Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 230097611	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA ENDOSCOPY CENTER	53830 GENERATIONS DR STE A , SOUTH BEND, Indiana, 46635

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S0000	INITIAL COMMENTS This visit was for a state licensure survey of an Ambulatory Surgery Center. Facility Number: 009761 Survey Dates: 08/14/23 to 08/15/23. QA: 8/21/23	S0000		
S0156	GOVERNING BODY; POWERS AND DUTIES CFR(s): 410 IAC 15-2.4-1 410 IAC 15-2.4-1 (c)(5) (E) Require that the chief executive officer develop and implement policies and programs for the following: (E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.	S0156		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S0156	Continued from page 1 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview the facility failed to ensure annual performance evaluations were completed for six (6) of six (6) employees reviewed. (S # 1 Registered Nurse, S # 2 Registered Nurse, S # 3 Reprocessing Technician, S # 4 Registered Nurse, S # 5 Registered Nurse, and S # 6 Registered Nurse) Findings include: 1. The facility policy titled, Files Employee, PolicyStat ID 11754118, indicated the general employee file content should include a job performance evaluation. This policy was last revised in 12/2021. 2. The facility policy titled, Performance Management and Annual Review, PolicyStat ID 11754028, indicated each employee's supervisor should conduct performance and salary reviews annually. This policy was last revised in 12/2021. 3. Review of employee files indicated the following staff lacked an annual performance evaluation: a. S # 1 - Registered Nurse (RN) - Date of Hire (DOH) 03/21/2003 - last evaluation 03/2022 b. S # 2 - RN - DOH - 06/03/1997 - last evaluation 06/2022 c. S # 3 - Reprocessing Technician - DOH - 01/07/2019 - last evaluation 01/2022 d. S # 4 - RN - DOH - 05/03/2022 - lacked evaluation 4. In interview on 08/15/2023 at approximately 11:00 am with administrative staff member A # 1 (Center Director), confirmed the above employees should have had an annual performance evaluation conducted.	S0156		
S0182	GOVERNING BODY; POWERS AND DUTIES CFR(s): 410 IAC 15-2.4-1 410 IAC 15-2.4-1 (c)(5) (O) Require that the chief executive officer develop and implement policies and programs for the following:	S0182		

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S0182	Continued from page 2 (O) Annual implementation of internal and external disaster preparedness plans with documentation of outcome. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the facility Governing Body failed to ensure implementation of external disaster plan with documented outcomes occurred in the previous year. Findings include; 1. Review of facility Emergency Preparedness Drills and administrative documents provided indicated no external disaster preparedness occurred over the previous 4 quarters. 2. In interview on 8/15/23 at approximately 2:45 pm, A 1 (Center Director) confirmed the above and no other documentation was provided prior to exit.	S0182		
S0230	GOVERNING BODY; POWERS AND DUTIES CFR(s): 410 IAC 15-2.4-1 410 IAC 15-2.4-1(e)(5) 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: (5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.	S0230		

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S0230	Continued from page 3 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, the faciltiy failed to conduct utilization review of its operations over the last 4 quarters. Findings include; 1. Review of facility Governing Board minutes over the previous 4 quarters and administrative documents provided indicated that no Utilization Review (UR) activities were conducted. 2. In interview on 8/15/23 at approximately 2:45 pm, A 1 (Center Director) confirmed the above and no other documentation was provided prior to exit.	S0230		
S0400	INFECTION CONTROL PROGRAM CFR(s): 410 IAC 15-2.5-1 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview the facility failed to ensure a clean and safe environment in two (2) areas toured. (Procedure Hallway and Clean Supply Room) Findings include: 1. The hospital policy titled, Environment of Care Rounds, PolicyStat ID 11744065, indicated housekeeping daily services for all areas should include dusting all exposed horizontal surfaces (shelves). Tile and hard floors should be dust mopped or swept and wet mopped as needed. This policy was last revised in 01/2013. 2. The hospital policy titled, Storeroom Basics, PolicyStat ID 11756012, indicated the storeroom must be kept clean. Floors are damp-dusted frequently, at least weekly, and shelves are damp-dusted periodically. This policy was last revised in 10/2009.	S0400		

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S0400	Continued from page 4 3. The hospital policy titled, Exposure Control Plan, PolicyStat ID 11754831, indicated the facility should be maintained in a clean and sanitary condition. This policy was last revised in 12/2021. 4. The hospital policy titled, Cleaning Patient Treatment and Care Areas, PolicyStat ID 11754369, indicated housekeeping surfaces require regular cleaning and removal of soil and dust. Areas to be cleaned on a routine basis includes all horizontal surfaces, and the clean and soiled storage areas. This policy was last revised in 09/2016. 5. During tour on 08/14/2023 at approximately 9:00 am with administrative staff member A # 1 (Clinical Director) the following was observed to have visible/wipeable dust: a. Procedure Hallway - eight (8) of eight (8) cabinet shelves (clean supplies) b. Clean Supply Room - two (2) metal carts with twelve (12) of twelve (12) shelves (clean supplies) c. Clean Supply Room - floor (under metal carts) d. Procedure Hallway - Crash Cart base e. Procedure Hallway - floor (under Crash Cart) 6. In interview on 08/14/2023 at approximately 9:45 am with administrative staff member A # 1, confirmed there should not be visible/wipeable dust on/under the above.	S0400		
S0446	INFECTION CONTROL PROGRAM CFR(s): 410 IAC 15-2.5-1 410 IAC 15-2.5-1(f)(2)(E)(x) The infection control committee responsibilities must include, but are not limited to: (E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to	S0446		

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S0446	Continued from page 5 infection control. These include, but are not limited to, the following: (x) A program of linen management. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation and interview, the facility failed to maintain a sanitary condition for linen storage in one (1) instance. (Pre/Post Operative Area) Findings include: 1. The facility policy titled, Cleaning Patient Treatment and Care Areas, PolicyStat ID 11754369, indicated housekeeping surfaces require regular cleaning and removal of soil and dust. This policy was last revised in 09/2016. 2. During tour on 08/14/2023 at approximately 9:00 am with administrative staff member A # 1 (Clinical Director), the linen cart in the pre/post operative area was observed to have visible/wipeable dust on the cover (top/side), shelves (corners), and on the floor (under/behind) the cart. 3. In interview on 08/14/2023 at approximately 9:45 am with administrative staff member A # 1, confirmed there should not be visible/wipeable dust on/under the above.	S0446		
S1198	PHYSICAL PLANT, EQUIPMENT MAINTENANCE, CFR(s): 410 IAC 15-2.5-7 410 IAC 15-2.5-7(c)(6) (c) A safety management program must include, but not be limited to, the following: (6) Emergency and disaster preparedness coordinated with appropriate community, state, and	S1198		

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S1198	Continued from page 6 federal agencies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview the facility failed to coordinate/participate in emergency preparedness drills with other appropriate community/state/federal agencies for the last 4 quarters. Findings include; 1. Review of facility Emergency Preparedness Drills and administrative documents provided indicated no participation with other agencies occurred over the previous 4 quarters. 2. In interview on 8/15/23 at approximately 2:45 pm, A 1 (Center Director) confirmed the above and no other documentation was provided prior to exit.	S1198		