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	15C0001062	A. BUILDING 00 B. WING	01/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
S 0000 Bldg. 00	This visit was for a state licensure survey of an Ambulatory Surgery Center. Facility Number: 008902 Survey Dates: 1/3/2022 - 1/5/2022 QA: 1/6/2022	S 0000		
S 0153 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review and interview, the facility failed to provide an orientation to 1 of 11 (N10) personnel files reviewed. Findings Include: 1. Review of policy titled: Hiring and Pre-Employment (PolicyStat ID: 9766966) last approved 03/2021, indicated that orientation will occur within 30 days of hire and documentation of this orientation is maintained in the employee's personnel file.	S 0153	The Center Administrator (CA) of Northside GI Endoscopy Center reported the results of survey to the Medical Director and Governing Board (GB) to ensure corrective measures are implemented and a plan is in place to monitor ongoing compliance. Plan of Correction & Systematic change: C.1-3 The CA reviewed the policy named Hiring and Pre-employment # 9766966 and understands the responsibility	03/14/2022

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	2. Review of N10's (Registered Nurse) personnel file (hired 08/12/19) lacked documentation of orientation. 3. Interview on 01/05/22 at 11:45 am with A1 (Center Director) confirmed that N10's personnel file lacked documentation of orientation.		for orienting new staff within 30 days of hire. The CA completed the orientation for N10 and placed orientation documents in the employee file. Responsible Party and Monitoring: New hire files will be reviewed by the office manager for completeness on all employees hired. The CA will place the facility's Hiring and Pre-Employment policy in the file of each newly hired employee as a reminder and confirmation that required education and orientation documents are complete. Minutes from the Quality Assurance and Performance Improvement (QAPI) Committee will serve as a validation the information was shared and the systematic changes addressed here were recommended to and approved by the GB	
S 0156 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 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			

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	contract and agency personnel, who are not subject to a clinical privileging process. Based on document review and interview, the facility failed to provide annual (2021) performance reviews in 11 of 11 (N1, N2, N3, N4, N5, N6, N7, N8, N9, N10 and N11) personnel files. Findings Include: 1. Review of policy titled: Files Employee (PolicyStat ID: 9766950) last approved 03/2021, indicated that an employee's personnel file will contain a performance appraisals. 2. Review of 11 of 11 (N1, N2, N3, N4, N5, N6, N7, N10 and N11 - each a Registered Nurse; N8 and N9 - each a Technician) personnel files lacked documentation of 2021 performance evaluations. 3. Interview on 01/05/22 at 11:45 am, A1 confirmed that performance appraisals were not completed for N1, N2, N3, N4, N5, N6, N7, N8, N9, N10 and N11 in 2021.	S 0156	The CA of Northside GI Endoscopy Center reported the results of survey to the Medical Director and Governing Board to ensure corrective measures are implemented and monitored ongoing compliance. The CA is responsible for completing annual performance evaluations (PE) and placing the documents in the employee files. The CA reviewed the policy # 9766950 in that indicates an employee file will contain an annual PE. Registered Nurses: N1, N2, N3, N4, N5, N6, N7, N10, N11, N8, and N9 on Endoscopy Technicians by March 14, 2022. The CA will report these findings to the GB and Medical Director. Systematic Change: The CA placed a reminder on the 2022 calendar indicating due dates for to completing annual PEs for all employees. Responsible Party and Monitoring: The CA is responsible for completing PE's annually. Files will be reviewed by the office manager, medical director and or other proxy for completeness on all employees hired. These reviews will continue for 6 months beginning on 3/14/2022. The targeted goal for compliance is 100% each newly hired employee. If the compliance goal is not met, monitoring will continue until compliance is met	03/14/2022

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			for at least six newly hired employees. Minutes from the QAPI Committee will serve as a validation the information was shared and the systematic changes addressed here were recommended to and approved by the GB.	
S 0164 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H) Require that the chief executive officer develop and implement policies and programs for the following: (H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program. Based on document review and interview, the facility failed to follow policy regarding post offer physicals in 8 of 11 (N1, N2, N3, N5, N7, N8, N9 and N11) personnel files reviewed; lack of background checks on 6 of 11 (N1, N3, N5, N9, N10 and N11) personnel files reviewed; and lack of immunizations in 2 of 11 (N8 and N10) personnel files reviewed. Findings Include: 1. Review of policy titled: Hiring and Pre-Employment (PolicyStat ID: 9766966) last approved 03/2021 indicated that all employees will have a post offer physical, to include immunity to Rubella, Rubeola and Chicken Pox, completed by a third party healthcare practice and background checks.	S 0164	The CA of Northside GI Endoscopy Center reported the results of survey to the Medical Director and GB to ensure corrective measures are implemented and monitored ongoing compliance. Plan of Correction: H.1-3 The CA reviewed the policy named Hiring and Pre-employment # 9766966 last approved on 03/02/2021, which states that all employees will have a background check and post-offer physical exam, to include confirmation of immunity for Rubella, Rubeola and Chicken Pox, completed by a third-party healthcare practice. Employee	03/14/2022

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	2. Review of 8 of 11 (N1, N2, N3, N5, N7, and N11- each a Registered Nurse, and N8, N9 - both Technicians) personnel files had post offer physicals signed by employed physicians. Review of 3 of 11 (N4, N6 and N10 - each a Registered Nurse) personnel files lacked documentation of a post offer physical; and lack of background checks on 6 of 11 (N1, N3, N5, N9, N10 and N11) personnel files reviewed; and lack of immunizations in 2 of 11 (N8 and N10) personnel files reviewed. 3. Interview on 01/05/22 at 11:45 am with A1 (Center Director), confirmed 8 of 11 (N1, N2, N3, N5, N7, N8, N9 and N11) personnel files had post offer physicals signed by employed physicians. Review of 3 of 11 (N4, N6 and N10) personnel files lacked documentation of a post offer physical; lack of background checks on 6 of 11 (N1, N3, N5, N9, N10 and N11) personnel files reviewed; and lack of immunizations in 2 of 11 (N8 and N10) personnel files reviewed.		immunization files for N10 and N11 were reviewed for necessary documentation of vaccines. Staff missing documentation were sent for titers and results were placed in files on 2/18/2022. Background checks on N1, N3, N5, N9, N10 and N11 will be completed before 2/28/2022. Post-offer physicals will be completed by a third-party healthcare provider and are required for all newly hired employees moving forward. Systematic Change: All employee immunization files will be reviewed, and records needed requested and/or staff sent for titers. The CA reviewed the policy named Hiring and Preemployment # 9766966 and understands the responsibility for obtaining documentation of compliance with vaccine immunity for all members of the staff. The CA will include the Hiring and Pre-Employment policy and place this policy in the new hire file housing all new hire information and paperwork requirements. This process will assist the CA as a reminder to review the Hire and Pre-employment policy related to documentation of vaccines for all employees going forward. Responsible Party and Monitoring: New hire files will be maintained by the CA and each will be reviewed by the office manager, medical director and or other proxy for completeness. Minutes	

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			from the QAPI Committee will serve as a validation the information was shared and the systematic changes addressed here were recommended to and approved by the GB.	
S 0172 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L) Require that the chief executive officer develop and implement policies and programs for the following: (L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable. Based on document review and interview, the facility failed to ensure that 5 of 11 (N4, N5, N6, N8 and N9) personnel had annual tuberculin tests and 2 of 11 (N8 and N10) personnel had immunizations for personnel files reviewed. Findings Include: 1. Review of policy titled: Files Employee (PolicyStat ID: 9766950) last approved 03/2021 indicated that personnel files would contain annual tuberculin tests and immunizations. 2. Review of N4, N5, N6 (each a Registered Nurse	S 0172	The CA of Northside GI Endoscopy Center reported the results of survey to the Medical Director and Governing Board to ensure corrective measures are implemented and monitored ongoing compliance. Plan of Correction: The CA is responsible for having documentation of TB testing and immunizations on all employees. The CA reviewed the facility's policy # 9766950 which was last approved on 03/2021 that all personnel files would include	03/14/2022

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	[RN]) and N8 and N9's (each a Technician) personnel files lacked documentation of annual tuberculin tests and N8 and N10 (RN) lacked documentation of immunizations. 3. Interview on 01/05/22 at 11:45 am with A1 (Center Director) confirmed lack of tuberculin tests in N4, N5, N6, N8 and N9's personnel files and lack of immunizations in N8 and N10's personnel files.		annual TB testing and immunizations records. Immunization records have been obtained for N4, N5, N6 (each a Registered Nurse [RN]) and N8 and N9's (each Technician). Systematic Change: The CA is responsible for reviewing all health information in staff files for completeness. The CA will review all staff health information files for completeness annually. This process will assist the CA as a reminder to review the Hire and Preemployment policy with all new hired employees going forward. Additionally, the CA will place the Hire and Pre-employment policy in the newly hired employee's file housing all new hire documents. To prevent this from happening again, files will be reviewed for 6 months beginning on 3/14/2022. The targeted goal for compliance is 100% each newly hired employee. If the compliance goal is not met, monitoring will continue until compliance is met for at least six newly hired employees. Responsible Party and Monitoring: New hire files will be maintained by the CA and reviewed by the office manager, medical director and or other proxy for completeness. The CA placed a reminder on the 2022 calendar indicating due dates for to completing annual PEs for all employees. Minutes from the QAPI Committee will serve as a	

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			validation the information was shared and the systematic changes addressed here were recommended to and approved by the GB.	
S 0176 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M) Require that the chief executive officer develop and implement policies and programs for the following: (M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures. Based on document review and interview, the facility failed to ensure nursing competency for Point of Care in 2 of 9 (N4 and N6) nursing personnel files reviewed. Findings Include: 1. Review of policy titled: CLIA Waived Testing (PolicyStat ID: 9767424) last approved 03/2021, indicated documentation of successful yearly competency evaluation of waived tests. 2. Review of N4 and N6's (each a Registered Nurse) personnel file lacked documentation of annual blood sugar and pregnancy waived tests competency. 2. Interview on 01/05/22 at 11:45 am with A1 (Center Director) confirmed lack of documentation for annual blood sugar and pregnancy waived	S 0176	The CA shared the results of this survey with the Medical Director and GB. Plan of Correction: The competencies for N4 and N5 were completed on 1/11/2022. The CA reviewed the CLIA Waived Testing policy in # policy 9767424 on annual blood sugar and pregnancy test waived tests for successful competency of waived tests, last approved on 03/2021. Systematic Change: The CA placed a reminder on the 2022 calendar indicating due dates for to completing annual competencies for all nursing personnel for point-of care testing. Responsible Party and Monitoring: New hire files will be maintained by the CA and reviewed by the office	03/14/2022

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	tests competency in N4 and N6's personnel files.		manager, medical director and or other proxy for completeness. The CA is responsible for completing competencies annually. Files will be reviewed by the office manager, medical director and or other proxy for completeness on all employees hired. These reviews will continue for 6 months beginning on 3/14/2022. The targeted goal for compliance is 100% each newly hired employee. If the compliance goal is not met, monitoring will continue until compliance is met for at least six newly hired employees. Minutes from the QAPI Committee will serve as a validation the information was shared and the systematic changes addressed here were recommended to and approved by the GB.	
S 0428 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i) 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 infection control. These include, but are not limited to, the following: (i) Sanitation. Based on document review and interview, the facility failed to follow policy regarding employee	S 0428	The CA shared the results of this survey with the Medical Director	02/18/2022

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	exposure in 1 of 3 areas toured (Pre-operative). Findings Include: 1. Review of policy titled: Exposure Control Plan (PolicyStat ID: 9767251) last approved 03/2021, indicated Employees are prohibited from eating or drinking in a work area where there is contamination with body substances. 2. Tour of facility on 01/05/22 at 10:45 am with A1 (Center Director), this surveyor noted 16 containers of drinks sitting on top of counter at nursing station in the Pre-operative area; 2 containers had straws. 3. Interview on 01/05/22 with A1 at 11:45 am confirmed that nursing had 16 containers of drinks sitting on the counter of the nursing station in the Pre-operative area.		and GB on 02/18/2022 discussing corrective measures to include ongoing compliance. Plan of Correction: Staff were re-educated via staff meeting and education was provided to only store staff beverages in designated "Hydration Station Areas" and no beverages are to be located in areas where they could be contaminated by infectious materials. Systematic Change: Daily observation audits will be conducted for 3 consecutive weeks for beverage storage to achieve 100% compliance and then monthly during infection control rounds (Attachment B). Any episode of non-compliance will be reported to the CA immediately, and corrective actions and re-education will be conducted by the CA and documented in personnel files. Responsible Party and Monitoring: The CA is responsible to ensure all corrective actions are implemented and ongoing compliance is maintained. Minutes from the QAPI Committee will serve as a validation the information was shared and the systematic changes addressed here were recommended to and approved by the GB.	
S 0862 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(C)			

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	Requirement for surgical services include: (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: (C) A provision for the following equipment and supplies to be available to the surgical and recovery areas: (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. Based on document review and interview, the facility failed to have appropriate emergency supplies in 1 of 1 crash carts reviewed. Findings Include: 1. Review of policy titled: Emergency Crash Cart (PolicyStat ID: 9767518) last approved 03/2021, indicated that equipment and medications are available to support ACLS (advanced cardiac life support) protocols. 2. Tour of the Post-operative area on 01/05/22 at approximately 10:55 am, this surveyor noted the crash cart lacked a tracheostomy kit or equipment	S 0862	(2)(C)(vi) 1-3 Results of this survey were reported to the GB and the Medical Director on 02/18/2022. The CA is responsible to ensure compliance with appropriate emergency supplies in crash carts. The CA conducted education and in-service for staff and anesthesia providers on 3/9/2022, identifying the addition of the tracheostomy set to emergency cart contents, education on how the set is used with a hands-on demonstration. A sign-in roster is used as proof of	02/18/2022

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	to perform a tracheostomy. 3. Interview with A1 (Center Director) on 01/05/22 at 11:45 am, A1 confirmed that the crash cart lacked a tracheostomy kit or equipment to perform a tracheostomy.		attendance and with education on the tracheostomy set added to the emergency cart (Attachment A). Plan of Correction: A tracheostomy set was purchased and placed in the crash cart on 02/10/2022. Systematic Change: A tracheostomy set was added to the crash cart inventory list and is checked monthly along with other supplies for expiration. The contents of the crash cart will be discussed at the next staff meeting scheduled for 3/9/2022.	
S 1196 Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAc 15-2.5-7(c)(5) (c) A safety management program must include, but not be limited to, the following: (5) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with center policy and state and local regulations. Based on document review and interview, it could not be determined if the facility was inspected by a local fire control agency for 2021. Findings include: 1. On 1/4/2022 at 1500 hours, employee S1, Center Director was requested to provide documentation that the facility was inspected by a local or state fire control agency in 2021.	S 1196	Results of this survey were reported to the GB and the Medical Director on 02/18/2022. Plan of Correction: The CA is responsible to ensure local fire and state perform regular inspections are in accordance with center policy and state and local regulations. The Fire Marshal was contacted by the CA to request an inspection. The fire marshal	02/02/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTHSIDE GASTROENTEROLOGY ENDOSCOPY CENTER, L	8424 NAAB ROAD, SUITE 3G INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	2. In interview on 1/5/2022 at 1300 hours, employee S1, Center Director confirmed that no documentation of inspection by a state or local fire control agency for 2021 was available for review before the survey exit.		inspection was conducted on 2/2/2022, no deficiencies were identified (Attachment C). Documentation of the inspection is on file at the center. System Change: The CA placed a reminder on the 2022 calendar indicating due dates for to completing annual inspections with the fire control agency. Responsible Party and Monitoring: Minutes from the QAPI Committee will serve as a validation the information was shared and the systematic changes addressed here were recommended to and approved by the GB	