

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001027	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/06/2016
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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 N MERIDIAN ST INDIANAPOLIS, IN 46202
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S 0000 Bldg. 00	This visit was for a state licensure survey. Facility Number: 005408 Survey Date: 07-05-2016 - 07-07-2016 QA: 8/24/16 jlh	S 0000		
S 0153 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review interview the facility failed to ensure a general orientation for 1 of 1 Infection Control Coordinators (N1). Findings Include: 1. Review of policy/ procedure 1.06, Personnel Records, on page 1 indicated the following: 1. Administration shall maintain and monitor employee records of all personnel. This record shall include the following:	S 0153	S 153 410 IAC 15-2.4-1 (c) (5) (C) 1. Deficiency will be corrected with New Employee Orientation/In-Service Infection Prevention and Control Checklist. Departmental orientation checklist was completed by the employee on 3/16/2012. See attached documentation. 2. Correction of future deficiencies: Orientation Checklist and New Employee Orientation/In-Service Infection Prevention and Control Checklist will be completed in the future on all new infection control nurses.	07/11/2016

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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S 0156 Bldg. 00	<p>f. Orientation checklist</p> <p>2. Review of the personnel file for N1, Infection Control Coordinator, indicated a lack of documentation of a new employee general orientation.</p> <p>3. Interview on 7-6-16 at 0927 hours with staff # 50, Director of Nursing, confirmed the finding.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the facility failed to ensure a job description for 1 of 1 Infection Control Coordinators (N1).</p> <p>Findings Include:</p>	S 0156	<p>This will prevent future deficiencies.</p> <p>3. Responsible party: Jennifer Knepp, Administrator and Katie Ralston, RN, DON</p> <p>4. Completed: 7/11/2016.</p>	07/11/2016

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S 0162 Bldg. 00	<p>1. Review of policy\ procedure 1.06, Personnel Records, on page 1 indicated the following: 1. Administration shall maintain and monitor employee records of all personnel. This record shall include the following: c. Signed and dated job description</p> <p>2. Review of the personnel file for N1, Infection Control Coordinator, indicated a lack of documentation for an Infection Control Coordinator job description.</p> <p>3. Interview on 7-6-16 at 0927 hours with staff # 50, Director of Nursing, confirmed the finding.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following: (G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care. Based on document review and interview, the facility failed to ensure cardiopulmonary resuscitation (CPR)</p>			S 0162	<p>Infection Control Nurse Responsibilities/Job Description. This will prevent future deficiencies. 3. Responsible party: Jennifer Knepp, administrator and Katie Ralston, RN, DON 4. Completed: 7/11/2016</p> <p>S 162 410 IAC 15-2.4-1 (c) (5) (G) 1. Deficiency will be corrected by insuring all employees and credentialed individuals will</p>		08/25/2016

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	<p>competence, hands-on demonstration, in accordance with current standards of practice for 1 of 2 allied health credential files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of 2 allied health credential files indicated AH#1, optometrist, had a document from The American Academy of CPR and First Aid, Inc. Review of this document indicated AH#1 had completed CPR training and certification. Review of an e-mail dated July 6, from #R1, representative of The American Academy of CPR and First Aid, Inc., indicated "We are NOT affiliated with any organization such as American Heart Association (AHA) or American Red Cross (ARC)." Further review indicated "We provide total online CPR and First Aid training and certification." Based on the above, it could not be determined the facility could ensure CPR competence, hands-on demonstration, in accordance with current standards of practice. In interview, on 07-06-2016 at 10:30 am, employee #A1, Administrator, confirmed all the above and no other 		<p>complete CPR training through accompany using American Heart Association (AHA) standards with competence, hands-on demonstration. AH #1, optometrist has received noticed of suspension of credentials until CPR is completed. CPR is scheduled for September 19, 2016.</p> <p>2. Correction of future deficiencies: All CPR training will be completed using American Heart Association (AHA) standards with competence, hands-on demonstration. This will prevent future deficiencies.</p> <p>3. Responsible party: Jennifer Knepp, administrator and Katie Ralston, RN, DON</p> <p>4. Completed: 8/25/2016</p>	

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S 0430 Bldg. 00	<p>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)(ii)</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>(ii) Universal precautions, including infectious waste management.</p> <p>Based on document review, observation and interview the facility failed to ensure proper infection waste management as related to the sharps container in the Operating Room, OR, "Big Room."</p> <p>Findings include:</p> <p>1. Review of policy\ procedure 10.05, Work Practice Controls, on page 2 indicated the following: 8. Used sharps are placed in the appropriate containers for disposal. This container is replaced when two-thirds full or when the preplaced manufacturer's guideline is reached on the container.</p>	S 0430	<p>S 430 410 IAC 15-2.5-1 (f) (2) (E) (ii)</p> <p>1.Deficiency will be corrected by ensuring all sharps containers are emptied with the preplaced manufactures full mark is reached. Staff was educated at the monthly staff meeting on the policy for emptying the sharps when at the proper full mark. See attached documentation. Sharps box was changed on 7/6/2016.</p> <p>2.Correction of future deficiencies: Staff were educated on the proper procedure for emptying the sharps boxes at the preplaced manufactures marked full line. Sharps boxes will continue to be checked on a daily basis and emptied at the</p>	07/11/2016

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S 0432 Bldg. 00	<p>2. While on facility tour on 7-6-16 at 1238 hours, the sharps container in OR "Big Room" was observed to be filled above the manufacturer's preplaced full mark.</p> <p>3. Interview on 7-6-16 at 1238 hours with staff # 50, Director of Nursing, confirmed the finding of the sharps container was filled above the preplaced manufacturer full mark.</p> <p>410 IAC 15-2.5-1 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 document review, observation and interview, the facility failed ensure proper cleaning as related to the Pre\Post Operative, OP, area and Operating Room , OR, " Small Room."</p> <p>Findings include:</p>	S 0432	<p>preplaced full mark. Staff will also be monitored and educated on a yearly basis in the annual inservice education on biohazardous waste. This will prevent future deficiencies.</p> <p>3.Responsible party: Jennifer Knepp, administratorand Katie Ralston, RN, DON</p> <p>4.Completed 7/11/2016</p>	07/11/2016

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	<p>1. Review of policy\ procedure 8.13, Housekeeping (Perioperative), on page 1 indicated the following: Procedure: Housekeeping Personnel: Damp dust all flat surfaces and fixtures every evening at the end of the schedule. Use a germicide-dampened disposable cloth.</p> <p>Ambulatory Care Services Personnel: Check all flat services, light fixtures for dust every morning before start of first procedure. Clean with an EPA approved germicidal wipes if needed.</p> <p>2. While on facility tour of the Pre\ Post OP area on 7-6-16 the following observations were made:</p> <p>a. Bay 1 had heavy dust on horizontal equipment surfaces.</p> <p>b. Bay 2 had heavy dust on horizontal equipment surfaces.</p> <p>c. Bay 4 had heavy dust on horizontal equipment surfaces and the window sill.</p> <p>d. Heavy dust was on the top of the blanket warmer and on the inside bottom shelf.</p> <p>3. Interview with staff #50, Director of Nursing, on 7-6-16 at 1252 hours confirmed the findings in the Pre\ Post OP area.</p> <p>4. While on facility tour of the Operating</p>		<p>procedures for dust and othercleaning issues. If area needs furtherattention with cleaning, the staff are to use an EPA approved germicidal wipe(EZ- wipes) to clean the area. The staffshould also notify administration so the cleaning company can be called. Bay 1, 2, and 4s horizontal surfaces werecleaned by the cleaning company. The microscope and disco ball were cleaned bythe staff. Please note that the facilitywas not open for surgery on the week of 7/6/2016. See attached documentation.</p> <p>2.Correction of future deficiencies: The facilityis reviewing the cleaning contract and schedule with City Wide the contractedhousekeeping company at this time. Weare also reviewing other cleaning companies to meet the needs for thefacility. Staff and administration willmonitor the cleanliness of the facility on a daily basis before procedures areperformed and clean as needed. This willprevent future deficiencies.</p> <p>3.Responsible party: Jennifer Knepp, administratorand Katie Ralston, RN, DON</p> <p>4.Completed: 7/11/2016</p>	

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S 1146 Bldg. 00	<p>Room "Small Room" on 7-6-16 the following observations were made:</p> <p>a. Heavy dust was on the top edge of the large microscope.</p> <p>b. Heavy dust was on top of the disco ball hanging in the middle of the ceiling.</p> <p>5. Interview with staff # 50 on 7-6-16 at 1303 hours confirmed the findings in OR " Small Room."</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.</p> <p>Based on observation, the facility created conditions which resulted in a hazard to patients and employees in 2 instances.</p> <p>Findings include:</p> <p>1. On 07-05-2016 at 1:45 pm in the presence of employee #A1, Administrator, it was observed in the</p>	S 1146	S1146 410 IAC 15-2.5-7 (b) (2) 1.Deficiency was corrected by contactingfacilities maintenance to replace cover on electrical box located in the basement. Irish mechanical was informed to keep allelectrical boxes closed when not present working in the area even if working inthe building. Alcohol-based hand sanitizer was removedfrom the desk in the	07/06/2016			

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S 1154 Bldg. 00	<p>basement mechanical equipment room, there was an opening in the wall that contained an electrical box with wires and equipment. This opening was uncovered, leaving the wiring and equipment exposed, and created a safety hazard if someone came in contact with the open area.</p> <p>2. On 07-06-2016 at 1:50 pm, in the presence of employees #A1, it was observed in the post operative exam room, there was an alcohol-based hand sanitizer on a desk. It was also observed the room was carpeted and did not have an overhead water sprinkler. The use of this product in an area carpeted and without an overhead water sprinkler posed a fire hazard if the alcohol substance got into the carpet.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(C)</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</p>				<p>post-operative exam room.</p> <p>2. Correction of future deficiencies: Allelectrical boxes will remain closed and covered when not being repaired or accessed by the contracted maintenance personnel. All electrical boxes will be checked and monitored by maintenance personnel after service is completed to make sure they are closed. They will also check them by visual inspection on a daily basis to make sure they are closed. Visual inspection of the post-operative room will be done on a daily basis to make sure alcohol-based hand sanitizer is not present in the room. Staff was educated and will continue to be monitored. This will prevent future deficiencies.</p> <p>All alcohol-based hand sanitizers will be removed from carpeted non-sprinkled rooms. This will prevent further deficiencies.</p> <p>1. Responsible party: Jennifer Knepp, administrator and Katie Ralston, RN, DON 1. Completed: 7/6/2016</p>		

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	<p>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>(C) Operational and maintenance control records must be established and analyzed at least triennially. These records must be readily available on the premises.</p> <p>Based on document review and interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 3 of 6 systems of equipment.</p> <p>Findings include:</p> <p>1. On 07-05-2016 at 10:15 am, employee #A1, Administrator, was requested to provide documentation of the operational and maintenance control records for the heating, ventilation, air conditioning, emergency generator, smoke detector, and fire alarm systems having been analyzed at least triennially to determine if the process used to conduct the preventive maintenance was current and in accordance with manufacturer's recommendations.</p> <p>2. Review of facility documents</p>	S 1154	<p>S 115 410 IAC 15-2.5-7 (b) (3) (C)</p> <p>1. Deficiency was corrected by receiving documentation from Irish Mechanical on the inspections used of current standards and manufacturer's recommendation on preventative maintenance of heating, cooling, and ventilation system. See attached documentation.</p> <p>2. Correction of future deficiencies: Letter was received from the president of Irish Mechanical on the training and information used in the preventative maintenance of the heating, cooling, and ventilation systems. This will be done every three years to prevent future deficiencies.</p> <p>3. Responsible party: Jennifer Knepp, administrator and Katie Ralston, RN, DON</p> <p>4. Completed: 7/7/2016</p>	07/07/2016	

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	<p>indicated there was no documentation for the heating, ventilation, and air conditioning systems having been analyzed at least triennially to determine if the process used to conduct the preventive maintenance was current and in accordance with manufacturer's recommendations.</p> <p>3. Interview of employee #A1, on 07-06-2016 at 11:05 am, confirmed there was no above-requested documentation. No other documentation was provided prior to exit.</p>			