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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001025 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/17/2014 |
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| NAME OF PROVIDER OR SUPPLIER MERIDIAN PLASTIC SURGERY CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 170 W 106TH ST INDIANAPOLIS, IN 46290 |
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| S000000 | <p>This visit was for a State licensure survey.</p> <p>Facility Number: 005406</p> <p>Survey Date: 12-15/17-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 01/26/15</p> | S000000 | S 0000 Not necessary | |
| S000442 | <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 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</p> | | | |

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>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 and interview, the infection control committee failed to maintain an employee health program which ensures that all employees are immune to preventable communicable diseases in 4 (employees # 9, 12, 14, and 16) of 16 staff personnel files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of facility policy entitled "Employee Orientation", 3.023, last reviewed 6/30/2014, indicated that the job orientation checklist, "at a minimum, shall include g. Current TB testing". 2. Review of facility policy "Universal Precautions for Disease Control", 10.09, last reviewed 6/30/2014, indicated that I. <u>Pre-Employment Physical Examination</u>, A. A complete medical history, including communicable diseases, i.e., Rubella, chicken pox, measles, mumps, tuberculosis, hepatitis, shigella, salmonella or typhoid fever, chronic skin | S000442 | S 0442 Director responsible. TB test and vaccination records have been obtained on all employees. The contract employees have had their 2 step TB testing completed. They have been added to our annual testing list for employees. Policy and procedure have been updated. | 01/28/2015 |

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| S001198 | <p>lesions, etc., will be completed." C. "A PPD (Purified Protein Derivative; tuberculosis skin test) is performed annually, as well as other tests deemed appropriate by the Medical Staff. II. <u>Immunization</u> A. Rubella immunity is mandatory for all Category I and II (registered nurses and certified surgical techs) employees and must be documented in Employee Personnel Records within 30 days after receiving a non-immune report.</p> <p>3. Review of 15 nursing and 1 contracted staff personnel files indicated that employees # 9, 12, 14, and 16 lacked evidence of immunization to all of the diseases listed as required in facility policies.</p> <p>4. In interview on 12/16/2014 at 11:15 AM, staff member #2, the facility manager, confirmed the above and in the instance of the contracted employee #16, contacted the housekeeping company, and was told that they do not keep employee health files.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT</p> | | | | | | |

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| | <p>MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the facility failed to perform a disaster drill on a regular basis.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 12-15-14 at 9:30 am, employee #A1, Practice Administrator, was requested to provide documentation of the most recent disaster drill performed by the facility. In interview, on 12-15-14 at 2:50 pm, employee #A2, Director, indicated in year 2014, the facility only conducted a disaster in-service [instruction/discussion but not performance by individuals] pertaining to a disaster drill. No further documentation was provided prior to exit. | S001198 | S 1198 Director responsible. A disaster drill will be conducted this year, and annually, not a Disaster " in service". A new form to guide and evaluate the Drill has been been created and cards for each individual to define their duties and action during the drill. (see attached). | 02/24/2015 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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