

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2011
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NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8805 N MERIDIAN ST INDIANAPOLIS, IN46260
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 003032</p> <p>Survey Date: 11/16/2011 through 11/18/2011</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: cloughlin 12/02/11</p>	S0000		
S0432	<p>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 review,</p>	S0432	All staff has been reinstructed in	12/16/2011

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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	<p>document review, and interview, the facility failed to ensure the operating room was adequately disinfected between cases in 1 of 1 cases observed.</p> <p>Findings included:</p> <p>1. At 3:00 PM on 11/17/11, the cleaning of the operating room after a case and prior to the next case, was observed. Staff member #21 sprayed the instrument table with Cavicide disinfectant, wiped the area after approximately 2 minutes, and set a new pack of sterilized instruments on the table.</p> <p>Staff member #18 sprayed the operating bed with Cavicide disinfectant and immediately wiped the area. A second staff member then immediately remade the bed with clean linens. The blood pressure cuff, oxygen saturation probe, and support sling for the arms, that had been used on the last patient, were not disinfected.</p> <p>Immediately after this cleaning, staff member #21 opened the pack of sterile instruments, which indicated the cleaning procedures were completed.</p> <p>2. A support roll that had been used for positioning was cleaned with the disinfectant; however, both ends of the</p>		terminal cleaning procedures. A timer and a new bolster for positioning have been purchased. Over the next 30 days terminal cleaning procedures will be added to the Orientation Checklist. The Infection Control officer will perform random surveillance to insure compliance with terminal cleaning procedures. The Infection Control Officer is responsible for these corrective actions.				

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	<p>roll were torn with padding exposed and therefore, could not be adequately disinfected.</p> <p>3. The facility policy #320, titled "Environmental Cleaning/Sterilizing" stated, ..."End of case cleaning is the use of mechanical friction with a facility-approved agent to clean: 1. Equipment, furniture, and any other component of the surgical suite or patient care area that is visibly soiled. 2. OR table and transport vehicles are considered soiled and contaminated through patient contact."</p> <p>4. Manufacturer's directions for the Cavicide disinfectant were to spray the product on the surfaces and allow to remain visibly wet for 3 minutes.</p> <p>5. At 1:30 PM on 11/18/11, staff member #1 indicated this was not the normal practice between OR cases and indicated all items used on the patient should be disinfected after use, regardless of whether or not they are visibly soiled.</p>				

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S0440	<p>410 IAC 15-2.5-1(f)(2)(E)(vii)</p> <p>The infection control committee responsibilities must include, but not be 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>(vii) A system, which complies with state and federal law, to monitor the immune status of health care workers exposed to communicable diseases.</p> <p>Based on document review, the facility failed to ensure that the annual Mantoux tests were placed and read within 48 to 72 hours for 4 of 10 staff members (#13, 16, 17, and 18).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Tuberculosis Screening for Employees policy states, "The Mantoux test should be read 48 to 72 hours after the injection." 3. CDC guidelines specifies the Purified Protein Derivative (PPD) timed skin test responses should be measured 48-72 hours after administration. 4. Staff member #13 PPD Mantoux Skin Test was placed 10/11/11 and read on 10/13/11. The time was not recorded to ensure the skin test was placed and read 	S0440	A new form has already been created for TB testing. This form includes a place to indicate a time for both the placement and reading of the test. This was completed by the Infection Control Officer.	12/14/2011	

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	<p>within 48 and 72 hours.</p> <p>5. Staff member #16 PPD Mantoux Skin Test was placed 10/10/11 and read on 10/13/11. The time was not recorded to ensure the skin test was placed and read within 48 and 72 hours.</p> <p>6. Staff member #17 PPD Mantoux Skin Test was placed 10/11/11 and read on 10/13/11. The time was not recorded to ensure the skin test was placed and read within 48 and 72 hours.</p> <p>7. Staff member #18 PPD Mantoux Skin Test was placed 10/11/11 and read on 10/13/11. The time was not recorded to ensure the skin test was placed and read within 48 and 72 hours.</p>				

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S0442	<p>410 IAC 15-2.5-1(f)(2)(E)(viii)</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>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on document review, the facility failed to ensure medical documentation for immunization of Rubella, Rubeola and Varicella for 5 of 10 staff members (#12, 13, 14, 16 and 18)</p> <p>Findings included:</p> <ol style="list-style-type: none"> Center for Special Surgery Policy and Procedure #113 states, "The health record will include any appropriate occupational health services provided to each employee as mandated by federal or state law." The facility provided health records for 10 staff members. Each record contained an Infectious Disease and Immunization History self reporting documentation signed by an employee health nurse. Five 	S0442	<p>Staff files have been audited. Over the next 30 days the missing information for the 5 staff members will be obtained as well as the three missing signatures. The Infection Control Officer will obtain this information. In the future the Administrator will audit new staff files upon completion.</p>	12/16/2011	

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S0646	<p>of the 10 staff members did not provide documentation of immunization for Rubella, Rubeola, and Varicella (#12, 13, 14, 16 and 18). Three of the five did not sign the self-reporting documentation in the employee signature box (#13, 14 and 16).</p> <p>3. At 2:00 PM on 11/16/2011, staff member #3 verified the lack of documentation.</p> <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 on medical record review, policy review, and interview, the facility failed to ensure physician verbal orders were authenticated, dated, and timed according to policy in 5 of 5 patient records reviewed that indicated verbal orders (#P5, P7, P16, P20, and P21).</p> <p>Findings included:</p>	S0646	The Nurse manager met with the Medical Director and the Administrator on 12/15/11 to determine a course of action. Over the next 30 days the Standing Orders Form will be revised by the Nurse Manager to include a separate section for verbal orders distinct from the standing orders. The verbal orders section will include required fields for physician name, date and time of the order,	12/15/2011	

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	<p>1. Medical record #P5 indicated a verbal order from the physician to the nurse at 1308 on 11/15/11. The order was written on the Standing Order form that had been signed by the physician at 1245 on 11/15/11. The record failed to indicate a physician authentication following the verbal order.</p> <p>2. Medical record #P7 indicated a verbal order from the physician to the nurse written in as an "Additional Order" on the Standing Orders form. The nurse failed to indicated a date or time for the verbal order.</p> <p>3. Medical record #P16 indicated a verbal order from the physician to the nurse for 2 intravenous (IV) medications written on the Standing Orders form. The nurse failed to indicated a date or time for the verbal order; however, documentation on the Post-Operative Nursing Documentation form indicated the nurse called the physician at 0850 on 08/25/11 and received the order. The Standing Orders form indicated a physician authentication at 0800 on 08/25/11 and failed to indicate any additional authentication following the verbal order.</p> <p>4. Medical record #P20 indicated a verbal order from the physician to the nurse written on the Standing Orders form in the</p>		nurse signature, physician authenticating signature, and date and time of physician signature.				

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	<p>Preoperative Orders Section. The nurse failed to indicated a date or time for the verbal order.</p> <p>5. Medical record #P21 indicated a verbal order from the physician to the nurse at 1410 on 11/30/10. The order was written on the Standing Order form that had been signed by the physician at "105" on 11/30/10. The record failed to indicate a physician authentication following the verbal order.</p> <p>6. Facility policy #301 titled "Orders", stated, ..."Verbal orders are to be authenticated with a signature and time and date of authentication within twenty-four (24) hours of the order being given if the responsible individual is physically available to provide authentication."</p> <p>7. Facility policy #304 titled "Chart Documentation", stated on page 2, ..."b. Every entry, including transcribed reports, is dated and authenticated by the author. c. Each verbal order shall contain the date, time, signature of the licensed nurse accepting the order, and the name of the person giving the order. In addition, the record documents who implemented each verbal order. Each verbal order is also dated and authenticated within 30 days by the person who gave it." Both policies</p>			

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S1146	<p>were reviewed 09/28/11.</p> <p>8. At 12:30 PM on 11/18/11, staff member #3 indicated the most stringent policy would be followed.</p> <p>9. At 1:30 PM on 11/18/11, staff member #1 confirmed the medical record findings and indicated the verbal orders appeared to have been added after the physician signed the Standing Orders and the verbal orders were not authenticated.</p> <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, the facility failed to ensure clean supplies were not contaminated by chemicals in the pre/post area and the operating room.</p> <p>1. During the tour of the pre/post area at</p>	S1146	The Cavicide has been moved to another location where there are no clean supplies or medications. The Infection Control Officer completed this corrective action and will continue to monitor storage of the Cavicide.	12/14/2011	

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	<p>2:00 PM on 11/17/11, accompanied by staff member #1, spray bottles of Cavicide disinfectant were observed stored on the shelf next to open boxes of clean gloves, tissues, and other supplies in the patient cubicles.</p> <p>2. During the surgical case observation at 3:00 PM on 11/17/11, a spray bottle of Cavicide disinfectant was observed on a work counter next to an open vial of Xylocaine.</p>				