

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001158	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/10/2015
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NAME OF PROVIDER OR SUPPLIER  TERRE HAUTE SURGICAL CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E MCCALLISTER DR TERRE HAUTE, IN 47802
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S 0000  Bldg. 00	This visit was for a State licensure survey.  Facility Number: 005650  Survey Date: 11/9/2015 to 11/10/2015  QA: cjl 12/15/15	S 0000		
S 0328  Bldg. 00	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)  (b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:  (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.  Based on document review and interview, the facility failed to document opportunities for improvement for two contracted services (Housekeeping and Laundry).  Findings included:	S 0328	Written action plans were developed for the two contracted service providers identified on 2014/2015 evaluation forms as not in compliance. The goal for the contracted laundry service was improvement of quality for blankets, sheets, and pillowcases. The steps to	12/22/2015

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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S 0414 Bldg. 00	<p>1. Review of two contracted services (Housekeeping and Laundry) evaluation reports for 2014/2015 indicated the reports had no written action plans for not meeting the criteria that was defined by the center.</p> <p>2. In interview at 10:30 AM on 11/10/2015, staff member #2 (Administrator) confirmed above and no other documentation was provided by exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 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</p>		<p>resolution were documented, beginning with initiation in January 2015 and ending with completion of goal in October 2015. (attached) Secondly, the goal for the contracted housekeeping service was to strip and clean the wax buildup on the facility's baseboards. Resolution of this issue was documented, beginning with initiation in July 2014 and ending with completion of goal in June 2015. (attached) Going forward, this action plan template will be utilized if any further non-compliance issues are identified on contracted service evaluations. Quality nurse will present to Administrator any annual evaluations with deficiencies and Administrator will be responsible to ensure an action plan is created and completed.</p>	

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	<p>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. Based on document review and interview, the facility failed to ensure the Infection Control Nurse attended the quarterly Infection Control Meetings.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Review of the minutes from the Board of Managers' meeting from October 22, 2014 indicated staff member #9, a pre/post-op registered nurse, was approved as the Infection Control Facilitator.</li> <li>Review of the personnel file for staff number #9 indicated a job description for the Infection Control Facilitator, signed 12/03/14. The job description indicated under Essential Job Duties and Responsibilities: ... 7. Reports activities related to infection control to the Quality Committee.</li> <li>Review of the minutes from the Quality Assurance/Risk Management</li> </ol>	S 0414	The Clinical Director spoke with the Infection Control Nurse to inform her that she would need to be in attendance at all quality meetings. The Infection Control Nurse was in agreement to attend the meetings going forward. On December 8, 2015, the quarterly quality meeting was held and the Infection Control Nurse was in attendance. (meeting minutes w/ attendance roster attached) The Clinical Director will be responsible to inform the Infection Control Nurse of the dates and times of quality meetings and to oversee her attendance.	12/08/2015

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S 0432 Bldg. 00	<p>Committee, which was also the Infection Control Committee, indicated staff member #9 was not present at the meetings on February 24, 2015, June 23, 2015, and September 8, 2015. The minutes indicated the infection control information was presented by staff member #4, the Clinical Director.</p> <p>4. At 2:30 PM on 11/10/15, staff member #2, the Administrator, confirmed the Infection Control Nurse had not attended the meetings.</p> <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 document review, observation and interview, the infection control committee failed to ensure environmental services were provided to ensure the safety and well-being of the patients treated in the facility.</p>	S 0432	On November 11, the contracted housekeeping service was contacted by the Administrator for the need to correct the cleaning product dilution, including use of properly marked, graduated containers. As well, the housekeeping contracted	12/04/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility policy, Infection Control- Housekeeping Disinfectant Terminology, last approved 01/24/13, indicated Environmental infection-control strategies and engineering controls can effectively prevent these infections. The incidence of health-care-associated infections and pseudo-outbreaks can be minimized by 1) appropriate use of cleaners and disinfectants.</li> <li>2. Review of the facility policy, Cleaning of Facility: Daily Routine (Contracted), last approved 01/25/13, indicated, The Safety Officer/Administrator will oversee the contracts and supervision of outside vendors providing cleaning services and pest control.</li> <li>3. At 9:15 AM on 11/10/15, the contracted cleaning staff member, #7, was interviewed by phone. He/she indicated he/she cleaned at the facility for about 4 years and received training and orientation upon hire. He/she indicated the company owner instructed him/her to mix one part of the ProForce Disinfectant with two parts of water. He/she indicated he/she poured a couple of inches of chemical in the spray bottle and filled it</li> </ol>		<p>employee was re-educated regarding the facility's protocol of cleaning high to low. On November 17, the facility safety officer performed a housekeeping audit wherein the housekeeping employee was found to be in compliance with high to low cleaning, but not in compliance with proper dilution of cleaning product. (audit attached) Reinforced with contracted housekeeping regarding following manufacturer's instructions for dilution and the use of marked containers. On December 4, the facility safety officer performed a housekeeping audit, finding the container replaced with one having graduated markings as well as cleaning solution dilution in accordance with manufacturer's instructions. (audit attached) The monthly audit form has been updated with the following: dilution of product, high to low cleaning process, areas observed, observer's name, and date. (audit form attached) Safety officer, Administrator, or Clinical Director will perform monthly audits. Administrator will be responsible to ensure monthly audits are performed and any issues identified are addressed.</p>	

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	<p>with water, but did not measure the chemical. Staff member #7 described his/her procedure for cleaning the operating rooms as wiping the surfaces, then dusting the high surfaces before mopping.</p> <p>4. At 9:30 AM on 11/10/15, the housekeeping closet in the surgery corridor was checked with staff member #4, the Clinical Director. The manufacturer label directions on the container of ProForce Disinfectant indicated the dilution for adequate disinfection was two ounces of chemical to each gallon of water. No measuring devices were observed in the closet. A quart spray bottle of the disinfectant solution, with a hand written label indicating the dilution was 1:3, was observed on the housekeeper's cart in the closet.</p> <p>5. At 9:30 AM on 11/10/15, staff member #4 confirmed the correct dilution for the quart bottle would be 1/2 ounce of chemical to the bottle of water. He/she also confirmed the high dusting should be done before wiping the surfaces. He/she indicated the Safety Officer performed monthly environmental checks and observed the actual staff once a quarter, but did not document what procedures were actually observed.</p>			

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S 1010 Bldg. 00	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on document review, observation and interview, the facility failed to ensure multidose medication vials were marked to prevent outdated usage in two of two open medication vials observed.</p> <p>Findings include:</p> <p>1. Review of the facility policy, Medication Administration, last approved 01/24/13, indicated, III. Multiple Dose Vials: ... When multi-dose vials must be used, the following procedure must be implemented: ... Upon opening a multi-dose vial, the employee is responsible for dating the vial. ... The vial will be discarded upon the expiration date.</p>	S 1010	<p>The two opened multidose medication vials were discarded on November 9th. The facility's policies "Medication Administration" and "Pharmacy-Policies and Procedures" were updated to come into agreement with policy "Medication - Disposal or Outdated", previously revised 09/16/15 and reflective of labeling multi dose medications with the beyond use date. (attached) These policies will go to the board for approval February 11, 2016. Clinicial Director will be responsible to re-educate staff on this policy change for labeling as beyond use date versus the date opened at the December 23rd staff meeting. (staff meeting agenda attached) Monthly outdate checklist for consistent tracking to be implemented beginning January 2016. Clinical</p>	12/23/2015

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	<p>2. Review of the facility policy, Pharmacy- Policies and Procedures, last approved 01/24/13, indicated, ... 3. Multi-dose vials will be dated and initialed when opened- refrigerated or stored according to manufacturer recommendations as necessary, and discarded at 28 days or sooner, depending upon the manufacturer recommendations.</p> <p>3. Review of the facility policy, Medication- Disposal or Outdated, revised 09/16/15, indicated, ... 4. Multi-dose vials opened shall be dated with the BUD (beyond use date) which is 28 days after the bottle is opened (or sooner if manufacturer's instructions state) or if composition appears altered i.e. particulates appear or there is change in clarity or color.</p> <p>4. During the tour of the pre/post area at 2:05 PM on 11/09/15, accompanied by staff members #2, the Administrator, and #4, the Clinical Director, two of two open vials of Labetalol were observed in the medication cabinet. One vial was hand dated 09/23/15 and the other was dated 10/07/15, with no designation to determine if the dates were the open dates or the beyond use dates.</p> <p>5. At 2:10 PM on 11/09/15, staff member #2 confirmed the dates on the</p>		Director will be responsible to ensure monthly checks completed and documented.	

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	vials were past 28 days, regardless of whether they were the open or discard dates. Staff member #2 also confirmed the confusion with the facility policies regarding the appropriate way to date mark any multi-dose vials.				