

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001086	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/05/2015
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NAME OF PROVIDER OR SUPPLIER  BELTWAY SURGERY CENTERS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 151 PENNSYLVANIA PKWY INDIANAPOLIS, IN 46280
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S 0000  Bldg. 00	This visit was for a State licensure survey.  Facility Number: 002277  Survey Date: 11/2-11/4/2015  QA: cjl 12/07/15	S 0000		
S 0444  Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)  The infection control committee responsibilities must include, but are not limited to:  (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:  (ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.  Based on document review, observation and interview, the infection control committee failed to ensure the medical staff followed facility policy regarding dress code in the operative setting; risking contamination of the open	S 0444	The Clinical Managers are responsible for ensuring correction of, and then compliance with the deficiency S 0444. The policy requiring all hair to be covered in the operating arena was reviewed with the employees and the physicians.	11/06/2015

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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	<p>surgical sites.</p> <p>Findings include:</p> <p>1. Facility policy titled: Dress Code: Perioperative Domain, ADM 3.02, indicated</p> <p>I. PURPOSE: To establish attire guidelines adhering to regulatory standards and create a safe, contaminant-free environment for patient care.</p> <p>II. SCOPE: All surgery personnel, physicians, allied healthcare and supervised allied healthcare staff.</p> <p>III. EXCEPTIONS: There are no exceptions to this policy.</p> <p>IV. RESTRICTED AREA: Includes operating rooms and procedure rooms.</p> <p>V. POLICY STATEMENTS:</p> <p>A. General</p> <p>2. All individuals entering the semi-restricted and restricted areas of the surgical suite will be in scrub attire and approved head coverings.</p> <p>C. Head/face</p> <p>1. Head and facial hair including sideburns should be covered. Standard, disposable bouffant and hood-style covers are preferred.</p> <p>2. During the observation of a patient surgery on 11/02/2015 at 1100 hours, it was noted that two physicians (MDs # 2</p>		<p>Reminder signs have been posted in the area where surgical head coverings are located and in the employee/physician locker rooms. The OR Clinical Managers will provide weekly spot checks and address anyone that is out of compliance. All employees were educated to continuously observe for breaches in the infection control policy and report immediately if seen. Education was begun on 11/6/2015</p>	

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S 0736 Bldg. 00	<p>and 3) were performing surgery on a patient with their hair not completely covered. Both physicians wore skull caps, which do not cover hair in the back and sides of their heads.</p> <p>3. On 11/5/2015 at 1320 hours, during a tour of a facility offsite #1, accompanied by staff member #4, Operating Room Clinical Manager, it was observed that physician #1 was operating on a patient with physician #1's hair not completely covered; wearing the skull cap, that does not fully cover hair in the back and on the sides.</p> <p>4. Staff member #4 indicated that physicians and other personnel are educated that they need to have their hair covered while in the O.R.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the</p>			

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	<p>medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p> <p>Based on document review and interview, it could not be determined the facility's medical staff met quarterly for 1 of 4 quarters in calendar year 2014.</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Meeting Minutes of 6-17-2014, indicated the meeting was for BSC (Beltway Surgery Center), Glen Lehman, [and] Indiana Hand to Shoulder.</p> <p>2. Further review of the minutes indicated there were 4 Medical Staff Present, MD#8, MD#9, MD#10 and MD#11. Further review of the minutes indicated there was no designation as to which of the above facility's medical staff each individual represented.</p> <p>3. Further review indicated the Medical Staff Bylaws, and Medical Staff Rules and Regulations were reapproved as presented. Further review of the minutes indicated it was not specific to which facility the bylaws and rules pertained.</p> <p>4. Interview of employee #A3, Clinical</p>	S 0736	The Clinical Directors are responsible to ensure the deficiency S 0736 is not repeated and the ruling is complied with going forward, A template for the medical staff meeting minutes was developed in order to identify which medical staff members are representing which facility, The template will be used to ensure approvals cover the appropriate centers, The 4th Quarter meeting was rescheduled to line up with the Board meetings better, which resulted in a missed meeting in 2014,	11/20/2015

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S 1146 Bldg. 00	<p>Director, at 10:10 am on 10-10-2015, indicated all 3 of the above-stated facilities were separately licensed, confirmed the above and no other documentation was provided prior to exit.</p> <p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 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. Based on document review and observation, the facility created a condition which resulted in a hazard to patients, public or employees in 2 instances.</p> <p>Findings:</p> <p>1. Review of Policy Number: PSF 10.16, approved July 2014, entitled OXYGEN SAFETY PRACTICES, indicated tanks must be stored in a designated site and</p>	S 1146	The company that delivers the medical gases was contacted immediately about this situation, A member of the surgical team has been assigned to do daily checks in the medical gas room to quickly correct any potential hazardous situations. The OR Clinical Manager is responsible for ensuring the medical gases are continuously properly secured. The daily checks will prevent this situation from going unnoticed in the future.	11/06/2015

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S 1148 Bldg. 00	<p>manner per accreditation and regulatory requirements.</p> <p>2. On 11-4-2015 at 9:10 am in the presence of employees #A4, Clinical Manager OR (operating room), and #A5, Clinical Manager PACU (post anesthesia care unit), it was observed in the medical gas storage area, there were 2 large compressed gas oxygen cylinders standing upright on the floor unsecured by chain or holder.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(A)</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 plant and equipment by qualified personnel as follows:</p> <p>(A) Operation, maintenance, and spare parts manuals must be available, along with training or instruction, or both, of the appropriate center personnel, in the maintenance and operation of fixed and movable equipment.</p>			

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	<p>Based on document review, observation and staff interview, the facility failed to be able to document annual preventive maintenance (PM) had been done on equipment in central processing, in one instance.</p> <p>Findings include:</p> <p>1. Policy Preventive Maintance for Medical Equipment, PM 8.01, indicates</p> <p style="padding-left: 40px;">I. PURPOSE:</p> <p style="padding-left: 80px;">The purpose of this policy is to establish a systemic scheduled maintenance program for equipment/device(s) to be utilized by the Ambulatory Surgery Center (ASC).</p> <p style="padding-left: 40px;">IV. POLICY STATEMENTS</p> <p style="padding-left: 80px;">A. The ASC contracts with a vendor for PM and repairs of medical equipment.</p> <p style="padding-left: 80px;">C. The contractor and the ASC shall be responsible for monitoring and managing the Scheduled Maintenance Program.</p> <p style="padding-left: 80px;">V. The contractor shall be responsible for:</p> <p style="padding-left: 120px;">1. Contacting the facility to schedule an appropriate time for performing the PM.</p> <p style="padding-left: 120px;">2. Completing their assigned PM tasks each month.</p> <p style="padding-left: 120px;">3. Affixing the completion identification sticker.</p> <p style="padding-left: 40px;">VI. RESPONSIBILITY</p>	S 1148	The Clinical Director contacted the Director of the IUH Clinical Engineering department regarding the failure of the IUH CI employee to provide the Center with documentation of the PM in a timely manner, resulting in a citation for the Center. The Clinical Managers are responsible for ensuring all equipment are up to date with PMs. To prevent this situation from recurring, a quarterly equipment PM check will be conducted.	11/05/2015			

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	<p>The ASC Medical Administer/Director, surgery center Administer/Director, Clinical Managers and/or their designee(s) are responsible for the consistent application of this policy.</p> <p>2. While on tour of Central Processing in the surgery department on 11/02/2015, accompanied by staff member #1, it was noted that a sticker on the Blue Way Ultrasonic dryer indicated that PM was due in 5/2015.</p> <p>3. The facility was unable to submit documentation that the needed PM had been done, as the sticker indicated, by exit.</p> <p>4. On 11/5/2015 at 1630 hours, staff member #1 concurred with these findings.</p>			