboratory testing will have competencies assessed at hire and annually, thereafter. Documentation of competencies will be maintained in the employee's personnel file. SYSTEMIC CHANGES: The Center Leader will ensure staff complete competencies for Blood Glucose Monitoring. RN N1, LPN N4 have completed competencies and a reverse competency for Center Leader/Infection Control Nurse has been completed. These documents are filed in the employees personnel file. MONITORING & RESPONSIBILITY: The Center Leader is responsible for ensuring laboratory service competencies are performed at hire and annually. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>		
	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
410	<p>IAC 15-2.5-4(b)</p> <p>(b) The medical staff shall adopt and enforce bylaws to carry out its responsibilities. These bylaws and rules must be as follows:</p> <p>Based on document review and interview, the facility failed to follow the medical staff by laws for Allied Health Professionals (AHP) AH#1, Certified Registered Nurse Anesthetist (CRNA) and AH#2, CRNA, in 1 instance each.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of the medical staff bylaws, reviewed by the medical staff on 02-23-2015 and approved by the governing board on 02-24-2015, indicated if the AHP's license requires supervision or direction by a physician, a signed written agreement between the AHP and the physician, who is a member in good standing of the Medical Staff, in which the physician agrees to provide such supervision or direction whenever the AHP exercises AHP Prerogatives." Review of a document entitled ALLIED HEALTH PROFESSIONAL APPLICATION, Statement of Employing / Supervising Physician (if applicable), indicated there were appropriate spaces for entry of information by the AHP, to be signed and dated by the physician, and 	S 0728	<p>410 IAC 15.2.5-4 Medical Staff; Anesthesia and Surgical PLAN OF CORRECTION: The Center will follow approved bylaw requirements when appointing and reappointing Allied Health Professionals. Documentation and signature of supervising physicians has been obtained. SYSTEMIC CHANGES: The Center Leader obtained the sponsoring physician signatures to the credentialing file for the AHP#1 CRNA and AHP#2 CRNA, See Attachment D: Signed CRNA Supervision Forms. These documents were approved through a Board Resolution, See Attachment K: Board Resolution and added to AHP 1 and AHP2's credentialing files. The Center Leader is responsible for the review of each AHP credentialing file and for ensuring all required documentation is present at the time the AHP is presented to the Medical Executive Committee and the Governing Board for credentialing and re-credentialing. The Center Leader has reviewed the files and determined they are current. RESPONSIBILITY AND MONITORING: The Center Leader working with the Medical Director is responsible for the</p>	03/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 0826 Bldg. 00	<p>to be initialed and dated by the AHP.</p> <p>3. Review of the credential file of AHP#1, CRNA, indicated there was an above-described form in the file, initialed and dated by AHP#1, but not signed and dated by the supervising physician.</p> <p>4. Review of the credential file of AHP#2, CRNA, indicated there was an above-described form in the file, initialed and dated by AHP#2, but not signed and dated by the supervising physician.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</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>(E) Safety training required of personnel. Based on document review and interview, the facility failed to provide documentation of safety training in areas where anesthetics are used for 2 gastroenterologists (MD#2, MD#4) of 7 medical staff credential files reviewed and 2 of 2 allied health credential files (AH#1 and AH#2).</p>	S 0826	<p>review of each AHP credentialing file and for ensuring all required documentation is present at the time the AHP is presented to the Medical Executive Committee and the Governing Board for credentialing and re-credentialing. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p> <p>410 IAC 15-2.5-5 Medical Staff; Anesthesia and Surgical PLAN OF CORRECTION: The medical staff has written and implemented policies and procedures and the governing body has approved policies and procedures which include, but are not limited to safety training of required personnel. SYSTEMIC</p>	03/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L			STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260		
(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	
S 1154 Bldg. 00	<p>1. Review of 7 medical staff credential files indicated files MD#2 and MD#4, both gastroenterologists, did not contain any documentation of safety training in areas where anesthetics are used.</p> <p>2. Review of 2 allied health credential files indicated files AH#1, a Certified Registered Nurse Anesthetist (CRNA) and AH#2, a CRNA, did not contain any documentation of safety training in areas where anesthetics are used.</p> <p>3. Interview of employee #A2, AmSurg Clinical Director, on 02-03-2016 at 9:30 am, confirmed all the above and no other documentation was provided by exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(C)</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>CHANGES: The Center Leader will provide safety training on areas where anesthetics are used for MD #2 and MD #4, and for AH#1 CRNA and AH#2 CRNA. See Attachment O: Electrocautery Safety Training Materials. RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring all physicians and AHPs are provided with safety training on areas where anesthetics are used and on all areas of safety, when newly credentialed and annually ongoing. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016	
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L				STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260			
(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			
S 1168	<p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Operational and maintenance control records must be established and analyzed at least triennially. These records must be readily available on the premises.</p> <p>Based on interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 3 systems of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 02-01-2016 at 10:15 am, employee#A1, Nurse Manager, was requested to provide documentation of the operational and maintenance control records for the heating, ventilation and air conditioning systems having been analyzed at least triennially. Interview of employee #A1, on 02-03-2016 at 1:30 pm, confirmed there was no above-requested documentation and no other documentation was provided prior to exit. 	S 1154	<p>410 IAC 15-2.5-7 Physical Plant, Equipment Maintenance PLAN OF CORRECTION: The Center is maintained in accordance with 410 IAC15-2.5-7(b)(3)(C). SYSTEMIC CHANGES: The heating, ventilation and air conditioning systems' operational and maintenance control records will be reviewed at least triennially and documented in the QAPI meeting minutes. RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring the HVAC preventative maintenance records will be reviewed at least triennially and maintaining documentation of the review. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>	03/25/2016			
	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
Bldg. 00	<p>MAINTENANCE, 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 facility failed to document electrical current leakage checks for 2 (cardiac monitor and emergency call code system) of 5 pieces of patient care equipment and failed to conduct triennial analysis of the procedures to conduct preventive maintenance (PM) for 4 (patient stretcher, sterilizer, suction/vacuum pump, wheelchair) of 7 pieces of patient care equipment.</p> <p>Findings include:</p> <p>1. On 02-01-2016 at 10:15 am, employee #A1, Nurse Manager, was requested to</p>	S 1168	<p>410 IAC 15-2.5-7 Physical Plant, Equipment and Maintenance PLAN OF CORRECTION: The Center is maintained in accordance with 410 IAC15-2.5-7(b)(4)(B)(iii). SYSTEMIC CHANGES: 1. Electrical leakage check on all the cardiac monitors (Mindray & Datascope) was performed. See Attachment P: TriMedx Biomed Report. All monitors are given a "pass" rating & have an acceptable leakage current listed. The Code Call System is to be modified. The system is fixed plant equipment that is completely insulated from any conductive surface except the two metal face plate screws.</p>	03/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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>provide documentation of electrical current leakage checks for 5 pieces of patient care equipment.</p> <p>2. Review of facility documentation provided indicated there was no documentation of current electrical leakage checks for the following pieces of equipment:</p> <p>Cardiac monitor Emergency call code system</p> <p>3. Interview of employee #A1 on 02-03-2016 at 1:30 pm confirmed there was no documentation of current electrical leakage checks for the above-stated pieces of equipment.</p> <p>4. On 02-01-2016 at 10:15 am, employee #A1 was requested to provide documentation of a triennial analysis of the procedures to conduct PM for 7 pieces of patient care equipment:</p> <p>5. Review of facility documentation provided indicated there was no documentation of a triennial analysis of the procedures to conduct PM for the following pieces of equipment:</p> <p>Patient stretcher Sterilizer Suction/vacuum pump</p>		<p>Non-conductive nylon screws will replace the metal screws, eliminating all conductive surfaces. 2. Preventive maintenance procedures will be reviewed for the patient stretchers, sterilizer, suction/vacuum pump, and wheelchairs. The reviews will be documented in the QAPI meeting minutes and updated at least triennially. RESPONSIBILITY AND MONITORING: The Center Leader is responsible for ensuring all patient care equipment is tested per manufacturer's instructions for use to include for electrical leakage and triennial analysis as appropriate. The Center Leader is responsible for contracting with a biomedical vendor to perform equipment checks on patient care equipment per the manufacturer's instructions for use. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260
--	---

(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
S 1198 Bldg. 00	<p>Wheelchair</p> <p>6. Interview of employee #A1 on 02-03-2016 at 1:30 pm confirmed there was no documentation of a triennial analysis of the procedures to conduct PM for the above-stated pieces of equipment and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on interview, the facility failed to document current coordination of emergency disaster and preparedness with an appropriate governmental agency.</p> <p>Findings include:</p> <p>1. On 02-01-2016 at 10:15 am, employee #A1, Nurse Manager, was requested to provide documentation of the coordination of current emergency</p>	S 1198	410IAC 15-2.5-5 Physical Plant, Equipment Maintenance PLAN OF CORRECTION: The Center will coordinate emergency preparedness with the appropriate government agency. SYSTEMIC CHANGES: The Center will contact the state and local emergency management agency to discuss what the Center's role will be in a community disaster. Communications with the agencies will be documented and maintained for reference at the	03/18/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001062	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/03/2016
NAME OF PROVIDER OR SUPPLIER NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L			STREET ADDRESS, CITY, STATE, ZIP CODE 8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260		
(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>disaster and preparedness with an appropriate governmental agency</p> <p>2. In interview, on 02-03-2106 at 2:45 pm, employee #A1 confirmed the facility did not provide documentation of current coordination of emergency disaster and preparedness with an appropriate governmental agency and no other documentation was provided prior to exit.</p>		<p>Center. See Attachment A: Disaster Preparedness Documentation RESPONSIBILITY AND MONITORING: The Center Leader is responsible for contacting the local and state emergency management agencies to identify the Center's role in a community emergency situation. Education will be provided to Center staff on their role in a community disaster. Results of this survey, actions taken, monitoring activities and any additional actions taken will be reported at the regularly scheduled QAPI meetings for review and input prior to reporting to the governing body for review and final approval.</p>		