

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 006214</p> <p>Survey Date: 1/24/13 through 1/25/13</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 01/28/13</p>	S000000		

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:  15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S000122	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body.</p> <p>Based on documentation review and staff interview, the facility failed to ensure the Medical Staff approved rules and regulations.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Medical Staff Bylaws Article VIII Section 8.3, last approved 2/24/2011, states, "The present rules and regulations of the Medical Staff are hereby readopted and placed into effect pursuant to these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws."</li> <li>2. Staff member could not provide Medical Staff Rules and Regulations as the Medical Staff Bylaws references. The facility</li> </ol>	S000122	<p>The Medical Staff members review the Community Center for Digestive Care Policy/Procedure which includes the policies for the Medical Staff during the credentialing process and with any change after they are credentialed. The Medical Director and the Executive Director developed Medical Staff Rules and Regulations which consists of rules/policies from current Medical Staff Bylaws and Facility Policy. The Medical Staff reviewed and approved these on February 24th, 2013. The Medical Staff will review and approve the Medical Staff Rules and Regulations triennially and with any change. This process will be reflected in the Medical Staff Meeting notes. The Executive Director will include the review and approval of Medical Staff Rules and Regulations in the Medical Staff Meeting Agenda and Notes. This will be done prior to final approval by the Board of Managers.</p>	03/24/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>could not provide documentation that the facility's policies and procedures were reviewed and approved by the Medical Staff before they were reviewed and approved by the Governing Board.</p> <p>3. At 3:10 PM on 2/24/2013, staff member #1 indicated the Medical Staff do not have Rules and Regulations. The Medical Staff are expected to comply with the facility's policies and procedures. However, the Medical Staff have never reviewed and approved the facility's policies and procedures.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000432	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, policy and procedure review and interview, the infection control committee failed to ensure the patient care areas were cleaned according to policy to prevent cross-contamination between patients.</p> <p>Findings included:</p> <p>1. During the tour of the pre/post area at 2:10 PM on 01/24/13, staff member #N2 was observed cleaning a patient unit after the discharge of the patient. Staff member #N2 used the approved disinfectant wipes to clean the patient cart, including siderails, pillow, and top of supply stand. He/she removed the trash and indicated the cart could be remade with linens after 5 minutes, then would be ready for the next patient. The equipment used on the patient, including</p>	S000432	The policy Cleaning of Clinical Areas was reviewed with the Center staff on 1/28/13. During the review they were reminded of the necessity of cleaning thoroughly the finger probes, blood pressure cuffs and cords. Staff were reminded to speak up if they noticed that another staff member was not following policy for cleaning. The Infection Control Officer will be responsible for performing random audits of staff cleaning of clinical areas and report at the next QA meeting on April 10th, 2013. Responsible party-Team Leader	01/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a blood pressure cuff and oxygen saturation probe, and all the connecting cords were not disinfected and had been wound up and hung on the equipment, ready for use.</p> <p>2. The facility policy, "Cleaning of Clinical Areas by Staff", last reviewed 11/27/2012, indicated, "2. After a patient has vacated a cart or patient room, the surfaces that were exposed to patient contact or equipment contact will be wiped with a damp cloth with a hospital grade disinfectant per label instructions."</p> <p>3. At 2:15 PM on 01/24/13, staff member #N2 indicated all of the equipment should have been cleaned between patients.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
S000668	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(11)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(11) Condition on discharge, disposition of the patient, and time of dismissal.</p> <p>Based on medical record review and interview, the facility failed to ensure the records for all patients who received medication for conscious sedation had documentation of condition on discharge, time of dismissal, and discharge to a responsible party for 4 of 16 records reviewed (#P6, P7, P12, and P13).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The medical record for patient #P6, who received conscious sedation medication for a procedure on 12/18/12, lacked documentation of condition on discharge, time of dismissal, and discharge to a responsible party.</li> <li>The medical record for patient #P7, who received conscious sedation medication for a procedure on 12/13/12, lacked documentation of condition on discharge, time of dismissal, and discharge to a responsible party.</li> </ol>	S000668	<p>The deficiency was noted when the facility was in the process of implementing a new EMR. The standard of documentation of condition on discharge, disposition of the patient, and time of dismissal will become a part of the Medical Record Consultant quarterly audit. The standard was reviewed with staff who are familiar with the standard, but cannot answer why it was not present in the medical record at the time of survey. If any discrepancies remain during random audits by the Team Leader, the staff member doing the documentation will be counseled and educated about the documentation process during discharge of the patient. Responsible Party: Team Lead/ Medical Record Consultants</p>	01/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>3. The medical record for patient #P12, who received conscious sedation medication for a procedure on 12/10/12, lacked documentation of condition on discharge, time of dismissal, and discharge to a responsible party.</p> <p>4. The medical record for patient #P13, who received conscious sedation medication for a procedure on 12/03/12, lacked documentation of condition on discharge, time of dismissal, and discharge to a responsible party.</p> <p>5. At 12:30 PM on 01/25/13, staff member #N1 confirmed the lack of the required documentation prior to discharge.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S001012	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(B)</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>(B) Drug administration according to established center policies and acceptable standards of practice.</p> <p>Based on medical record review and interview, the facility failed to ensure written policies or standing orders were in place to use topical or injectable medication prior to starting an intravenous line for 5 of 5 patients whose chart documentation indicated medication was used.</p> <p>Findings included:</p> <p>1. The medical record for patient #P1 indicated an injectable local anesthetic was used prior to the insertion of the intravenous line on 11/30/12, but the record lacked documentation of the name or dose of the medication or any order for the medication.</p> <p>2. The medical record for patient #P4 indicated an injectable local anesthetic</p>	S001012	<p>The clinical staff were re-educated regarding the need for physician orders( if patient requests numbing) to be documented in the new EMR which were formerly standing orders in reference to lidocaine given prior to IV starts. Staff was also reminded to document the exact medication dosage, route and time for each medication administration. Random Audits of this deficiency will be performed by the Team Leader and reported at the next QA meeting . Responsible Party: Team Leader</p>	01/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was used prior to the insertion of the intravenous line on 12/21/12, but the record lacked documentation of the name or dose of the medication or any order for the medication.</p> <p>3. The medical record for patient #P7 indicated a topical local anesthetic was used prior to the insertion of the intravenous line on 12/13/12, but the record lacked documentation of the name or dose of the medication or any order for the medication.</p> <p>4. The medical record for patient #13 indicated an injectable local anesthetic was used prior to the insertion of the intravenous line on 12/03/12, but the record lacked documentation of the name or dose of the medication or any order for the medication.</p> <p>5. The medical record for patient #14 indicated an injectable local anesthetic was used prior to the insertion of the intravenous line on 12/17/12, but the record lacked documentation of the name or dose of the medication or any order for the medication.</p> <p>6. At 1:10 PM on 01/25/12, staff member #N1 confirmed the medical record findings and indicated there was no policy or standing order for the use of topical or</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	injectable medication prior to the insertion of an intravenous line. He/she also confirmed the lack of documentation of exactly what medication or dose was used for each patient.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
S001024	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)</p> <p>Pharmaceutical service 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>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>Based on observation, policy review, and interview, the facility failed to ensure syringes of medication were labeled according to policy.</p> <p>Findings included:</p> <p>1. During the case observation at 1:20 PM on 01/24/13, the following items were observed in an unlocked cabinet drawer in procedure room A:</p> <p>A. Four syringes of Versed with labels indicating the dosage and strength, but no date or time prepared, no staff initials, and no medication expiration date.</p> <p>B. Two syringes of Fentanyl with labels indicating the dosage and strength, but no date or time prepared, no staff initials, and no medication expiration date.</p>	S001024	<p>The staff member involved in the deficiency was counseled by the Team Leader and Executive Director. The Medication Administration policy was reviewed by all clinical staff and will be reviewed again at the next Staff Meeting. The Team Leader will do random audits on Medication Administration and report at the next QA meeting. Responsible Party: Team Leader</p>	01/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/25/2013
NAME OF PROVIDER OR SUPPLIER  COMMUNITY CENTER FOR DIGESTIVE CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 MEDICAL ARTS BLVD STE 300 ANDERSON, IN 46011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>2. At 1:20 PM on 01/24/13, staff member #N7 in the procedure room, indicated he/she drew up the medications prior to the cases and indicated the drawer would be locked when no one was in the room.</p> <p>2. The facility policy titled "Medication Administration", last reviewed 11/27/2012, indicated, "7. All medication drawn up and not for immediate use will be labeled with the name of the drug, the strength, the dosage contained in the syringe, the date and time it was drawn up, and the initials of the person who drew it up. It will be stored in a locked drawer until used that day or disposed of at the end of the day."</p> <p>3. At 1:00 PM on 01/25/13, staff member #N1 confirmed the medication syringes were not labeled according to policy.</p>				