

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/29/2011
NAME OF PROVIDER OR SUPPLIER ENDOSCOPY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 13421 OLD MERIDIAN ST STE 150 CARMEL, IN 46032		
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 003498</p> <p>Survey Date: 12-28-11 to 12-29-11</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Karilyn Tretter, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 01/26/12</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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S0148	<p>410 IAC 15-2.4-1 (c) (4)</p> <p>(c) The governing body shall do the following:</p> <p>(4) Require that the chief executive officer designate in writing an administrative officer to serve during his or her absence.</p> <p>Based on document review and interview, the center policy failed to identify an active administration officer to serve when the chief executive officer was not present.</p> <p>Findings:</p> <p>1. The policy/procedure Chain of Command (reviewed 4-11) indicated the following: "When the Executive Director is not available, the Clinical Director would be in charge. When the Executive Director and the Clinical Director are not available, a designated staff person and the Medical Director will be in charge."</p> <p>2. During an interview on 12-28-11 at 1345 hours, staff #A1 confirmed that the position of Clinical Director had been vacant since the center opened in 2004 and the policy/procedure failed to indicate how a designated staff person would be determined and jointly administrate with the Medical Director.</p>	S0148	<p>The Surveyor was told repeatedly that the Endoscopy Charge Nurse also fills the Clinical Director Role. The facility does not have one person who is only the Clinical Director. *The Policy was changed to assist the Surveyor. *An RN is designated/assigned to be in charge when the Executive Director or Endoscopy Charge Nurse is not available. *Executive Director revised policy on 1/15/2012 and it was implemented on 01/15/2012.</p>	01/15/2012			

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S0182	<p>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.</p> <p>Based upon document review and interview, the center failed to document the performance of an annual disaster preparedness drill including an evaluation of the outcome.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-28-11 at 0930 hours, staff #A1 was requested to provide documentation of an annual disaster preparedness exercise and none was provided prior to exit. During an interview on 12-29-11 at 1430 hours, staff #A1 indicated that the center lacked documentation of an annual disaster exercise for 2010-2011. 	S0182	*A Disaster Exercise drill was performed on 2/3/2012. *The Endoscopy Charge Nurse will oversee yearly Disaster Preparedness drills. *Exercise was completed on 2/3/2012 and is documented.	02/03/2012			

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S0224	<p>410 IAC 15-2.4-1(e)(2)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(2) Ensure that the services performed under a contract are provided in a safe and effective manner and are included in the center's quality assessment and improvement program.</p> <p>Based on document review and interview, the governing body failed to ensure that services performed under contract were provided in a safe and effective manner for one contracted service.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance Plan (approved 4-11) failed to indicate the process for evaluating contracted services through the QA program.</p> <p>2. The administrative document Evaluation Of Contract Services HOUSEKEEPING (dated 1-24-11) indicated the following: " Quality of cleaning consistently inadequate ... [and] ... Housekeeping personnel do not consistently wear gloves when dumping hazardous materials then moving to</p>			S0224	<p>*Executive Director will be responsible for ensuring documentation is completed for all issues concerning contracted services. *In this case, the breach was discussed with the contracted service and an employee was dismissed from contracted service.</p>		02/06/2012

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	<p>another area." (signed by staff #A2).</p> <p>3. The Meeting Minutes of the QA Committee dated 1-28-11 and 4-28-11 failed to indicate discussion of concerns regarding the contracted service or document a corrective action plan. The QA report Endoscopy Center Quarterly Contract Review indicated that Housekeeping Services were 'OK' for the month of January, 2011.</p> <p>4. During an interview on 12-29-11 at 1510 hours, staff #A1 confirmed that the center documentation failed to indicate a corrective action in response to the identified concerns with the contracted service.</p>			
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S0300	<p>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 interview, the center failed to develop and maintain an effective quality assurance (QA) program addressing its contracted services of maintenance, hazardous waste, pathology and pest control.</p> <p>Findings:</p> <p>1. The Medical Staff Bylaws (approved 4-11) indicated the following: " The Quality Assurance Committee ... shall be responsible ... [for] ... establishing objective criteria [and] measuring actual practice against the criteria."</p> <p>2. Review of the Endoscopy Center Evaluation of Contract Services documentation for maintenance, hazardous waste, pathology and pest control failed to indicate specific, discrete, objective standards for evaluating each service and failed to</p>			S0300	<p>*The Executive Director changed the quarterly review process to be conducted similiarly to annual review process. *Contract s did meet this requirement on an annual basis as submitted. *The minutes did document that contracts were reviewed but did not indicate the issue with Housekeeping which the Executive Director will implement in the future minutes when an issue is identified. *The Executive Director did NOT agree that contracted services were not reviewed. They were reviewed and documented. They were not documented as Surveyor wanted them done.</p>		01/15/2012

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	<p>indicate how the standards could be reviewed over multiple periods for ongoing monitoring of each service.</p> <p>3. The Meeting Minutes of the Quality Assurance Committee failed to document committee discussion of contracted services of maintenance, hazardous waste, pathology and pest control, failed to document the ongoing evaluation of the standards applied to each contracted service and failed to document a corrective action plan for identified areas for improvement for maintenance, hazardous waste, pathology and pest control.</p> <p>4. During an interview on 12-29-11 at 1420 hours, staff #A1 confirmed that the current QA standards applied to the contracted services failed to objectively evaluate each service. Staff #A1 indicated that the QA committee minutes failed to document the ongoing review and revision of the standards for evaluation and failed to document a plan of correction for identified concerns.</p>				

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S0328	<p>410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the center failed to address deficiencies identified by the quality assurance (QA) program for the contracted housekeeping service.</p> <p>Findings:</p> <p>1. The policy/procedure Quality Assurance Plan (approved 4-11) failed to indicate the process for evaluating contracted services through the QA program.</p> <p>2. The administrative document Evaluation Of Contract Services HOUSEKEEPING (dated 1-24-11) indicated the following: " Quality of cleaning consistently inadequate ... [and] ... Housekeeping personnel do not consistently wear gloves when dumping hazardous materials then moving to</p>	S0328	*The Executive Director will make sure that follow up of issues is documented on Quality Assurance Committee minutes.	02/06/2012			

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	<p>another area." (signed by staff #A2).</p> <p>3. The Administrative document Housekeeping Observation 2011 entry (dated 1-25-11) failed to indicate an entry under Recommendations or otherwise document that the housekeeping services were notified of housekeeping performance concerns indicated on the evaluation tool.</p> <p>4. The Meeting Minutes of the QA Committee dated 1-28-11 and 4-28-11 failed to indicate discussion of concerns with the contracted service or document a corrective action plan. The QA report Endoscopy Center Quarterly Contract Review indicated that Housekeeping Services were 'OK' for the month of January, 2011.</p> <p>5. During an interview on 12-29-11 at 1510 hours, staff #A1 confirmed that the center documentation failed to indicate a corrective action in response to the identified concerns with the cleaning services.</p>			
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S0404	<p>410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review and interview, the center failed to address housekeeping identified problems.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Infection Control Plan (approved 1-11) indicated the following: " The Quarterly review shall include ... evaluation of the clinical and public environment in order to minimize risk to the patient and general population. " The policy/procedure lacked a provision for responding to identified infection control concerns with documentation of a corrective action and ongoing monitoring to follow-up on the effectiveness of the response. The administrative document Evaluation Of Contract Services HOUSEKEEPING (dated 1-24-11) 	S0404	*The Executive Director will make sure that follow up on Quality Assurance issues are documented in minutes.	02/06/2012			

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	<p>indicated the following: " Quality of cleaning consistently inadequate ... [and] ... Housekeeping personnel do not consistently wear gloves when dumping hazardous materials then moving to another area. " (signed by staff #A2).</p> <p>3. The Administrative document Housekeeping Observation 2011 entry dated 1-25-11 failed to indicate an entry under Recommendations or otherwise document that the housekeeping services were notified of housekeeping performance concerns.</p> <p>4. The Meeting Minutes of the Quality Assurance Committee dated 1-28-11 and 4-28-11 failed to indicate discussion of infection control concerns with the contracted housekeeping service or document a corrective action plan.</p> <p>5. During an interview on 12-29-11 at 1510 hours, staff #A1 confirmed that the center documentation failed to indicate a corrective action in response to the identified infection control concerns with the cleaning services.</p>						

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S0408	<p>410 IAC 15-2.5-1(d)</p> <p>(d) The center shall designate a person qualified by training or experience as responsible for the ongoing infection control activities and the development and implementation of policies governing control of infections and communicable diseases. Based on document review and interview, the center failed to implement a policy which included sequence of cleaning tasks to minimize potential cross-contamination.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The policy/procedure Housekeeping Policy (approved 4-11) failed to indicate a sequence of room and area cleaning tasks that minimized the potential cross-contamination of surfaces by cleaning personnel. 2. During an interview on 12-29-11 at 1510 hours, staff #A1 confirmed that the policy/procedure failed to indicate a sequence for area cleaning by the housekeeping staff that minimized the potential cross-contamination of surfaces at the center. 	S0408	<p>*The sequence was in the policy. *The policy has been revised and the Executive Director will implement the new policy and provide to Housekeeping contracted services.</p>	02/06/2012			

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S0414	<p>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 policy/procedure review, facility documentation review, and interview, the ASC failed to include the Infection Preventionist (E#10) as a member of the Infection Control Committee.</p> <p>Findings include:</p> <p>1. Review of the ASC's Medical Staff By-Laws on 12-28-2011 included, under Section C. Quality Assurance Committee (including Infection Control) "1. The Quality Assurance Committee shall consist of a chairperson, and two members who shall be appointed from the medical staff. This</p>	S0414	*Effective 1/15/12, the Infection Preventionist will attend Quality Assurance Meetings. *The Executive Director will oversee compliance.	01/15/2012			

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	<p>committee shall also have as members the following non-medical staff members: the Executive Director and the Director."</p> <p>2. Review of the QA/Infection Control Committee meetings during 2011 on 12-29-2011 did not include E#10 (the Infection Preventionist) as attending the quarterly meetings.</p> <p>3. During an interview with the ASC Administrator/Executive Director on 12-29-2011, he/she provided the names of the QA/Infection Control Committee members and it was stated that E#10 "does not attend the meetings, but his/her information is provided to the committee."</p>				

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S0424	<p>410 IAC 15-2.4-1(f)(2)(D)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(D) Written reports of quarterly meetings.</p> <p>Based on document review and interview, that center failed to maintain written reports of quarterly meetings for the infection control committee.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. The Quality Assurance Plan (approved 4-11) indicated the following: "The infection Control Committee ... monitors ... employee infections and health and center practices and procedures related to infection control including housekeeping, sterilization and maintenance and recommends practice changes to improve infection control. Minutes of committee meetings are submitted to the Quality Assurance Committee." 2. During an interview on 12-28-11 at 0950 hours, staff #A1 indicated that the infection control meeting functions were integrated in the quality assurance meetings and the center did not conduct separate meetings of the infection control committee and forward minutes to the quality assurance committee. 3. Review of the Quality Assurance 	S0424	*There is a section in each set of minutes for infection control issues. *There were no infections reported.*There was no equipment failures to report.*Executive Director will continue to assure any issues will be documented in minutes.	02/03/2012			

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	Committee meeting minutes for 1-28-11, 4-28-11, and 8-12-11 failed to indicate discussion of infection control issues including recommendations to improve infection control for the center.				

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S0620	<p>410 IAC 15-2.5-3(c)(5)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(5) Plain paper facsimile orders, reports, and documents are acceptable for inclusion in the medical record if allowed by the center policies.</p> <p>Based upon document review and interview, the center lacked a policy/procedure for including plain paper facsimile documents in the medical record (MR).</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-28-11 at 0930 hours, staff #A1 was requested to provide documentation indicating that plain paper facsimile documents were approved for inclusion in the MR and none was provided prior to exit. On 12-29-11 at 1100 hours, staff #A1 confirmed the center lacked a policy/procedure that allowed plain paper facsimile documentation to be entered in the patient record. 	S0620	*Executive Director revised policies to include that plain paper facsimile documents are included in Medical Records. *The facility has never had any other fax type documentation.	02/06/2012	

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S0640	<p>410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete.</p> <p>Based upon document review and interview, the center lacked a policy/procedure ensuring that all entries in the medical record (MR) were legible.</p> <p>Findings:</p> <p>1. On 12-28-11 at 0930 hours, staff #A1 was requested to provide a policy/procedure for verifying entries of questionable legibility and none was provided prior to exit.</p> <p>2. On 12-29-11 at 1105 hours, staff #A1 confirmed the center lacked a policy/procedure for verifying illegible information in the patient record.</p>	S0640	*Executive Director revised policy to include legibility statement and implemented immediately.	02/06/2012			

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S0644	<p>410 IAC 15-2.5-3(e)(2)</p> <p>All entries in the medical record must be as follows:</p> <p>(2) Made only by authorized individuals as specified in center and medical staff policies.</p> <p>Based on document review and interview, the center lacked a policy/procedure specifying which individuals, staff members and medical professionals are permitted to make entries in the medical record (MR).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 12-28-11 at 0930 hours, staff #A1 was requested to provide documentation indicating which individuals are authorized to make entries in the MR and none was provided prior to exit. 2. During an interview on 12-29-11 at 1103 hours, staff #A1 confirmed that the center lacked a policy/procedure indicating which individuals, employees and medical professionals were authorized to make entries in the MR. 	S0644	*Executive Director revised policy and procedure to state that RN and MD are authorized to document in medical records.	02/06/2012	

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S0646	<p>410 IAC 15-2.5-3(e)(3)</p> <p>All entries in the medical record must be as follows:</p> <p>(3) Authenticated and dated in accordance with section 4(b)(3)(N) of this rule.</p> <p>Based upon document review and interview, the center lacked a policy/procedure ensuring that all entries in the medical record (MR) were dated and timed when signed by the person making the entry.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-28-11 at 0930 hours, staff #A1 was requested to provide a policy/procedure regarding verbal orders and none was provided prior to exit. The Rules and Regulations of the Medical Staff (approved 4-11) indicated the following: " An order shall be considered to be in writing if dictated to a Registered Nurse and signed by the attending physician. Orders dictated over the telephone shall be signed by the Registered Nurse to whom dictated, with the name of the physician, who shall sign the order within 24 hours of implementation. " The medical staff rule lacked the requirement for dating and timing the order when authenticated by the physician to validate compliance with the requirement. On 12-29-11 at 11 hours, staff #A1 confirmed the medical staff rule failed to ensure all MR entries would be dated and timed when authenticated. 			S0646	*Executive Director revised medical records policy to include verbal orders and that signatures be dated and timed.		02/06/2012

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S0862	<p>410 IAC 15-2.5-4(d)(2)(C)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(C) A provision for the following equipment and supplies to be available to the surgical and recovery areas:</p> <p>(i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff.</p> <p>Based on document review and interview, the center failed to ensure that required emergency equipment was available for use for 1 of 9 required emergency equipment.</p> <p>Findings:</p> <p>1. The policy/procedure Crash Cart Content (approved 4-11) failed to indicate that an oximeter was listed as available for use on the code cart. 2. During an interview on 12-29-11 at 1330 hours, staff #A2 confirmed that the policy/procedure lacked the required equipment.</p>			S0862	*The Endoscopy Charge Nurse makes sure oximeters are in each room. *The provision requires that an oximeter is available in surgery and recovery areas -- not on crash cart. *There is an oximeter in each patient room and in each procedure room.		02/06/2012

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S1146	<p>410 IAC 15-2.5-7(b)(2)</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>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation and interview, the center failed to ensure the immediate availability of eye wash station equipment for the gross decontamination and endoscope cleaning area of the center.</p> <p>Findings:</p> <p>1. During a tour on 12-29-11 at 0912 hours in the presence of staff #s A1, A4 and A5, it was observed there was no immediate availability of eye wash station equipment for the gross decontamination and endoscope cleaning area of the center. It was necessary to travel over 50 feet and pass through two doorways to gain use of the eye wash station.</p> <p>2. During an interview on 12-29-11 at 0915 hours, staff A1 confirmed the eye wash equipment was not immediately available.</p>	S1146	<p>*The Executive Director did NOT agree that the eye wash station was not immediately available.</p> <p>*There have been two (2) inspections by OSHA certified personnel who have approved the location of the eye wash station.</p> <p>*1000cc bottle of water is now available in scope processing room to begin eye flushing and the person would be taken to the eye wash station. *The Executive Director has implemented the procedure on 2/6/2012.</p>	02/06/2012	

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S1154	<p>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>(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 document review and interview, the center failed to perform a triennial analysis on its operational and maintenance records for all mechanical equipment at the center.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-28-11 at 0930 hours, staff #A1 was requested to provide documentation of triennial analysis for the mechanical equipment in use at the center and none was provided prior to exit. On 12-28-11 at 1410 hours, staff #A1 confirmed that the center was not performing a triennial analysis of its operational and maintenance control records. 	S1154	*Effective 1/15/2012, the Executive Director will assure that triennial analysis for mechanical equipment by documented triennially.	01/15/2012			

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S1168	<p>410 IAC 15-2.5-7(b)(4)(B)(iii)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the center lacked documentation of electrical current leakage testing or triennial analysis of preventive maintenance (PM) records on its patient care equipment in use at the center.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-28-11 at 0930 hours, staff #A1 was requested to provide documentation of triennial analysis of patient care equipment PM records and none was provided prior to exit. Documentation of patient care equipment PM dated 6-30-11 and 12-12-11 failed to indicate that ground current leakage testing was performed and recorded as either pass/fail or otherwise indicate the test measurements on the documentation. During an interview on 12-28-11 at 1410 	S1168	*On 02/06/2012, the Executive Director contacted Tri Med X to provide documentation for ground testing on patient care equipment. *Tri Med X will have completed this project and provided documentation by 2/27/2012.	02/06/2012			

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	hours, staff #A1 confirmed that the center PM records lacked documentation of electrical current leakage testing and confirmed that a triennial analysis of the patient care equipment PM was not being performed.			

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S1170	<p>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 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 center failed to perform inspection and testing for its defibrillators as recommended by the manufacturer.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-28-11 at 0930 hours, staff #A1 was requested to provide a policy/procedure for performing daily defibrillator checks per the manufacturer ' s recommendations and none was provided prior to exit. The policy/procedure Operation of Zoll Pacemaker/Defibrillator/Monitor (approved 4-11) and Crash Cart Content (approved 4-11) failed to indicate a provision for daily checks to ensure the equipment was readily available if needed. The Zoll PD 1200 Pacemaker/Defibrillator 	S1170	*The Endoscopy Charge Nurse wrote policy and procedure for defibrillator checks to reflect manufacturer's guidelines and implemented this on 1/15/2012.	01/15/2012
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	<p>Service Manual indicated that the energy setting for the daily defibrillator test was 200 Joules and the daily operational checks included a visual inspection of 5 steps, a power-up sequence check with 13 steps, a pacer accuracy check with 10 steps, a delivered energy and discharge check with 12 steps, and a recorder operation check with 9 steps recommended by the manufacturer.</p> <p>4. The document Surgery Center Code Cart Daily Emergency Equipment Checklist dated November 2011 indicated that the defibrillator energy setting documented each day by staff was 30 Joules and that the defibrillator was discharged one time per month.</p> <p>5. During an interview on 12-29-11 at 1330 hours, staff #A2 confirmed that the center lacked a policy/procedure regarding daily defibrillator checks that included the manufacturer's recommendations and the current center documentation of daily defibrillator checks failed to follow the manufacturer's recommendations.</p>				

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S1180	<p>410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on document review and interview, the center failed to establish a safety management program that included a review of safety functions by a committee appointed by the chief executive officer and included representatives from administration and patient care services.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-28-11 at 0930 hours, staff #A1 was requested to provide documentation of a safety management program including committee minutes and none was provided prior to exit. During an interview on 12-28-11 at 0950 hours, staff #A1 indicated that the safety management functions were integrated in the Quality Assurance Program at the center. The Quality Assurance Plan (approved 4-11) failed to indicate a safety function, provision or reference to a safety management committee that included representatives from administration and 			S1180	<p>*As was repeatedly told to the Surveyor, the Quality Assurance Committee is also the Safety Committee. *The Executive Director discussed the safety program was a part of the Quality Assurance committee with representatives from patient care and administration. *There is a section in Quality Assurance minutes where a monthly safety checklist is reviewed. *Any incidents would be examined under incident reports. *There were no issues in 2011 to examine. *The generator runs are reviewed once per quarter. *The Quality Assurance Plan was revised by Executive Director to better clarify what is actually done.</p>		01/15/2012

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	<p>patient care.</p> <p>4. During an interview on 12-29-11 at 1345 hours, staff #A1 confirmed that the center lacked a safety management program.</p>				

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S1182	<p>410 IAC 15-2.5-7(c)(2)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(2) An ongoing center-wide process to evaluate and collect information about hazards and safety practices to be reviewed by the committee.</p> <p>Based on document review and interview, the center failed to establish an ongoing, center-wide process for assessing and evaluating hazards and safety practices by a committee.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-28-11 at 0930 hours, staff #A1 was requested to provide documentation of a safety management program including committee minutes and none was provided prior to exit. During an interview on 12-28-11 at 0950 hours, staff #A1 indicated that the safety management functions were integrated in the Quality Assurance Program at the center. The Quality Assurance Plan (approved 4-11) failed to indicate a provision for the ongoing review and evaluation of hazards and safety practices by a committee. During an interview on 12-29-11 at 1530 hours, staff #A1 confirmed that the quality assurance plan lacked a provision for assessing and evaluating hazards and safety practices at the center. 	S1182	*Please see S1180 for response.*Quality Assurance Plan was revised by Executive Director to better clarify what is actually done.	01/15/2012			

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S1184	<p>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. (B) Health care worker safety. (C) Public and visitor safety.</p> <p>Based on document review and interview, the center failed to establish a safety management program that included patient, public, visitor, and health care worker safety.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-28-11 at 0930 hours, staff #A1 was requested to provide documentation of a safety management program that included patient, public, visitor and health care worker safety and none was provided prior to exit. During an interview on 12-28-11 at 0950 hours, staff #A1 indicated that the safety management functions were integrated in the Quality Assurance Program at the center. The Quality Assurance Plan (approved 4-11) failed to indicate a provision or reference to a safety management program that addressed patient, public, visitor and health care worker safety issues and problems. During an interview on 12-29-11 at 1345 hours, staff #A1 confirmed that the center lacked an effective safety management program. 	S1184	*The Executive Director did NOT verify the facility lacked an effective safety program. *The documentation from minutes is included with this reponse. *The Quality Assurance Plan was updated to include the safety program to reflect what is actually done by the Executive Director.	01/15/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001130	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/29/2011
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S1188	<p>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. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on document review and interview, the center failed to maintain and follow its fire control plan.</p> <p>Findings:</p> <p>1. The policy/procedure Emergency Operations (approved 4-11) indicated the following: " The Executive Director and Clinical Director shall be trained in the actions to be taken in the event of an emergency affecting the Center ...In the event of an alarm the Director of Clinical Operations shall proceed to the central alarm panel ... The Director of Clinical Operations shall determine if a fire exists ...The Director of Clinical Operations</p>	S1188	<p>*The Surveyor was repeatedly told that the Endoscopy Charge Nurse functions as the Director of Clinical Operations. *To assist the Surveyor with this difficult concept, the policy and procedure was changed to only have Endoscopy Charge Nurse effective 2/7/2012. *The Executive Director and the Endoscopy Charge Nurse were able to read signatures. *This policy does state that Endoscopy Charge Nurse makes sure everyone has left the building. *The Executive Director added a statement to policy and procedure that all staff reports to dumpster area effective 2/7/12.</p>	02/07/2012	

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	<p>shall conduct the fire drill and complete the checklist ... The Director of Clinical Operations will tour the facility to ensure that no one remains in the center. "</p> <p>2. During an interview on 12-28-11 at 1345 hours, staff #A1 confirmed that the position of Clinical Director had been vacant since the center opened in 2004.</p> <p>3. Fire drill documentation dated 9-21-11, 6-29-11, 3-30-11 and 12-20-10 failed to indicate that an Endoscopy Center staff had conducted the fire drill. It could not be determined which center staff had participated in the drills due to illegible signatures.</p> <p>4. During an interview on 12-29-11 at 1335 hours, staff #A7 indicated that the fire drills were conducted with the adjacent Surgery Center and the attendance roster included staff from both facilities. Staff #A7 confirmed that the fire control plan lacked a location for staff, patients, and visitors to assemble ensuring the building was clear in the event of a fire.</p>				

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S1198	<p>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 upon document review and interview, the center lacked documentation of a disaster preparedness and participation with community, state and federal emergency and disaster preparedness agencies.</p> <p>Findings:</p> <p>1. The policy/procedure Emergency Operations (approved 4-11) indicated the following: "It is therefore the policy of the center to not participate in the event of an external disaster and to so notify and inform appropriate community/governmental parties." The policy/procedure failed to indicate the state requirement for coordinating a response with appropriate agencies in the event of a community disaster, lacked a provision for sheltering in place, lacked a center response to specific emergency types (Bomb, Chemical Spill, Tornado) listed on the Emergency Drill Checklist, and lacked a provision for conducting an annual disaster drill at the center.</p> <p>2. A letter dated 5-21-2008 indicated that the center attempted contact with Iarea hospital for the purpose of participating in emergency and disaster preparedness activities. The center lacked documentation of a reply or ongoing attempts to</p>	S1198	<p>*The Surveyor could not articulate what he wanted.*Both letters were provided to him and he only took one.*This Center has met with St. Vincent's Carmel several times to coordinate resources for disaster. *This Center does participate in District 5 Disaster planning meetings and radio drills. *The Executive Director will continue to develop and participate in Disater Preparedness in District 5.</p>	02/07/2012			

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	<p>establish and coordinate a disaster preparedness relationship with the hospital since 2008.</p> <p>3. During an interview on 12-29-11 at 1300 hours, staff #A1 indicated that the staff person attended District 5 Disaster Preparedness meetings and that the center lacked documentation of an ongoing relationship with an area hospital in the event of a community disaster.</p>			
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