

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (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 |
|--------------------|---|---------------|--|----------------------|
| S000000 | This visit was for a State licensure survey. Facility Number: 008858 Survey Date: 7-28/31-14 Surveyor: Jack I. Cohen, MHA Medical Surveyor QA: cloughlin 08/08/14 | S000000 | | |
| S000824 | 410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(D) 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: (D) Safety rules to be followed. Based on document review and interview, the facility failed to ensure a medical staff safety policy for medical staff personnel for areas where procedures were performed. Findings: | S000824 | S824 - Laura Allen RN, Clinical Director drafted a Center policy "New Physician Orientation/Annual Safety Training" (Exhibit A). New physician staff will have a General Orientation (Exhibit D), tour and safety review prior to performing procedures in the Center. Safety Training on Bloodborne | 08/25/2014 |

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: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (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 |
|--------------------|---|---------------|---|----------------------|
| S000826 | <p>1. Review of the facility's policies and procedures indicated there was no medical staff safety policy for medical staff personnel for areas where procedures were performed.</p> <p>2. In interview, on 7-28-14 at 10:10 am, employee #A1 confirmed the above and no documentation was provided prior to exit.</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.</p> <p>Based on document review and interview, the facility failed to provide documentation of safety training in procedure areas for 7 of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 7 medical staff credential files indicated files MD#1, MD#2, MD#3, MD#4, MD#5, MD#6, and MD#7</p> | S000826 | <p>Pathogen, Infection Control and Fire/Emergency Preparedness will be conducted annually thereafter, for all Professional Staff members. Laura Allen RN, Clinical Director, will be responsible for assuring that the annual safety training for the Professional Staff is completed.</p> <p>Tag Number S826 - 410 IAC 15-2.5-4 Medical Staff; Anesthesia and Surgical, 410 IAC 15-2.5-4(c)(1)(E). 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:(E) Safety training required of personnel. Dispute: The Physician files reviewed had Bloodborne Pathogen and Infection Control training</p> | 08/25/2014 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (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>lacked documentation of safety training in procedure areas</p> <p>2. In interview, on 7-31-14 at 10:10 am, employee #A1 confirmed the above and no documentation was provided prior to exit.</p> | | <p>documented within their files at the time of survey (Exhibit B). Surveyor stated that the standard had not been met due to the physician files that he reviewed were void of the Physician General Orientation documentation. We implemented the Physician General Orientation documentation in 2009 for new future physicians being hired to the practice. The physician files reviewed were physicians that have been in regular active practice in our Center for greater than 8 years. These same files, however, did contain the Bloodborne Pathogen and Infection Control training (Exhibit B) and they had received, but had not completed, the Fire and Emergency Preparedness training (Exhibit C). Administration disputes that by not having the General Orientation documentation on senior physician partners that have been working at the Center, some since the opening, does not demonstrate that we are not in compliance. These reviewed physician files were compliant with the safety training as evidenced by the documentation of Bloodborne Pathogen and Infection Control training in their files (Exhibit B) We were able to demonstrate that all new physicians are receiving the General Orientation training and have been since 2009 (Exhibit D). Bloodborne Pathogen</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (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 |
|--------------------|---|---------------|--|----------------------|
| S001000 | <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6</p> <p>The center shall provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services. Pharmaceutical services must have the following: Based on observation, the facility failed to store drugs in a safe and effective manner, in accordance with accepted professional practice.</p> <p>Findings:</p> <p>1. On 7-30-14 at 10:00 am, in the presence of employees #A1 and #A2, it was observed in a refrigerator adjacent to the nursing station, there was 1 vial of 25 mg 15 ml Diltiazem HCl injection with a manufacturer's expiration date of 6-14. Thus, the medication was available to use after the expiration date.</p> | S001000 | <p>training is a safety measure per OSHA and the physicians have completed this training and are therefore compliant with the standard. It is hereby requested by Administration that this tag citation for Tag S826 be removed from the Center's Statement of Deficiencies, dated 8/11/2014, and that no plan of correction be warranted.</p> <p>Tag S1000 - Laura Allen RN, Clinical Director, destroyed the expired medication found during survey at the time of discovery. When conducting monthly checks for outdated drugs and biologicals, the drug or biologic will be pulled from available use 1 month prior to the actual expiration date on the item. Replacements can be ordered at that time, and then the expired item will be destroyed upon arrival of the new replacement. This will allow time for an additional monthly check, to discover any expired item that was missed or was not pulled from stock on the</p> | 07/31/2014 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (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 |
|--------------------|--|---------------|--|----------------------|
| S001152 | <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(B)</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>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plan and equipment by qualified personnel as follows:</p> <p>(B) All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the facility failed to perform maintenance in accordance with the manufacturer's recommendation for 1 of</p> | S001152 | <p>previous monthly check, but still allow for the item to be not expired. Laura Allen RN, Clinical Director, and/ or her assignee will be responsible for the proper identification of expired drugs or biologics and have them destroyed in a timely manner before the date of expiration is reached.</p> <p>Tag S1152-410 IAC 15-2.5-7 Physical Plant, Equipment Maintenance, 410 IAC 15-2.5-7(b)(3)(B) (b) the condition of the physical plant and the</p> | 08/25/2014 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>1 piece of mechanical equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a document entitled Carrier GEMINI Installation, Start-Up and Service Instructions, for an air conditioning unit, the manufacturer indicated to inspect the coils monthly and clean them as required. Review of periodic maintenance documents indicated there was only quarterly maintenance performed on the air conditioning unit. In interview, on 7-29-14 at 4:00 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit. | | <p>overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (3) Provision must be made for the periodic inspectin, preventative maintenance, and repair of the physical plant and equipment by qualified personnel as follows: (B) All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule. Dispute: The air conditioner unit is part of the exterior physical plant and maintains comfortable conditions within Center during warm weather. The Center performs GI Endoscopy procedures only, elective in nature, average length of proceure being 15-30 minutes on average and with moderate (conscious) sedation only being administered. Should the one small internal coil in this air conditioner fail, patients within the Center can be safely recovered in enough time and discharged to home before conditions within the Center would become unfavorable or uncomfortable. No further cases would be started and procedures could be cancelled and rescheduled if the air conditioner should fail. There</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| | | | is NO safety risk to the patient or the patient's comfort. The air conditioner unit is serviced and has preventative maintenance conducted on a quarterly basis and as needed per a qualified, licensed contracted service vendor. Since this is not a direct piece of patient equipment and the coils are inspected during the quarterly preventative maintenance, the unit is not located in a coastal area or in a environmentally contaminated area, quarterly preventative maintenance is deemed appropriate. The added expense of a monthly inspection of one internal coil is viewed as unnecessary for a piece of equipment that is not a threat to the patient's safety. The monthly inspection would entail having the unit turned off , taken apart in sections to reach the 1 internal small coil, which will leave us without air conditioning while being inspected. In conversation with Kris Griffith, with Ferrer Mechanical, a qualified, licensed contracted service vendor, on 8/25/2014, he states that the coil could be inspected monthly for cleanliness, but this will not be an indication or warning as to IF and WHEN the coil may fail which is why it is not conducted on a montly basis, but instead on a quarterly preventative maintenance inspection. He also states that no other healthcare facility that he services is having | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| S001170 | <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly</p> | | <p>coils checked on a monthly basis. In the regulation (standard) under (B) it states "All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice OR the manufacturer's recommended maintenance schedule." We provided a documented maintenance schedule that is appropriate in frequency in accordance with acceptable standards for this piece of equipment, which is quarterly and as needed. Administration hereby requests that this tag citation, S1152, be removed from the Center's Statement of Deficiencies, dated 8/11/2014, and that no plan of correction be warranted.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (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>serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to document defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator.</p> <p>Findings:</p> <p>1. Review of the ZOLL AED Plus manual, section entitled Maintenance and Troubleshooting, indicated a Pass/Fail Maintenance Checklist to be used when periodically checking the unit:</p> <p>Are there any cracks or loose parts in the housing? Verify electrodes are connected to the unit and sealed in their package. Replace if expired. Are all cables free of cracks, cuts and exposed or broken wires? Batteries within expiration date. Replace if expired.</p> <p>2. Review of a document entitled CRASH CART - AED <u>DAILY CHECK SHEET</u>, for the month of August, 2013, indicated it did not include the above</p> | S001170 | <p>Tag S1170 - Laura Allen RN, Clinical Director added the provided manufacturer's suggested daily checklist (Exhibit E) to the daily checks conducted by Center staff on the AED (automatic external defibrillator). Staff were instructed on 8/25/2014 as to what to inspect on the AED and how to use the provided checklist to document their checks on the equipment. Laura Allen RN, Clinical Director, and or her assignee, will be responsible for confirming that the daily checks for the AED are complete and documented appropriately on the attached checklist.</p> | 08/25/2014 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| S001196 | <p>daily checks.</p> <p>3. In interview, on 7-29-13 at 4:25 pm, employees #A1 and #A2 confirmed the above and no further 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)(5)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(5) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with center policy and state and local regulations.</p> <p>Based on document review and interview, the facility failed to maintain documentation of regular inspection and approval of the facility by a state or local fire control agency.</p> <p>Findings:</p> <p>1. Review of documents indicated the last time there was a State or local fire agency inspection was July 23, 2012. Review of documents indicated there was</p> | S001196 | Tag S1196 - Laura Allen, RN Clinical Director contacted the Department of Homeland Security, Fire Code Enforcement on 7/30/2014 and requested an Fire Safety and Fire Code inspection. Chris Clouse with the DHS explained that the inspector for our division would not be available until after August 17th, 2014. On August 19, 2014, Laura Allen, Clinical Director spoke with Russell Dorsey of DHS and scheduled an inspection for 8/25/2014. Russell Dorsey, from the DHS, inspected the facility on | 08/25/2014 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001058 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/31/2014 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER THE ENDOSCOPY CENTER AT ST FRANCIS LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 8051 S EMERSON AVE STE 150 INDIANAPOLIS, IN 46237 | | |
| (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>no documentation of request for a State or local fire agency inspection for year 2013.</p> <p>2. In interview, on 7-30-14 at 9:30 am, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p> | | <p>8/25/2014 and deemed the Center in compliance with Fire and Building Enforcement as evidenced by report attached (Exhibit F). Laura Allen RN, Clinical Director will be responsible for assuring that the Fire Safety and Fire Code Inspection is conducted annually and the proper documentation is obtained.</p> | | |