

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001108	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2015
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NAME OF PROVIDER OR SUPPLIER UNITY SURGICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1411 S CREASY LANE, SUITE 200 LAFAYETTE, IN 47905
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Q 0000 Bldg. 00	This visit was for a recertification of an ambulatory surgery center. Dates of survey: 11/16/2015 to 11/18/2015 Facility number: 002746 QA: cjl 11/30/15	Q 0000		
Q 0041 Bldg. 00	416.41(a) CONTRACT SERVICES When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner. Based on document review and interview, the Governing Body failed to document appropriate actions in response to opportunities for improvement identified through the Quality Assurance program for four (4) contracted services (Pathology, Housekeeping, Transcription and Pest Control). Findings included:	O 0041	1. How are you going to correct the deficiency? Unity Surgical Center's administrator will continue oversight and assess the facility's contracted services for safety and effectiveness. The administrator will provide , at a minimum, an annual report to the governing body as to how each contract is assessed for safety and effectiveness of the services provided to the center. In the event, goals are not met for contracted services, reports for	02/17/2016

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>1. Review of the Unity Surgical Center Quality Plan/Program (last reviewed April 2015) indicated additional corrective actions are required if the initial actions did not meet the desired goal.</p> <p>2. Review of the 2014/2015 Board of Manager meeting minutes, Medical Advisory Committee minutes, Quality Operations Committee Meeting minutes and Quality Assessment of Contracted Services reports confirmed facility goals were not met for four (4) contracted services (Pathology, Housekeeping, Transcription and Pest Control). The minutes and reports did not document corrective action plans for the facility to reach its desired goals.</p> <p>3. In interview at 10:30 AM on 11/17/2015, staff member #1 (Administrator) confirmed above and no other documentation was provided by exit.</p>		<p>the plan of correction and result of such plans will be reported to the governing body and documented in the governing body minutes by the Administrator. In the above deficiencies, two of the contracted services did not meet facility goals, however corrective action plans were initiated. The correction plans and results were not documented in the governing body minutes. The administrator will prevent this in the future, by following up and reporting all corrective action regarding any contracted service to the Medical Advisory Committee and Board of Managers. In two the above deficiencies, Unity Surgical Center, used the contracted facility management company Cornerstone to assist with the oversight of the contracted services (Pest Control, Housekeeping). The Administrator will now exercise oversight over these contractors to verify standards are met and provide a report to the Medical Advisory Committee and Board of Managers regarding the safety and effectiveness of their services. 2. How are you going to prevent this deficiency in the future? The Administrator will maintain direct oversight over all contracts and consistently report results. The Administrator will initiate plan of corrections with contracted services who do not meet the center's standards and</p>		

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Q 0101 Bldg. 00	416.44(a)(1) PHYSICAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner		all plan of corrections with their results will be reported to the Medical Advisory Committee and Board of Managers. The Administrator will make sure all reports are documented in the meeting minutes for the Medical Advisory Committee and Board of Managers. 3. Who is going to be responsible for numbers 1 and 2 above? Unity Surgical Center's Administrator-Tami Robinson 4. By what date are you going to have the deficiency corrected? The plan of correction for the contracted services that did not meet the center's goals along with the final results have been placed on the agenda for the next Medical Advisory Committee/Board of Managers meeting which is scheduled to meet February 17, 2016. An updated evaluation of the contracted services which were not directly assessed by the Administrator were immediately evaluated and a report will be provided at the next Medical Advisory Committte/Board of Managers meeting which is scheduled to meet February 17, 2016.		

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	<p>that protects the lives and assures the physical safety of all individuals in the area. Based on document review and interview, the facility failed to ensure 4 of 4 operating rooms met the required temperatures as defined by the surgery center's policy and PeriOperative Standards and Recommended Practices (AORN); and failed to ensure the two boilers had a valid Certificate of Inspection.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Environmental Control of the Operating Room policy #SC 422 indicated temperature in the operating room will be maintained at 68 to 72 degrees. The policy was last approved April 2015. 2. AORN supports the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines on temperature ranges for perioperative settings. The Operating Rooms temperature range should be between 68 F and 73 F. 3. Review of the Operating Room Daily Temperature and Humidity Logs for April, May and June of 2015 indicated 4 of 4 operating rooms temperatures were not consistently 68 degrees Fahrenheit or 	O 0101	<ol style="list-style-type: none"> 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. 2015 AORN Guidelines for Perioperative Practice state that Operating Room Temperatures range from 68-75 degrees Fahrenheit. USC updated Policy and Procedure IC 20-Air Quality section D (Attachment A) to reflect the above AORN guidelines. The Operating Room Daily Temperature and Humidity Logs (Attachment B) were updated to reflect the above AORN guidelines. Education was provided on 01/06/16 to staff regarding the updated policy and procedure, and updated Operating Room Temperature and Humidity Logs. 2. How are you going to prevent the deficiency from recurring in the future? The infection control nurse will perform random audits of the temperature logs to verify compliance with the temperature/humidity standards. The infection control nurse will collect the temperature/humidity logs monthly and will review the logs for compliance. Staff was provided additional education at the January 6, 2016 staff meeting regarding the new policy and procedure and updates to the temperature/humidity logs. 3. Who is going to be responsible for numbers 1 and 2 above? The 	01/06/2016			

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	<p>above.</p> <p>A. Operating Room #1 temperature read less than 68 degrees Fahrenheit 26 of 64 days.</p> <p>B. Operating Room #2 temperature read less than 68 degrees Fahrenheit 44 of 66 days.</p> <p>C. Operating Room #3 temperature read less than 68 degrees Fahrenheit 29 of 65 days.</p> <p>D. Operating Room #4 temperature read less than 68 degrees Fahrenheit 36 of 64 days.</p> <p>4. In interview at 10:30 AM on 11/18/2015, staff member #6 (Infection Control Nurse) confirmed above and no other documentation was provided by exit.</p> <p>5. Review of two (2) facility boiler's Certificate of Inspections indicated the expiration date of the certificates was 8/15/2015.</p> <p>6. In interview at 10:45 AM on 11/18/2015, staff member #3 (Maintenance) confirmed the above and no other documentation was provided by exit.</p>		<p>Infection Control Nurse-Karl Bennett 4. By what date are you going to have the deficiency corrected? The medical director approved updates to the Policy and Procedure IC 20 on December 22, 2016. The updated temperature and humidity logs were placed in all operating rooms on January 4, 2016. The infection control nurse informed all Operating Room Staff of the updates regarding this process on January 4, 2016. Staff education was again provided at the January 6, 2016 unit meetings. How are you going to correct the deficiency? The inspection of the boiler was completed on July 8, 2015. However the invoice for the Certificate of Inspection had not been paid. Upon discovery of this deficiency during the survey, the invoice was paid on 11/19/15 (See Attachments, O, P, Q, R) Response to finding #5 How are you going to prevent the deficiency from recurring in the future? It was determined the invoice was sent to the attention of the incorrect individual within Unity, which was the reason the invoice was not promptly paid. Notification was sent to the Department of Homeland Security, Boiler and Pressure Vessel Safety Division to change the department who receive these invoices. These invoices will not be sent to the Director of Operations. Who is going to be responsible for numbers 1 and 2?</p>		

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Q 0223 Bldg. 00	<p>416.50(b) NOTICE - PHYSICIAN OWNERSHIP The ASC must disclose, in accordance with Part 420 of this subchapter, and where applicable, provide a list of physicians who have financial interest or ownership in the ASC facility. Disclosure of information must be in writing.</p> <p>Based on document review and interview, the center failed to ensure that notice of physician ownership including a list of physicians with ownership interest was provided to patients prior to the start of the procedure for 19 of 19 medical records (MR) reviewed (patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 & 19).</p> <p>Findings include:</p> <p>1. Review of Unity Surgical Center Patient Information pamphlet that is provided to all patients before surgery included the patient rights and responsibility in the pamphlet. The patient rights do not list the physicians which have financial interest or ownership in the center.</p>			O 0223	<p>The Administrator-Tami Robinson with the assistance of the Unity Healthcare Director Of Operations.</p> <p>1. How are you going to correct the deficiency? A list of physicians with ownership interest (Attachment C) will be given to every patient at the time of registration. Policy and Procedure RC 10, Section K-9 (Attachment D) was updated to state all patients will receive a complete list of all physicians with an ownership in Unity Surgical Center (USC). The Conditions of Outpatient Services Consent Section 9 (Attachment E) was updated to include a statement which states the patient was provided a complete listing of all physicians with an ownership interest in USC. Each patient will initial this section of this consent which is an acknowledgment from the patient they received the list of physicians with an ownership interest in USC. Education was provided to staff on 01/06/16</p>		01/07/2016

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	<p>2. In interview at 11:10 AM on 11/18/2015, staff member #8 (Clinical Nurse manager) indicated the list of physicians who have financial interest in the center is online and a patient needs to request the information from the Administrator. The list of physicians was not available at the receptionist desk.</p> <p>3. Interview with 2 of 2 patients prepping for surgery at 11:15 AM on 11/18/2015, indicated they were not notified that physicians at the center have financial interest in the facility.</p> <p>4. The Notice of Patient Rights document titled Conditions of Outpatient Services indicated the following: I acknowledge that Unity Healthcare, LLC and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center (USC). I understand that I am free to determine which facility to utilize for health care services and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC. I have been informed of the information in writing by my physician's office in advance of the date of my procedure. The Conditions of Outpatient Services document failed to indicate the names of all physicians with ownership interest and otherwise failed to indicate each patient was provided a list</p>		<p>regarding the updates to the policy and procedure. 2. How are you going to prevent the deficiency from recurring in the future? A list of physicians who have ownership interest in Unity Surgical Center will be given to every patient at the time of registration. Each patient will need to acknowledge they received a copy of the list of physicians who have financial interest in the center by initialing section 9 of the Outpatient Services Consent. 3. Who is going to be responsible for numbers 1 and 2? The front office staff will provide to every patient during registration. The Office Supervisor will randomly audit this process to very compliance. 4. By what date are you going to have deficiency corrected? Consents were updated on January 7, 2016 and placed in circulation January 11, 2016.</p>				

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Q 0241 Bldg. 00	<p>of physicians with ownership interest.</p> <p>5. On 11-18-15 at 0924 hours, the director of nursing, staff A1, was requested to provide a list of physicians with ownership interest and no documentation was provided prior to exit.</p> <p>6. Review of the MR for patient #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 & 19 indicated the document Conditions of Outpatient Services was present in each record and no documentation indicated that a list of physicians with ownership interest was provided to each patient prior to the procedure.</p> <p>7. During an interview on 11-18-15 at 1300 hours, the director of nursing, staff A1, confirmed the MR documentation failed to indicate each patient received a list of physician owners prior to their procedure and confirmed that a list of physician owners was not available.</p> <p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on document review and</p>	O 0241	1. How are you going to correct	12/02/2015			

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	<p>interview, the center failed to provide a safe and healthful environment that minimized risk and infection exposure to patients, staff, and visitors for 1 occurrence.</p> <p>Findings include:</p> <p>1. The Association of periOperative Registered Nurses (AORN) Recommended Practices for Environmental Cleaning (2014) indicated the following: II(c) ...hospital-grade disinfectants should be used to disinfect surfaces in the perioperative setting ...II(c)(5) Disinfectants should be applied and reapplied as needed, per manufacturers ' instructions, for the dwell time required to kill the targeted organism ...II(c)(6) Spray and misting methods (eg., a spray bottle) should not be used to apply chemicals in the perioperative setting.</p> <p>2. The policy/procedure Terminal Clean (revised 1-15) obtained from the contracted housekeeping services manual indicated the following: 1. Prepare hospital approved disinfectant solution according to manufactures (sic) instructions ...7. Damp wipe the overhead fixtures, surgical lights, ledges, and vents (both ceiling and wall) with wall washer unit dipped in germicidal solution ...9.</p>		<p>this deficiency? Spray Nozzle devices were removed from the facility so that all cleaning is performed using a facility approved disinfectant and a clean-low linting cloth. Re-education was provided to the housekeeping staff as it relates to the terminal cleaning procedures of the Operating Rooms and requirements that when using the Virex 256 for terminal cleaning, there should be a 10 minute dwell time. Policy and Procedure IC 35 (Review of Cleaning Agents and Practices) was updated to include dwell times for disinfectant agents used throughout the center. (See Attachment F). A copy Policy and Procedure IC 35 was provided and reviewed with housekeeping staff. 2. How are you going to prevent the deficiency from recurring in the future? Random, unannounced audits of the housekeeping staff will be performed by the infection control nurse, administrator, and/or operating room Certified Surgical Technologist (CST) to evaluate the terminal cleaning procedures for the center are compliant. The Infection Control Nurse will provide annual education on terminal cleaning and housekeeping procedures to the housekeeping staff. 3. Who is going to be responsible for numbers 1 and 2 above? The Infection Control Nurse</p>				

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	<p>Use a new cloth dipped in germicidal solution for the following ...</p> <p>3. During a telephone interview on 11-17-15 at 1500 hours with the contracted housekeeping personnel, staff A6, in the presence of the infection control nurse, staff A3, and the director of nursing, staff A1, the staff A6 indicated they (A6) spray down the operating room surfaces with Virex 256 (an approved disinfectant with a 10 minute wet contact time) and allow the surfaces to remain wet for a minimum of 5 minutes. The staff A6 indicated that they (A6) spray the mop used to clean the operating room walls with the disinfecting solution. The staff A6 indicated they (A6) clean the 3 procedure rooms with Virex while allowing the surfaces to remain wet for a minimum of 5 minutes and indicated that no other disinfectant products are used by them (A6).</p> <p>4. During an interview on 11-17-15 at 1520 hours, the director of nursing, staff A1, confirmed that the contracted housekeeping personnel, staff A6, indicated the Virex 256 disinfectant with a 10 minute wet contact time was applied and allowed to remain wet for a minimum of only 5 minutes.</p>		<p>and Administrator. Operating Room Certified Scrub Technologist (CST) may assist with the unannounced random audits of the housekeeping staff. 4. By what date are you going to have the deficiency corrected? Re-education was provided to the housekeeping staff on 11/18/2015. The Infection Control Nurse performed a random audit of the housekeeping staff terminal cleaning procedures on 12-02-15 at 2000 (See Housekeeping Evaluation Tool dated 12-02-15-Attachment G) Housekeeping staff demonstrated compliance regarding terminal cleaning procedures.</p>		

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S 0000 Bldg. 00	<p>5. During an interview on 11-18-15 at 1010 hours, the infection control nurse, staff A3, confirmed the contracted housekeeping personnel, staff A6, was not following the approved policy/procedure for performing terminal cleaning in the restricted access areas of the center and confirmed the use of spray bottles for applying disinfectants was not a recommended practice.</p>			
S 0230 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002746</p> <p>Survey Date: 11/16/2015 to 11/18/2015</p> <p>QA: cjl 11/30/15</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are</p>	S 0000		

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	<p>delivered under contracts. The governing body shall do the following:</p> <p>(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. Based on document review and interview, the facility failed to provide for a periodic review of the center and its operation by three or more licensed physicians having no financial interest in the facility.</p> <p>Findings include:</p> <p>1. Review of Utilization Review Committee reports for 2015 indicated the facility had only one physician with no financial interest in the facility provide periodic review of the center and its operations.</p> <p>2. In interview at 2:15 PM on 11/16/2015, staff member #1 (Administrator) confirmed above and no other documentation was provided by exit.</p>	S 0230	<p>1. How are you going to correct the deficiency? Currently, Unity Surgical Center has one physician, who does not have any financial interest in the facility, that performs a periodic review of the center and its operation. An agreement will be initiated with two additional physicians to perform a periodic review of the center and its operation. 2. How are you going to prevent the deficiency from recurring in the future? The governing body will appoint two additional physicians who do not have any financial interests in the facility which will perform a periodic review of the center and its operation. The addition of these two physicians, who do not have any financial interest in the center, will provide a total of three physicians on the committee that performs a periodic review of the center and its operation. 3. Who is going to be responsible for numbers 1 and 2? Unity Surgical Center Administrator is facilitating the agreements between Unity Surgical Center and two physicians who do not have any financial interest in the center to</p>	01/29/2016

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S 0328 Bldg. 00	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 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 document</p>	S 0328	<p>perform a periodic reive of the center and its operation. Unity Surgical Center Board of Managers will appoint these additional two physicians to the committee that provides the periodic review of the center and its operation. 4. By what date are you going to have this deficiency corrected. The Administrator initated verbal discussions on January 5, 2016 with the above two physicians. Agreements are projected to be finalized by January 29, 2016. The next Board of Managers meeting is scheduled for February 17, 2016 at which time, the board will appoint the two physicians to the committe which provide periodic reivev of the center and its operation.</p> <p>1. How are you going to correct the deficiency? Unity Surgical</p>	02/17/2016	

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	<p>appropriate actions in response to opportunities for improvement identified through the Quality Assurance program for four (4) contracted services (Pathology, Housekeeping, Transcription and Pest Control).</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the Unity Surgical Center Quality Plan/Program (last reviewed April 2015) indicated additional corrective actions are required if the initial actions did not meet the desired goal. 2. Review of the 2014/2015 Board of Manager meeting minutes, Medical Advisory Committee minutes, Quality Operations Committee Meeting minutes and Quality Assessment of Contracted Services reports confirmed facility goals were not met for four (4) contracted services (Pathology, Housekeeping, Transcription and Pest Control). The minutes and reports did not document corrective action plans for the facility to reach its desired goals. 3. In interview at 10:30 AM on 11/17/2015, staff member #1 (Administrator) confirmed above and no other documentation was provided by exit. 		<p>Center's administrator will continue oversight and assess the facility's contracted services for safety and effectiveness. The administrator will provide , at a minimum, an annual report to the governing body as to how each contract is assessed for safety and effectiveness of the services provided to the center. In the event, goals are not met for contracted services, reports for the plan of correction and result of such plans will be reported to the governing body and documented in the governing body minutes by the Administrator. In the above deficiencies, two of the contracted services did not meet facility goals, however corrective action plans were initiated. The correction plans and results were not documented in the governing body minutes. The administrator will prevent this in the future, by following up and reporting all corrective action regarding any contracted service to the Medical Advisory Committee and Board of Managers. In two the above deficiencies, Unity Surgical Center, used the contracted facility management company Cornerstone to assist with the oversight of the contracted services (Pest Control, Housekeeping). The Administrator will now exercise oversight over these contractors to verify standards are met and provide a report to the Medical</p>	

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			<p>Advisory Committee and Board of Managers regarding the safety and effectiveness of their services. 2. How are you going to prevent this deficiency in the future?The Administrator will maintain direct oversight over all contracts and consistently report results. The Administrator will initiate plan of corrections with contracted services who do not meet the center's standards and all plan of corrections with their results will be reported to the Medical Advisory Committee and Board of Managers. The Administrator will make sure all reports are documented in the meeting minutes for the Medical Advisory Committee and Board of Managers. 3. Who is going to be responsible for numbers 1 and 2 above? Unity Surgical Center's Administrator-Tami Robinson 4. By what date are you going to have the deficiency corrected? The plan of correction for the contracted services who did not meet the center's goals and final results have been placed on the agenda for the next Medical Advisory Committee/Board of Managers meeting which is scheduled to meet February 17, 2016. An updated evaluation of the contracted services which were not directly assessed by the Administrator were immediately evaluated and a report will be provided at the next Medical Advisory Committte/Board of Managers meeting which is</p>	

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S 0400 Bldg. 00	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on document review and interview, the facility failed to ensure 4 of 4 operating rooms met the required temperatures as defined by the surgery center's policy and PeriOperative Standards and Recommended Practices (AORN) and failed to provide a safe and healthful environment that minimized risk and infection exposure to patients, staff, and visitors for 1 occurrence.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of Environmental Control of the Operating Room policy #SC 422 indicated temperature in the operating room will be maintained at 68 to 72 degrees. The policy was last approved April 2015. 2. AORN supports the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) guidelines on temperature ranges for 	S 0400	<p>scheduled to meet February 17, 2016.</p> <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. 2015 AORN Guidelines for Perioperative Practice state that Operating Room Temperatures range from 68-75 degrees Fahrenheit. USC updated Policy and Procedure IC 20-Air Quality section D (Attachment A) to reflect the above AORN guidelines. The Operating Room Daily Temperature and Humidity Logs (Attachment B) were updated to reflect the above AORN guidelines. Education was provided on 01/06/16 to staff regarding the updated policy and procedure, and updated Operating Room Temperature and Humidity Logs. Spray Nozzle devices were removed from the facility so that all cleaning is performed using a facility approved disinfectant and a clean-low linting cloth. Re-education was provided to the housekeeping staff as it relates to the terminal cleaning procedures</p>	01/06/2016

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	<p>perioperative settings. The Operating Rooms temperature range should be between 68 F and 73 F.</p> <p>3. Review of Operating Room Daily Temperature and Humidity Logs for April, May and June of 2015 indicated 4 of 4 operating rooms temperatures were not consistently 68 degrees Fahrenheit or above.</p> <p>A. Operating Room #1 temperature read less than 68 degrees Fahrenheit 26 of 64 days.</p> <p>B. Operating Room #2 temperature read less than 68 degrees Fahrenheit 44 of 66 days.</p> <p>C. Operating Room #3 temperature read less than 68 degrees Fahrenheit 29 of 65 days.</p> <p>D. Operating Room #4 temperature read less than 68 degrees Fahrenheit 36 of 64 days.</p> <p>4. In interview at 10:30 AM on 11/18/2015, staff member #6 (Infection Control Nurse) confirmed above and no other documentation was provided by exit.</p> <p>5. The Association of periOperative Nurses (AORN) Recommended Practices</p>		<p>of the Operating Rooms and requirements that when using the Virex 256 for terminal cleaning, there should be a 10 minute dwell time. Policy and Procedure IC 35 (Review of Cleaning Agents and Practices) was updated to include dwell times for disinfectant agents used throughout the center. (Attachment F). A copy Policy and Procedure IC 35 was provided and reviewed with housekeeping staff. 2. How are you going to prevent the deficiency from recurring in the future? The infection control nurse will perform random audits of the temperature logs to verify compliance with the temperature/humidity standards. The infection control nurse will collect the temperature/humidity logs monthly and will review the logs for compliance. Staff was provided additional education at the January-2016 staff meeting regarding the new policy and procedure and updates on the temperature parameters. Random, unannounced audits of the housekeeping staff will be performed by the infection control nurse, administrator, and/or operating room certified scrub technicians to evaluate the terminal cleaning procedures for the center are compliant. The Infection Control Nurse will provide annual education on terminal cleaning and housekeeping procedures to the housekeeping staff. 3. Who is</p>	

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	<p>for Environmental Cleaning (2014) indicated the following: II(c) ...hospital-grade disinfectants should be used to disinfect surfaces in the perioperative setting ...II(c)(5) Disinfectants should be applied and reapplied as needed, per manufacturers' instructions, for the dwell time required to kill the targeted organism ...II(c)(6) Spray and misting methods (eg., a spray bottle) should not be used to apply chemicals in the perioperative setting.</p> <p>6. The policy/procedure Terminal Clean (revised 1-15) obtained from the contracted housekeeping services manual indicated the following: 1. Prepare hospital approved disinfectant solution according to manufactures (sic) instructions ...7. Damp wipe the overhead fixtures, surgical lights, ledges, and vents (both ceiling and wall) with wall washer unit dipped in germicidal solution ...9. Use a new cloth dipped in germicidal solution for the following ...</p> <p>7. During a telephone interview on 11-17-15 at 1500 hours with the contracted housekeeping personnel, staff A6, in the presence of the infection control nurse, staff A3, and the director of nursing, staff A1, the staff A6 indicated they (A6) spray down the operating room surfaces with Virex 256</p>		<p>going to be responsible for numbers 1 and 2 above? The Infection Control Nurse-Karl Bennett, Administrator-Tami Robinson, and Operating Room Certified Scrub Technicians may assist with the random audits of the evening housekeeping staff. 4. By what date are you going to have the deficiency corrected? The medical director approved updates to the Policy and Procedure IC 20 on December 22, 2016. The updated temperature and humidity logs were placed in all operating rooms on January 4, 2016. The infection control nurse informed all Operating Room Staff of the updates regarding this process on January 4, 2016. Staff education was again provided at the January 6, 2016 unit meetings. The Infection Control Nurse performed a random audit of the housekeeping staff terminal cleaning procedures on 12-02-15 at 2000 (See Housekeeping Evaluation Tool dated 12-02-15) Housekeeping staff demonstrated compliance regarding terminal cleaning procedures.</p>				

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	<p>(an approved disinfectant with a 10 minute wet contact time) and allow the surfaces to remain wet for a minimum of 5 minutes. The staff A6 indicated that they (A6) spray the mop used to clean the operating room walls with the disinfecting solution. The staff A6 indicated they (A6) clean the 3 procedure rooms with Virex while allowing the surfaces to remain wet for a minimum of 5 minutes and indicated that no other disinfectant products are used by them (A6).</p> <p>8. During an interview on 11-17-15 at 1520 hours, the director of nursing, staff A1, confirmed that the contracted housekeeping personnel, staff A6, indicated the Virex 256 disinfectant with a 10 minute wet contact time was applied and allowed to remain wet for a minimum of only 5 minutes.</p> <p>9. During an interview on 11-18-15 at 1010 hours, the infection control nurse, staff A3, confirmed the contracted housekeeping personnel, staff A6, was not following the approved policy/procedure for performing terminal cleaning in the restricted access areas of the center and confirmed the use of spray bottles for applying disinfectants was not a recommended practice.</p>			

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S 0428 Bldg. 00	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</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>(i) Sanitation. Based on document review and interview, the infection control (IC) committee failed to maintain its sanitation policy/procedures and ensure that the operating room (OR) cleaning and disinfecting was performed in a safe and effective manner.</p> <p>Findings include:</p> <p>1. The Association of periOperative Nurses (AORN) Recommended Practices for Environmental Cleaning (2014) indicated the following: Disinfectants should be applied and reapplied as needed, per manufacturers' instructions, for the dwell time required to kill the targeted organism ...Cleaning and disinfection activities should be performed in a methodical pattern that</p>	S 0428	<p>1. How are you going to correct the deficiency? Policy and Procedure IC 35 (Review of Cleaning Agents and Cleaning Practices-Attachment F) was updated to indicate the dwell time of cleaning agents used at Unity Surgical Center. Policy and Procedures IC 30 (Housekeeping Program-Attachment H), IC 32 (Housekeeping Guidelines-Attachment I), IC 33 (Cleaning of the Operating and Procedure Rooms-Attachment J), and IC 34 Terminal Cleaning-Attachment K) were updated to include a statement that directs readers to IC 35 for a list of cleaning agents and dwell times. Policy and Procedure IC 30 Section E, IC 32 Section B, IC 33 Section 2 and IC 34 Section B were updated to reflect an organized process is used to perform OR cleaning to prevent</p>	01/06/2016	

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	<p>limits the transmission of microorganisms. Cleaning an area in a methodical pattern establishes a routine for cleaning so that items are not missed during the cleaning process... [and] ... reduce the risk of cross contamination of environmental surfaces...Clockwise or counter-clockwise cleaning may be performed when used in conjunction with clean-to-dirty and top-to-bottom methods ...All high touch objects, in addition to objects cleaned as part of routine cleaning, should be cleaned and disinfected ... Cleaning of high-touch objects after each patient use should include cleaning of any soiled surface of the item and any frequently touched areas of the item (control panel, switches, knobs, work area, handles)...</p> <p>2. The policy/procedures titled Housekeeping Program, Housekeeping Guidelines, Cleaning of the Operating and Procedure Rooms, and Terminal Cleaning of the Operating Room (approved 2-15) failed to indicate the wet contact time for specific disinfectant products to be used in the OR, or a methodical process for performing OR cleaning to prevent contamination of previously disinfected surfaces, or a provision for cleaning all high-touch surfaces in the OR.</p>		<p>contamination of previously disinfected surfaces, and a statement indicating cleaning will be performed on all high-touch areas in the OR. The housekeeping log was updated to include statement indicating an organized process was used to prevent the contamination of previously disinfected surfaces. The organized process includes statements that cleaning is performed from cleanest to dirtiest areas, from top to bottom, and in a clockwise or counter clock wise method. 2. How are you going to prevent the deficiency from recurring in the future? The infection control nurse and/or administrator will perform random audits of the housekeeping staff and Unity Surgical Center staff to verify compliance with the above policies and procedures. Any time a new cleaning agent is approved, the dwell time will be documented in Policy and Procedure IC 35 and education provided to Unity Surgical Center Staff and any contracted housekeeping Staff. 3. Who is going to be responsible for numbers 1 and 2 above? The Infection Control Nurse-Karl Bennett and Administrator-Tami Robinson 4. By what date are you going to have the deficiency corrected? Policy and Procedure updates were approved on December 22, 2015. Education</p>	

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S 0438 Bldg. 00	<p>3. Review of the Housekeeping Log identified in the policy/procedure Housekeeping Program failed to indicate an organized process to ensure that the completion of services per the checklist did not result in the contamination of previously disinfected surfaces.</p> <p>4. During an interview on 11-17-15 at 1545 hours, the infection control nurse, staff A3 and confirmed that the policy/procedures failed to indicate the wet contact time for the specific disinfectant products to be used at the center and failed to indicate an organized process for cleaning and disinfecting to prevent contamination of previously disinfected surfaces.</p> <p>5. During an interview on 11-16-15 at 1535 hours, the director of nursing, staff A1, confirmed the policy/procedures lacked the indicated provisions and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(vi)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending</p>		was provided to staff on updated policy and procedures at January 6, 2016 unit meeting.	

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	<p>changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(vi) A patient isolation system.</p> <p>Based on document review and interview, the infection control (IC) program failed to develop an isolation system for airborne, contact and droplet precautions associated with communicable diseases at the center for one example.</p> <p>Findings include:</p> <p>1. The Centers for Disease Control (CDC) publication titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings prepared by the Healthcare Infection Control Practices Advisory Committee (HICPAC) indicated the following: Any infectious agents transmitted in healthcare settings may, under defined conditions, become targeted for control because they are epidemiologically important. Clostridium difficile is specifically discussed (below) because of wide recognition of its current importance in U.S. healthcare facilities ...Use of soap and water, rather than alcohol-based handrubs, for mechanical removal of spores from hands, and a bleach-containing disinfectant (5000</p>	S 0438	<p>1. How are you going to correct the deficiency? Policy and Procedure IC 16 Section K (Patient Isolation-Attachment M) and SC 700 Section H (Endoscopy Infection Control Guidelines-Attachment N) were updated to include a terminal cleaning process for patients being infected or recently diagnosed with Clostridium difficile (C diff) using a bleach solution. Policy and Procedure IC 35 (Review of Cleaning Agents and Practices Attachment-F) to include Bleach Germicidal Wipes which can be used for cleaning on areas, rooms, equipment that have been exposed to patients who are infected or recently diagnosed with Clostridium Difficile. A dwell time for this product is also documented in this policy and procedure. The Clorox Healthcare Bleach Germicidal Wipes are now maintained on site to use for cleaning after any patient who may have been infected or recently diagnosed with Clostridium Difficile. (See SDS Sheet -Attachment S) The Infection Control Nurse updated Unity Surgical Center Staff and housekeeping services of the updates to Policy and</p>	01/06/2016

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	<p>parts per million)=(a 1:10 dilution of sodium hypochlorite solution)... is recommended.</p> <p>2. The policy/procedures titled Patient Isolation (approved 2-15) and Endoscopy Infection Control Guidelines (approved 2-15) failed to indicate a terminal cleaning process for patients suspected of being infected or recently diagnosed with Clostridium difficile (C diff) using a 1:10 dilution sodium hypochlorite solution.</p> <p>3. The policy/procedure Review of Cleaning Agents and Practices (approved 2-15) failed to indicate a bleach-containing disinfectant on the list of approved products.</p> <p>4. During a telephone interview on 11-17-15 at 1500 hours with the contracted housekeeping personnel, staff A6, in the presence of the infection control nurse, staff A3, and the director of nursing, staff A1, the staff A6 indicated they use Virex 256 (a quaternary ammonium disinfectant) and indicated that no other disinfectant products are available for use.</p> <p>5. During an interview on 11-18-13 at 0945 hours, the infection control nurse, staff A3, confirmed that the policy/procedures lacked the indicated</p>		<p>Procedure IC 35 and Bleach Germicidal Wipes are available for use. 2. How are you going to prevent the deficiency from recurring in the future? Staff education was provided on January 6, 2016 regarding Policy and Procedures IC 16, IC 35, SC 700 on the updated cleaning procedures specific to patients who have been infected or diagnosed with Clostridium Difficile. Random audits will be performed by the infection control nurse to verify compliance with cleaning procedures. 3. Who is going to be responsible for numbers 1 and 2 above? The Infection Control Nurse 4. By what date are you going to have the deficiency corrected? January 6, 2016</p>		

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S 1152 Bldg. 00	<p>provisions and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(B)</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 plan and equipment by qualified personnel as follows:</p> <p>(B) All mechanical equipment (pneumatic, electric, sterilizing, or other) must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on document review and interview, the center failed to ensure the two boilers had a valid Certificate of Inspection.</p> <p>Findings include:</p> <p>1. Review of two (2) facility boiler's Certificate of Inspections indicated the</p>	S 1152	How are you going to correct the deficiency? The inspection of the boiler was completed on July 8, 2015. However the invoice for the Certificate of Inspection had not been paid. Upon discovery of this deficiency during the survey, the invoice was paid on 11/19/15 (See Attachments, O, P, Q, R) How are you going to prevent the deficiency from recurring in the future? It was	11/19/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001108	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/18/2015
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	<p>expiration date of the certificates was 8/15/2015.</p> <p>2. In interview at 10:45 AM on 11/18/2015, staff member #3 (Maintenance) confirmed above and no other documentation was provided by exit.</p>		<p>determined the invoice was sent to the attention of the incorrect individual within Unity, which was the reason the invoice was not promptly paid. Notification was sent to the Department of Homeland Security, Boiler and Pressure Vessel Safety Division to change the department who receive these invoices. These invoices will not be sent to the Director of Operations. Who is going to be responsible for numbers 1 and 2? The Administrator-Tami Robinson with the assistance of the Unity Healthcare Director Of Operations. By what date are you going to have the deficiency corrected? The updated and current copy of the boiler certificate of inspection was reviewed with the surveyor and posted on 11/19/2015.</p>		