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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15C0001128 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                     |  | X3) DATE SURVEY COMPLETED<br><br>11/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MEDICAL CONSULTANTS ENDOSCOPY CENTER LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>800 S TILLOTSON AVE<br>MUNCIE, IN 47304 |  |   |  |
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| S0000  | <p>This visit was for a State licensure survey.</p> <p>Facility Number: 003754</p> <p>Survey Date: 11/7/12 through 11/8/2012</p> <p>Surveyors:<br/>Saundra Nolfi, RN<br/>Public Health Nurse Surveyor</p> <p>Albert Daeger<br/>Medical Surveyor</p> <p>QA: claughlin 11/16/12</p> | S0000   |   |  |  |   |  |

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

TITLE

(X6) DATE

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

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| S0110  | <p>410 IAC 15-2.4-1<br/>GOVERNING BODY; POWERS AND DUTIES<br/>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 documentation review and staff interview, the facility failed to conduct quarterly meetings of the Governing Board as defined by the Governing Board By-laws.</p> <p>Findings included:</p> <p>1. Governing Board By-laws Article III (last reviewed 4/23/2011) states, "The Governing Board will meet at least four (4) times a year and function as an organized body."</p> <p>2. The Quality Improvement Program (last reviewed 9/21/2011) states, "... QA committee will meet</p> | S0110   | <p>The Governing Board met to confirm 2013 meetings inclusive Quality Improvement quarterly with the following dates: January 16, April 10, July 17 and October 9. The posting of a planned calendar without cancellation per Governing Board chariperson to prevent deficiency in the future. The administrator will implement and monitor the process.</p> | 11/19/2012   |  |   |  |

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|  | <p>quarterly, as part of the Medical Staff meeting and Governing Board meeting, which are integrated into the same meeting."</p> <p>3. Medical Consultants Board of Directors Minutes (includes Quality Improvement Committee) for the previous 12 months evidenced only 1 meeting held on November 1, 2012 and the previous meeting to the November meeting was held on December 11, 2011. Therefore, the facility only conducted 1 Governing Board committee meeting for 2012.</p> <p>4. At 2:15 PM on 11/8/2012, staff member #1 confirmed the Governing Board/Quality Assurance Committee only met once in 2012.</p> |   |   |                      |   |

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| S0153  | <p>410 IAC 15-2.4-1<br/>GOVERNING BODY; POWERS AND DUTIES<br/>410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review, personnel file review, and interview, the facility failed to ensure 1 of 4 registered nurses (RNs- #A11) and 1 of 1 housekeeping staff members (#A9) received job specific orientation.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility document "Employee Files", which listed all items that should be contained in the staff records, indicated, "...Orientation checklist within 4 weeks of start date".</li> <li>The personnel file for RN #A11, hired 10/27/03, indicated a "Business Office Orientation Sheet" and a "Clinical Orientation Sheet" that were initialed by the employee and signed by staff member A1, but the forms lacked any dates to determine when orientation was done.</li> </ol> | S0153   | The personnel file of the housekeeping staff reviewed job specific orientation and the hired RN reviewed the job orientation with current date. The job checklist was updated and reviewed by the administrator as well as the infection control nurse with the housekeeper and RN. | 11/27/2012   |  |   |  |

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|                    | <p>3. The personnel file for the housekeeping staff member, #A9, hired 09/24/10, lacked documentation of job specific orientation.</p> <p>4. At 4:00 PM on 11/08/12, staff member #A1 confirmed the personnel file findings.</p> |               |   |                      |

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| S0176  | <p>410 IAC 15-2.4-1<br/>GOVERNING BODY; POWERS AND DUTIES<br/>410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on policy review, personnel file review, and interview, the facility failed to ensure 4 of 4 registered nurses (RNs) received training in the administration of moderate sedation (#A5, A7, A11, and A12).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Sedation/Analgesia", last reviewed 04/23/11, indicated, "...d. Personnel requirements- an RN may administer sedation/analgesia under the supervision of the endoscopist. Verbal orders must be given to the nurse by the physician that defines the medication and dosage to be given. All RNs must have training about administering sedation/analgesia and the antagonist therapy for those specific agents."</li> <li>Review of the personnel files for RNs, staff members #A5, hired 10/27/03, #A7, hired 09/02/04, #A11, hired 10/27/03, and #A12, hired 09/24/03, lacked documentation of training in administering sedation/analgesia and antagonist therapy for those medications.</li> <li>At 4:00 PM on 11/08/12, staff member #A1</li> </ol> | S0176   | <p>Sedation/Analgesia reviewed and training with test documented and logged into staff file. Also updated the policy and procedure Moderate Sedation with anesthesia consultant and approved by the governing board 11/19/2012. The safety and compliance of this policy is monitored by the Administrator and will be reported as quality and safety management at the Governing Board meetings per administrator</p> | 11/26/2012   |  |   |  |

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|                    | confirmed the lack of documentation in the personnel files, but indicated the training was conducted annually and included skill testing. |               |   |                      |

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| S0182  | <p>410 IAC 15-2.4-1<br/>GOVERNING BODY; POWERS AND DUTIES<br/>410 IAC 15-2.4-1 (c)(5) (O)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(O) Annual implementation of internal and external disaster preparedness plans with documentation of outcome.<br/>Based on documentation review and staff interview, the facility failed to document the performance of an annual disaster preparedness plan with documentation of outcome.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>At 12:10 PM on 11/8/2012, staff member #1 was requested to provide documentation of an annual disaster preparedness exercise and none was provided prior to exit.</li> <li>At 12:15 PM on 11/8/2012. staff member #1 indicated that the center lacked documentation of annual disaster exercise for 2010 to November 2012. The staff member</li> </ol> | S0182   | <p>Annual implementation and documentation of internal and external disaster preparedness plans will be reviewed and look at outcomes for improvement. Anticipation of approval by the Governing Board on January 16 2013 will be presented by the administrator. Disaster exercise with the hospital and local health department will be reviewed and confirmed on Dec. 12 2012 attending by the administrator.</p> | 12/12/2012   |  |   |  |

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|                    | indicated the facility entered into an agreement with IU Ball Memorial Hospital on 4/11/12 to participate with them on their disaster exercise. However, as of 11/8/12, the center has not participated in any disaster exercise with the hospital. |               |   |                      |

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| S0184  | <p>410 IAC 15-2.4-1<br/>GOVERNING BODY; POWERS AND DUTIES<br/>410 IAC 15-2.4 (c)(5)(P)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(P) Development, implementation, and monitoring of a safety management program to include, but not be limited to, the following:</p> <p>Based on documentation review and staff interview, the facility failed to ensure the Medical Consultants Endoscopy Center had an effective well organized Safety Management Program.</p> <p>Findings included:</p> <p>1. Medical Consultants Inc. oversees the operation of the Medical Consultants Endoscopy Center. The Medical Consultants Inc. Board of Directors Minutes held on August 30, 2010 explained the Medical Consultants Inc. complex will adopt Eagle Associates in establishing guidelines for the complex of assorted businesses (including the</p> | S0184   | <p>Effective and organized own Safety Management program complex to an ASC (Endoscopy Center) will be developed and implemented using the Eagle Associates guidelines by the administrator and will be approved on January 16 2013 by the Governing Board.</p> | 12/06/2012   |  |   |  |

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|                    | <p>ASC) in OSHA, EPA, CDC, NFPA and other federal, state, and local laws. The Safety Manual that was provided to the complex indicates the facility can use the safety manual as provided for reference, but the facility must adopt their own Safety Management Program.</p> <p>2. At 11:47 AM on 11/8/12, staff member #1 indicated the facility has some policies that could be part of a safety program. The facility has not created a facility specific safety management program.</p> |               |   |                      |

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| S0300  | <p>410 IAC 15-2.4-2<br/>QUALITY ASSESSMENT AND IMPROVEMENT<br/>410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>Based on document review, and staff interview, the facility failed to ensure Quality Assurance Committee met quarterly as defined by the Quality Improvement Program.</p> <p>Findings included:</p> <p>1. The Quality Improvement Program (last reviewed 9/21/2011) states, "The Quality Improvement will include all members of the Medical Staff and the DON. The DON will coordinate collection of data for review by the QA committee will meet quarterly, as part of the Medical Staff meeting and Governing Board meeting,</p> | S0300   | The Governing Board will meet quarterly as the dates confirmed January 16, April 10, July 17 and October 9 reviewing the Quality Management program which will include Moderate Sedation, Patient Wait time and Pathology reporting. The Quality Management Meeting will be on January 10th, April 4, July 11 and Oct. 3 2013 inclusive of the MDs and the administrator. The planned meetings will facilitate compliance and no cancellation of meetings. This process is implemented and monitored by the administrator. | 11/19/2012   |  |   |  |

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|  | <p>which are integrated into the same meeting."</p> <p>2. Medical Consultants Board of Directors Minutes (includes Quality Improvement Committee) for the previous 12 months evidence only 1 meeting held on November 1, 2012 and the previous meeting to the November meeting was held on December 11, 2011. Therefore, the facility only conducted 1 Quality Assurance Committee meeting for the 4 quarters of 2012.</p> <p>3. At 2:15 PM on 11/8/2012, staff member #1 confirmed the Governing Board/Quality Assurance Committee only met once in 2012. The staff member indicated he/she thought the staff meetings can substitute for the Quality Assurance Committees; however, the staff meeting do not have presence a member of the medical staff.</p> |   |   |  |  |   |  |

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| S0320  | <p>410 IAC 15-2.4-2<br/>QUALITY ASSESSMENT AND IMPROVEMENT<br/>410 IAC 15-2.4-2(a)(2)</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>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer.<br/>(B) Infection control.<br/>(C) Medication errors.<br/>(D) Response to patient emergencies.</p> <p>Based on documentation review and staff interview, the facility failed to ensure Medication Errors was evaluated in the facility's Quality Assessment Program.</p> <p>Findings included:</p> <p>1. Quality Assurance Program (reviewed 9/21/11) indicated the facility will include ongoing and incident based monitors. The incident based monitors include Medication Errors.</p> <p>2. Quality Improvement/Risk Management Committee minutes</p> | S0320   | Quality assessment and improvement program will include all discharge and transfer, infection control issues, medication errors and patient emergencies. Quality Assessment Meeting held on Dec. 06 at 4:30 pm covered these functions with the MDs and the infection control nurse as well as the administrator was present. Again the confirmed dates posted for 2013 inclusive in S300 to facilitate this process inforced by the administrator, and the support of the infection control nurse as well as the Chariperson of the Governing Board. | 12/06/2012   |  |   |  |

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|  | <p>were reviewed for the previous 12 months. The documentation provided by staff member #1 evidenced that the indicator Medication Errors had not been discussed or evaluated by the committee.</p> <p>3. At 2:15 PM on 11/7/2012, staff member #1 confirmed Medication Errors were not evaluated by the Quality Improvement Committee.</p> |   |   |                      |   |

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| S0414  | <p>410 IAC 15-2.5-1<br/>INFECTION CONTROL PROGRAM<br/>410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on facility document review and interview, the facility failed to ensure the infection control committee was comprised of the required members and met quarterly as required.</p> <p>Findings included:</p> <p>1. The Medical Bylaws, last approved 08/10/11, indicated, "...Quality Improvement Committee (QIC): ...3. The QIC shall also incorporate the functions of a Medical Record Committee, Procedure Committee, Infection Control Committee, and Patient Care Committee. ...g. The QIC committee shall meet at the minimum of one</p> | S0414   | Implemented first medical staff meeting with the infection control nurse present and reporting surveillance, prevention and control of the program. The infection control nurse will attend with the administrator the Governing Board meeting on January 16, April 10, July 17 and October 9 2013. The administrator is supporting on going time allotted for the infection control nurse activities as well as ongoing | 12/06/2012   |  |   |  |

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|  | <p>time per quarter as part of the Governing Body/Medical Staff Meeting."</p> <p>2. The Governing Body/Medical Staff Meeting minutes provided indicated meetings were held Dec. 27, 2011 and not again until Nov. 1, 2012. The minutes indicated the attendance was comprised of the board members and the administrator, staff member #A1.</p> <p>3. At 3:40 PM on 11/07/12, staff member #A1 indicated the staff discusses QA (Quality Assurance), safety, infection control, etc. at staff meetings and minutes are kept. He/she then takes a summary of these minutes to the medical staff meetings. He/she indicated the staff member in charge of infection control, #A7, does not attend the medical staff meetings nor does any member of the medical staff attend the regular staff meetings where everything was discussed.</p> <p>4. At 10:00 AM on 11/08/12, the infection control nurse, staff member #A7, indicated he/she did not actually have a committee, but presented any infection control information at monthly staff meetings (nursing staff only). He/she also indicated the only documentation was the content he/she presented. He/she indicated he/she did not attend any meetings with the medical staff. He/she provided documentation of staff meetings from 01/05/12, 04/05/12, 05/03/12, 08/02/12, and 11/01/12.</p> |   | CEUs. This process is implemented and monitored by the administrator.   |                      |   |

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| S0616  | <p>410 IAC 15-2.5-3<br/>MEDICAL RECORDS, STORAGE, AND ADMIN.<br/>410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure the transfer orders were noted by the nurse as implemented in 4 of 4 patient records who were transferred (#N8, N19, N25, and N26).</p> <p>Findings included:</p> <p>1. The facility policy "Identification of Authors and Authentication of Medical Record Entries", last reviewed 04/23/11, indicated, "...An entry in the medical record is defined as legible documentation by a physician and other licensed health care professionals, who record the patient's history, assessments, progress, prescribed care, and treatment. These entries are authenticated and dated by the author. ...A. Authenticate means the author or responsible individual reviews the entry and validates the content by: 1. A full signature, including first initial, last name, and discipline. ...C. Each verbal order shall contain the date, time, signature of the licensed nurse accepting the order, and the name of the person giving the order.</p> | S0616   | Adequate medical records maintained with documentation of service rendered with authentication and security of the record entries with dates. The licensed nurse accepting the order needs date, time, and signature implemented of the order. The incidences were reviewed with the licensed nurses and medical staff on the Dec. 6 2012 meeting. Also the Med-Rec consultant reports observation and recommendation were shared. Administrator has facilitated for a new version of G-Med with staff member attending January 31 and Feb. 1 2013 meeting and completion of the new software by April 19 2013 will facilitate evidence of authentication of medical record entries. The Administrator will consult with the Med-Rec | 12/06/2012   |  |   |  |

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|  | <p>In addition, the record documents who implemented each verbal order."</p> <p>2. The medical record for patient #N8 indicated a physician order to transfer the patient, dated 04/16/12, but without a date, time, or signature of the person who implemented the order.</p> <p>3. The medical record for patient #N19 indicated a physician order to transfer the patient, dated 01/12/12, but without a date, time, or signature of the person who implemented the order.</p> <p>4. The medical record for patient #N25 indicated a physician order to transfer the patient, dated 01/19/12, but without a date, time, or signature of the person who implemented the order.</p> <p>5. The medical record for patient #N26, who was transferred from the facility on 10/01/12, lacked documentation of a transfer order.</p> <p>6. At 2:15 PM on 11/08/12, staff member #A10, who navigated the electronic medical record (EMR), confirmed the medical record findings and indicated, although the physician orders were written and not verbal, they should have been authenticated by the nurse who implemented them.</p> |   | <p>consultant on the new upgrades of G-Med. Ongoing monitoring of all transfer orders will be implemented and facilitated by the administrator and the infection control nurse with safety/infection audit tool and Med-Rec consultant audit. Also random audits of other orders.</p> |                      |   |

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| S0672  | <p>410 IAC 15-2.5-3<br/>MEDICAL RECORDS, STORAGE, AND ADMIN.<br/>410 IAC 15-2.5-3(f)(13)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(13) A copy of the transfer form, if the patient is referred to a hospital or other facility.</p> <p>Based on policy review, medical record review, and interview, the facility failed to follow their documentation policy for 4 of 4 patients who were transferred from the facility (#N8, N19, N25, and N26).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "Emergency Transfer", last reviewed 04/23/11, indicated, "...3. The Patient Transfer Form, attached to this policy, shall be completed and shall accompany the patient." Two forms were attached to the policy, "Patient Transfer Form", which provided a space for the condition at time of transfer, and "Transfer Record".</li> <li>The medical record for patient #N8, transferred 04/16/12, indicated a "Transfer Record", but lacked a "Patient Transfer Form". The "Transfer Record" lacked any notation of the condition at time of transfer.</li> <li>The medical record for patient #N19, transferred 01/12/12, indicated a "Transfer Record", but lacked a "Patient Transfer Form". The "Transfer Record" lacked any notation of the condition at time of transfer.</li> </ol> | S0672   | <p>The facility policy on Emergency Transfer must document and maintain a copy of the written transfer form. The transfer form will note patient condition at time of transfer and will scan into the EMR system the written form not just confirmations into the EMR findings. The administrator has facilitated new upgrade of the G-Med software which will facilitate this process in the EMR system to be printed on patient discharge as well as administrated tracking. The training start Jan. 31 to be fully implemented by April 19 2013. This process was reviewed with the licensed nursing staff and MDs on Dec. 6 2012 by the administrator and infection control nurse.</p> | 12/06/2012   |  |   |  |

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|  | <p>4. The medical record for patient #N25, transferred 01/19/12, indicated a "Transfer Record", but lacked a "Patient Transfer Form". The "Transfer Record" lacked any notation of the condition at time of transfer.</p> <p>5. The medical record for patient #N26, transferred 10/01/12, indicated a "Transfer Record", but lacked a "Patient Transfer Form". The "Transfer Record" lacked any notation of the condition at time of transfer.</p> <p>6. At 2:15 PM on 11/08/12, staff member #A10, who navigated the electronic medical records (EMR), confirmed the medical record findings.</p> <p>7. At 4:00 PM on 11/08/12, staff member #A1 indicated the second transfer form must not have gotten scanned into the EMR of the patients reviewed.</p> |   |   |                      |   |

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| S0780  | <p>410 IAC 15-2.5-4<br/>MEDICAL STAFF; ANESTHESIA AND SURGICAL<br/>410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure a physician's order was documented for medication in 1 of 1 patient records that had medication given that was not part of the routine standing orders (#N3).</p> <p>Findings included:</p> <p>1. The facility policy "Medication Administration", last reviewed 07/20/11, indicated, "...1. All medications require written or pre-printed orders prior to administration. ...2. Orders given orally must be followed by a written and signed physician's order."</p> <p>2. The medical record for patient #N3 indicated documentation by the nurse at 11:46 AM on 08/31/12, "Tylenol 1000 mg.P.O given for headache per md order". The record lacked any documentation of a written or verbal order for this medication.</p> | S0780   | In the staff meeting as well as the medical staff meeting on Dec. 6 2012 reviewed the provider orders need documented and authenticated. Reviewed an incident of an order to give atropine by the provider and the administrator consulted the provider after the procedure documentation of the order was not documented/signed. The provider corrected the deficiency immediately and later used at the meeting as an example. Ongoing audit with the peer review of the anesthesia consultant and our medical record consultant implemented by the administrator. | 12/06/2012   |  |   |  |

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|  | 3. At 2:15 PM on 11/08/12, staff member #A10, who navigated the electronic medical record (EMR), confirmed the absence of an order to give the Tylenol to the patient. |   |   |                      |   |

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| S1010  | <p>410 IAC 15-2.5-6<br/>PHARMACEUTICAL SERVICES<br/>410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on policy review, observation, and interview, the facility failed to ensure medication was drawn into syringes and that syringes were labeled according to policy and acceptable standards of practice.</p> <p>Findings included:</p> <p>1. The facility policy "Medication Administration", last reviewed 07/20/11, indicated, "...7. All medication will be labeled with the name of the drug, the date and time, strength and dosage after drawn up in the present of a team member for witness and confirmation of the drug after patient in the procedure room prior to start of the procedure for immediate use."</p> <p>2. At 11:25 AM on 11/07/12 in the prep area for the case observation, staff member #A3 used a syringe labeled "1% Xylocaine RK 11/07/12" prior to starting the patient's IV (intravenous line).</p> <p>3. At 11:40 AM on 11/07/12 in the procedure room for the case observation, staff member #A5 drew up the medications Versed and Fentanyl without another staff member as witness. The</p> | S1010   | <p>Drug handling and labeling with dispensing policy and procedure was reviewed with the staff at monthly meeting held on Dec. 6 2012 with diagram of label: medication, date, time, strength with expiration date and initials. This process is witnessed by another team member immediately prior to use. Also reviewed wasting medication and signature on completion of process. This safety measure was reviewed by the administrator as well as the infection control nurse on handling of needles, syringes and drawing up medication with the licensed nursing staff and the MDs at the Dec. 6 2012 meeting. The administrator and infection control nurse is responsible for facilitating and monitoring this process with random audits, and using the safety and infection control audit tool of a minimum quarterly. These monitoring audits will be reviewed and</p> | 12/06/2012   |  |   |  |

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|  | <p>syringes of medication were labeled with the name of the medication, strength of the medication, date, and staff member's initials.</p> <p>4. At 4:00 PM on 11/08/12, staff member #A1 confirmed the medication syringes were not labeled with the time of draw or expiration date or time since they were used soon after being drawn up, then discarded. He/she indicated another staff member was supposed to witness the medications being drawn up and labeled.</p> |   | <p>reported outcome improvements at the staff/MD meetings.</p>  |                      |   |

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| S1184  | <p>410 IAC 15-2.5-7<br/>PHYSICAL PLANT, EQUIPMENT MAINTENANCE,<br/>410 IAC 2.5-7(c)(3)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(3) The safety program includes, but is not limited to, the following:</p> <p>(A) Patient safety.<br/>(B) Health care worker safety.<br/>(C) Public and visitor safety.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the Medical Consultants Endoscopy Center had an effective well organized Safety Management Program that includes patient safety, health care worker safety, and public and visitor safety.</p> <p>Findings included:</p> <p>1. Medical Consultants Inc. oversees the operation of the Medical Consultants Endoscopy Center. The Medical Consultants Inc. Board of Directors Minutes held on August 30, 2010 explained the Medical Consultants Inc.</p> | S1184   | Update of the Eagle Associates safety program detailed to an Endoscopy Center with patient safety, immunization, ergonomics, universal precaution, OSHA,CDC, patient and visitor safety, fire and emergency preparedness etc. This process is ongoing with initial details being implemented with anticipation of adoption by the Governing Board meeting on January 16 2013 presented by the administrator. Enforcement of the monthly assigned compliance testing for the staff and MDs. | 01/16/2013           |   |

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|  | <p>complex will adopt Eagle Associates in establishing guidelines for the complex of assorted businesses (including the ASC) in OSHA, EPA, CDC, NFPA and other federal, state, and local laws. The Safety Manual that was provided to the complex indicates the facility can use the safety manual as provided for reference, but the facility must adopt their own Safety Management Program.</p> <p>2. At 11:47 AM on 11/8/12, staff member #1 indicated the facility has some policies that could be part of a safety program. The facility has not created a facility specific Safety management Program. The facility has policies in Infection Control Plan that explains safety precautions as it relates to infectious diseases.</p> |  |  |  |
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| S1188  | <p>410 IAC 15-2.5-7<br/>PHYSICAL PLANT, EQUIPMENT MAINTENANCE,<br/>410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires.<br/>(B) Extinguishing of fires.<br/>(C) Protection of patients, personnel, and guests.<br/>(D) Evacuation.<br/>(E) Cooperation with firefighting authorities.<br/>(F) Fire drills.</p> <p>Based on document review and staff interview, the facility failed to ensure fire drills are conducted one per quarter as defined by the Medical Consultants policies and procedures and the facility lacked a written fire control plan.</p> <p>Findings included:</p> <p>1. Medical Consultants Inc. oversees the operation of the Medical Consultants Endoscopy Center. The Medical Consultants Inc. Board of Directors Minutes</p> | S1188   | The Written Fire Control Plan will be adopted including prompt reporting of fires, extinguishing of fires, protection of patients, staff and visitors, evacuation, working with fireman (detailing the Eagles Associate specific to our center) and quarterly fire drills not 4x yearly detailing out leaving the bldg etc. Also, the tornado drill will be separate from the Fire Drill not inclusive. Implemented by the administrator quarterly not 4x a year. | 12/10/2012           |   |

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|                    | held on August 30, 2010 explained the Medical Consultants Inc. complex will adopt Eagle Associates in establishing guidelines for the complex of assorted businesses (including the ASC) in OSHA, EPA, CDC, NFPA and other federal, state, and local laws. The safety guidelines for fire drills 1.20d states, "The National Fire Protection Association (NFPA) recommends that fire drills be conducted quarterly on each shift to familiarize employees with their responsibilities during varied fire emergencies." The Safety Manual that was provided to the complex indicates the facility can use the safety manual as provided for reference, but the facility must adopt their own Fire Control Plan that contains provisions for the following: Prompt reporting of fires; Extinguishing of fires; Protection of patients, personnel, and guests; Evacuation; cooperation with firefighting authorities; and Fire drills.. |               |   |                      |

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|                    | <p>2. At 9:30 AM on 11/8/2012, staff member #1 was requested to provide documentation of the facility's Fire Control Plan. Staff member #1 could not provide a facility specific Fire Control Plan.</p> <p>3. At 9:45 AM on 11/8/2012, staff member #1 indicated the facility does not have a facility specific Fire Control Plan.</p> <p>4. Medical Consultants PC Fire Drill Records indicated fire drills were held: 12/28/11, 2/14/11, and 10/10/12. On 4/21/12, the facility held a Tornado Drill/Fire Drill. However, the drill discussed not leaving the building and gather in the hallways. The drill was primarily to respond to a tornado drill and did not reflect a fire drill response. Therefore, the ASC held only 2 fire drills for the previous complete 4 quarters.</p> <p>5. At 11:30 AM on 11/8/12, staff member #1 indicated the ASC was suppose to conduct 1 fire drill per</p> |               |   |                      |

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|  | quarter. The staff member confirmed the ASC did not conduct the required fire drills.                                  |   |   |                      |   |

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| S1198  | <p>410 IAC 15-2.5-7<br/>PHYSICAL PLANT, EQUIPMENT MAINTENANCE,<br/>410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on documentation and staff interview, the facility failed to have a written Emergency and Disaster Preparedness Plan that coordinates with appropriate community, state, and federal agencies.</p> <p>Findings included:</p> <p>1. The facility has written plan labeled Disaster Drills. The written plan has no date identified when the plan was last reviewed. The written plan is less than one page and it does not identify how the facility will coordinate their disaster drills with appropriate community, state, and federal agencies. The plan identifies a staff member may make the decision to</p> | S1198   | <p>Disaster Drill plan needs the evacuation event of immediate danger identified and the chain of command reviewed and approved at the next Governing Board meeting January 16 2013. As well as, understanding of use of our facility with the IU/BMH in the event a need arises identified at the next meeting Dec. 12, 2012. Also re-confirm with the local public health department a triage phone list for availability of nurses.</p> | 01/16/2013   |  |   |  |

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|  | <p>evacuate immediately in the event of immediate danger. Then plan does not explain the chain of command in case of an emergency.</p> <p>2. At 12:10 PM on 11/8/2012, staff member #1 indicated the facility has a written plan labeled 'Disaster Drills'. The staff member does not know when it was approved. The staff member indicated the written plan was not well written and does not explain how to coordinate with appropriate community, state, and federal agencies.</p> |   |   |                      |   |