

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2014
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NAME OF PROVIDER OR SUPPLIER BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005405</p> <p>Survey Date: 4-21/23-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 04/30/14</p> <p>Per the IDR Committee Meeting on 06-16-14 the following changes made to tag 0110 of deleting transcription services and modifying paragraph #5 in tag 0116.</p> <p>John Lee Program Manager Hospitals/ASCs</p>	S000000		
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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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S000110	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on document review and interview, the facility's governing board failed to review reports of the quality assessment performance improvement (QAPI) program for 1 of 4 quarters in calendar year 2013 and failed to review 1 contracted service (laboratory) during calendar year 2013 as part of the facility's QAPI program.</p> <p>Findings:</p> <p>1. Review of the governing board bylaws, last approved 12-4-12, <u>Section 6.6 Quorum for Meetings</u>, indicated unless otherwise provided by law or in the Articles of Incorporation, the presence of at least fifty-one percent</p>	S000110	<p>The governing board reviewed the second quarter QAPI program and laboratory services for 2013 in the Board Meeting dated 4/29/2014. The governing body will continue to review laboratory services and the QAPI program quarterly, effective immediately. Effective immediately, if a board of director is not physically present but present via phone or by other means, it will be noted in the meeting role call. Mindy Deno, RN, Director of Surgical Services will be responsible for the above correction.</p>	04/29/2014

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	<p>(51%) of the actual number of directors appointed and qualified, from time to time, is necessary to constitute a quorum for the transaction of business.</p> <p>2. In interview, on 4-22-14 at 3:30 pm, employee #A1 indicated MD#4 and OD#1 were the only directors.</p> <p>3. Review of a document entitled BOARD OF DIRECTORS MEETING, July 30, 2013, indicated there was only 1 director, OD#1 (50%) present. There was no documentation the other director (MD#4) was present either in person or via telecommunication, and MD#4 had not submitted any proxy. Thus, there was not a quorum present and the governing board, in effect, did not officially meet and transact business. The consequence of this was that the governing board only officially met and reviewed the QAPI program three times in calendar year 2013: January 29, April 30 and October 29.</p> <p>4. In interview, on 7-3-12 at 1:40 pm, employee #A2 confirmed the above and no other documentation was provided prior to exit.</p> <p>5. Review of the governing board meeting minutes for calendar year 2013 indicated the governing board failed to</p>			

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S000116	<p>review QAPI activities for the contracted service of laboratory.</p> <p>6. In interview, on 4-22-14 at 10:45 am, employee #A1 confirmed the governing board did not review the QAPI of laboratory and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</p> <p>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on document review and interview, the governing board failed to</p>	S000116	At the Board of Director's meeting dated 4/29/2014, the Board reviewed re-credentialing for the	04/29/2014			

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	<p>grant privileges to 14 of 14 members of the medical staff according to the governing board bylaws.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the governing board bylaws, last approved 12-4-12, <u>Section 6.6 Quorum for Meetings</u>, indicated unless otherwise provided by law or in the Articles of Incorporation, the presence of at least fifty-one percent (51%) of the actual number of directors appointed and qualified, from time to time, is necessary to constitute a quorum for the transaction of business. 2. In interview, on 4-22-14 at 3:30 pm, employee #A1 indicated MD#4 and OD#1 were the only directors. 3. Review of a document entitled BOARD OF DIRECTORS MEETING, July 30, 2013, indicated there was only 1 director, OD#1 (50%) present. There was no documentation the other director, MD#4, was present via telecommunication, nor had MD#4 submitted any proxy. Thus, there was not a quorum present and the governing board, in effect, did not officially meet and transact business. 4. Review of the above-stated board of 		<p>14 members of medical staff that was approved in the July 30, 2013 Credentialing Committee Meeting. It was decided by the Board of Director's that the members were considered credentialed since July 30th, 2013 and will continue to be privileged until July 30th, 2015. A quorum was met on the Board of Director's meeting dated 4/29/2014 by the presence of both directors. The Board of Directors, is responsible for the above correction.</p>	

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S000230	<p>410 IAC 15-2.4-1</p> <p>directors meeting minutes indicated the minutes of the Credentialing Committee were reviewed and unanimously approved by the Board.</p> <p>5. Review of a document entitled CREDENTIALING COMMITTEE MEETING, July 30, 2013, indicated the following medical staff member reappointments were approved: MD#4, MD#2, MD#3, MD#5, MD#1, MD#6, MD#7, MD#8, MD#9, MD#10, MD#11, MD#12, MD#13, and MD#14.</p> <p>6. In interview, on 4-22-14 at 3:30 pm, the above documentation was confirmed by employee #A1 and no further documentation was provided prior to exit.</p> <p>7. As a result of the governing board not officially meeting and transacting business, the above-stated medical staff members were not privileged as of July 30, 2013.</p>				

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	<p>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 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.</p> <p>Based on document review and interview, the facility failed to have a properly composed utilization review committee.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of Utilization Review Committee minutes on October 29, 2013, indicated physician MD#4 was a listed as Present. The minutes also indicated MD#4 reviewed 24 records of surgical cases performed this quarter and reviewed anesthesia performance for twenty-four surgical cases performed this quarter. In interview, on 4-21-14 at 2:05 pm, employee #A1 indicated MD#4 had a financial interest (ownership) in the facility and confirmed MD#4 had voting 	S000230	In the Utilization Review Committee meeting dated 4/29/2014, it was determined that physician MD#4 only reviews anesthesia records and not surgical cases due to financial interest. Also, the Utilization Review Committee voted and approved on 4/29/2014, the following members of the committee: Chairman: Dr. Richey, Voting Members: Dr (s). Richey, Chang, Mackey, and Johnson. Also, included in voting members: Mindy Deno, RN. Effective immediately, no voting member will hold financial interest. Mindy Deno, RN, Director of Surgical Services will be responsible for the above correction.	04/29/2014

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S000320	<p>rights.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for the activity of discharges in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include monitors and standards for the activity of discharges.</p> <p>2. In interview, on 4-22-14 at 10:45 am, employee #A1 confirmed the above and no documentation was provided prior to</p>	S000320	<p>On 4/29/2014, the Quality Assurance committee and the Governing Board approved the standard for discharge to be referred to the Policy and Procedure titled: Nursing: Discharge Criteria Section X.A. On 4/29/2014, Quality Assurance committee updated the program to include quarterly monitors and standards for discharges effective immediately. Mindy Deno, RN, Director of Surgical Services will be responsible for the above correction.</p>	04/29/2014	

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S000422	<p>exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk. Based on document review and staff interview, the infection control committee failed to review employee exposure incidents in 1 instance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of incident reports for previous 12 months indicated that a staff member had a needle stick injury on 10/9/13. 2. The infection control meeting minutes after the incident (10/29/13 and 1/28/14) lacked documentation that the committee reviewed the needle stick injury. 3. Staff member #A1 verified the above at 2:00 p.m. on 4/23/14. 	S000422	<p>1) The needle stick injury was reviewed at the April 29th, 2014 Infection Control Meeting. 2) Needle stick injuries have now been added on all the Infection control Committee's agendas which meet quarterly. 3) Mindy Deno, Director of Surgical Services will be responsible for the above.</p>	04/29/2014			
S000432	410 IAC 15-2.5-1						

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	<p>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 interview and document review, the infection control committee failed to ensure the surgical instrument cleaner was changed according to manufacturer guidelines in one (1) soiled processing room toured.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Staff member #N7 working in the soiled processing room indicated in interview at 11:30 a.m. on 4/22/14 that he/she uses Universal cleaner for cleaning instruments and changes the solution on a daily basis. Label instructions for the Universal surgical instrument cleaner states "Only use the Universal (tm) Cleaning Solution once per instrument set/load....reuse of the Universal (tm) Cleaner or other cleaners for multiple instrument sets is 	S000432	<ol style="list-style-type: none"> Loree Theodore, CRST, was educated on how to properly use the Universal cleaner and is now changing cleaner solution in between each instrument load. Monthly monitoring of proper use of the cleaner will be completed by Mindy Deno, RN, Director of Surgical Services Responsible: Mindy Deno, RN, Director of Surgical Services 	04/23/2014

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S000434	<p>never recommended."</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage. Based on observation and document review, the facility failed to ensure aseptic technique was maintained during 1 of 2 intravenous (I.V.) starts observed.</p> <p>Findings include:</p> <p>1. During observation of an I.V. start on patient #29 beginning at 11:10 a.m. on 4/22/14, the following was observed: (A) RN #1 placed the flush syringe with a Clave connector on a nonsterile field (chux) with the connector touching the chux. He/she then started the I.V. and the tip of the Clave connector that had been placed on the nonsterile surface was attached to the patients I.V. catheter.</p>	S000434	<p>1.) The RN that did not ensure aseptic technique was re-educated on proper technique. 2.) All staff will be re-educated on asepsis technique on May 6, 2014 at the staff meeting. 10% of staff will be monitored monthly and will be completed by Mindy Deno, RN, Director of Surgical Services 3.) Responsible: Mindy Deno, RN, Director of Surgical Services</p>	04/23/2014

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S000444	<p>2. The label for the Clave connector indicated it was a sterile product.</p> <p>3. Facility policy titled "INTRAVENOUS INFUSIONS AND INTERMITTENT INFUSION INFECTION DEVICES/SALINE LOCKS" last reviewed/revised 1/13 states on page 1 under procedure: "2..... Follow principles of asepsis."</p> <p>4. Facility infection prevention plan last reviewed/revised 11/13 states on page 7: "Use aseptic technique to avoid contamination of sterile injection equipment."</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</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>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on observation and document</p>	S000444	1) RN #1 was educated on proper	04/23/2014

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	<p>review, the infection control committee failed to ensure surgical masks were worn in accordance with policy and acceptable standards of practice in 1 instance and failed to define frequency of mask change in surgical attire policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During observation of the surgical area beginning at 10:25 a.m. on 4/22/14, RN #1 was observed with his/her mask below their nose frequently within the operating room (OR). The OR contained opened, sterile instruments. 2. Throughout the survey, staff were observed with masks hanging around their neck and staff were not observed changing their masks between cases. 3. Facility Infection Control Plan last reviewed/revised 11/13 states on page 6: ".....Appropriate PPE worn by employees.....All per CDC guidelines." 4. Facility policy titled "OPERATING ROOM ATTIRE" last reviewed/revised 1/13 states on page 1: "1. The mask must be worn over both the nose and mouth....." Page 2 states "3. Be changed frequently." 4. CDC guidelines for prevention of 		<p>coverage of mask to include nose and mouth. 2.) Staff will be re-educated on how to appropriately wear surgical masks at the staff meeting on May 6, 2014. Intermittent monitoring of 10 % of staff monthly will be conducted to ensure proper mask wear. 3.) The Infection Control Committee met on 4/29/2014 and determined and approved that policy X.A, Operative Attire for mask changing will state that surgical masks will be changed if visibly soiled, when a staff member breaks for lunch or leaves the surgery center area. 4.) Mindy Deno, RN, Director of Surgical Services will be responsible</p>	

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S001012	<p>surgical site infections states on page 268: "Wear a surgical mask that fully covers the mouth and nose when entering the OR if an operation is about to begin or already under way, or if sterile instruments are exposed....."</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(B)</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>(B) Drug administration according to established center policies and acceptable standards of practice. Based on observation, interview and document review, the facility failed to ensure prepared ocular antibiotic solution was administered according to acceptable standards of practice and facility policy for all cataract surgical patients.</p> <p>Findings include:</p> <p>1. During observation in the surgery area beginning at 10:25 a.m. on 4/22/14, one (1) vial of Sodium Chloride was observed within the circulating nurse's</p>	S001012	<p>1.) Cefuroxime is now reconstituted for each patient and thrown away after each patient, for now. 2.) Pharmakon is currently creating a quote for single patient cefuroxime compounded for per patient use during surgery. The staff will no longer need to reconstitute and single dose vials will not be used on multiple patients. This will be completed within a month. 3.) Responsible: Mindy Deno, RN, Director of Surgical Services</p>	04/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/23/2014
NAME OF PROVIDER OR SUPPLIER BLOOMINGTON SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403		
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S001024	<p>work area. A piece of tape was observed on the vial that stated "Cef" The Sodium Chloride vial was labeled as a single dose vial.</p> <p>2. At time of observation, staff member #A1 indicated the vial contained Cefuroxime which is mixed at the facility for use during the eye surgeries.</p> <p>3. At time of observation, RN #1 indicated the solution is mixed by the circulator and the vial is used the "whole day."</p> <p>4. The facility Infection Control Plan last reviewed/revised 11/13 states on page 7: "Follow CDC guidelines for safe injection practices which include:..... (page 8)..."Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use."</p> <p>5. Directions for mixture of the Cefuroxime solution provided by staff member #A1 state "DISCARD ALL VIALS AT THE END OF THE DAY."</p>				

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	<p>PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)</p> <p>Pharmaceutical service 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>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>Based on observation and interview, the facility failed to ensure medications were clearly labeled in 1 instance.</p> <p>Findings include:</p> <p>1. During observation in the surgery area beginning at 10:25 a.m. on 4/22/14, one (1) vial of Sodium Chloride was observed within the circulating nurse's work area. A piece of tape was observed on the vial that stated "Cef"</p> <p>2. Per staff member #A1, the vial contained Cefuroxime.</p>	S001024	<p>1.) Circulating nurses were educated on writing the complete drug name when labeling medications. 2.) The cefuroxime will already be labeled once the surgery center purchases single patient cefuroxime from Pharmakon. Also, 10% of staff will be monitored monthly to ensure they are labeling properly. 3.) Responsible: Mindy Deno, RN, Director of Surgical Services</p>	04/23/2014			