

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001142	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2014
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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4715 STATESMEN DR STE A INDIANAPOLIS, IN 46250
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S 000 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 004157</p> <p>Survey Date: 12-29/30-14</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>Nancy Otten, RN Public Health Nurse Surveyor</p> <p>QA: clauglin 01/28/15</p>	S 000		
S 172 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical</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>examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review and interview, the facility failed to document a post-offer physical exam on 1 (#N1) of 10 nursing personnel, and failed to document that 2 (#N4 and #N7) of 10 nursing personnel had immune status to infectious diseases.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a facility policy entitled Employee Physical, indicated "All employees will be given a post offer physical exam". Review of nursing personnel files #N1-N10 indicated Employee #N1, radiology tech, hire date 11/9/2011, lacked documentation of a post offer physical exam having been done. Employees #N4, registered nurse, hire date 5/13/2014, and #N7, certified surgical tech, hire date 4/5/2013, lacked documentation of having immune status to Rubella, Rubeola and Varicella. Staff member #1, administrator, was unable to provide further documentation prior to exit. 	S 172	<p>The missing physical for the rad tech in the citation will be completed by March 27, 2015. The missing immunity status for the CST will also be completed by March 27, 2015. The RN mentioned in the citation no longer works for our facility. The administrator is responsible for ensuring that these items are complete and in the employee's files in order to avoid this citation in the future.</p>	03/27/2015

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S 400 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 policy review, observation and interview, the nursing staff failed to follow their facility policy regarding hand hygiene.</p> <p>Findings: 1. Review of the Clinical Services Manual indicated: "General Hand Washing and Hand Hygiene: a. Policy: Each employee will cleanse their hands appropriately while in the facility. Wearing gloves is not a substitute for hand hygiene. Section 3. Hand Hygiene with an Alcohol-Based Rub: Performing hand hygiene with an alcohol based hand rub are recommended for the following circumstances; if hands are not visibly soiled, then a. before direct contact with patients. d. after direct contact with patient's skin</p>	S 400	The nurse mentioned in this citation insists she used alcohol foam on her hands. Regardless, the staff has been re-educated on our policies and the importance of hand hygiene to avoid this citation in the future. We will also install more alcohol foam in point of care areas. This education was completed by 2-20-2015. We will continue with hand washing surveillance approximately quarterly, at minimum biannually in order to monitor compliance. The administrator was/is responsible for this education and surveillance.	02/20/2015

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	<p>g. after contact with inanimate objects in the immediate vicinity of the patient</p> <p>h. after removing gloves.</p> <p>Section 4. If there has been any contact with the patient or the patient's environment, hands should be decontaminated when leaving the patient's bedside or room."</p> <p>2. Observation of patient #2, who was having surgery on 12/29/2014, noted nursing staff #2, registered nurse, failed to perform hand hygiene both before and after starting an intravenous (IV) solution in patient's right arm and performing a blood hemoglobin (Hgb) test, prior to surgery.</p> <p>3. It was observed that there was one alcohol based hand rub dispenser in the Pre and Post Anesthesia care unit (PACU), located at the nurses' station. There were none observed located in or near patient cubicles. While observing in PACU, no nurses used the alcohol based hand dispenser at the nurses' station, either while following patient #2 on 12/29/2014, or again on 12/30/2014 during tour of PACU.</p> <p>4. In an interview on 12/30/2014 at 1500 hours, staff member #1, administrator, indicated that he/she was not aware that</p>			

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S 166 Bldg. 00	<p>no one used the alcohol dispenser.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii)</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>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on document review and interview, the facility failed to provide evidence of preventive maintenance (PM) on 1 (large sterilizer) of 11 pieces of patient care equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility's PM reports indicated there was no documentation of PM for the large sterilizer. In interview, on 12-30-14 at 3:00 pm, 	S 166	The sterilizer company that performs our preventative maintenance website was not functioning properly during the survey. So we could not produce our PM record for our surveyor. We called several people within the company during the survey but did not receive our records until 1/9/2015. The PM's were indeed complete prior to the survey. The records are now present in the facility. The administrator is responsible for printing the PM logs from this company as soon as the service is rendered in order to prevent	01/09/2015

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S 222 Bldg. 00	<p>employee #A1, Administrator, indicated there was no documentation of PM for the large sterilizer and none was received prior to exit.</p> <p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(e)</p> <p>(e) Safeguards for patients, personnel, and public must be specified, including, but not limited to, the following:</p> <p>(1) Proper safety precautions must be maintained against radiation hazards in accordance with the center's radiation and safety program(s).</p> <p>(2) Hazards and faulty equipment identified must be promptly corrected in accordance with current standards of practice and applicable federal and state rules, including, but not limited to, collimation and filtration and evaluations of equipment performance.</p> <p>Based on policy review, observation and interview, the facility failed to ensure operating room personnel were protected from unnecessary exposure to radiation.</p>	S 222	<p>this citation in the future.</p> <p>The staff involved in this citation have been counseled on their actions, this was completed prior to 1/1/2015. The entire staff will be re-educated on our policies</p>	03/27/2015

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	<p>Findings included:</p> <ol style="list-style-type: none"> Review of the ASC policy titled "Radiology: C Arm Cases in the OR" Procedures: 4. All room staff shall be instructed in the hazards of radiation exposure and the techniques to minimize exposure. All staff will be issued radiation badges to wear whenever the radiologic equipment is in use. Badges will be stored away from the exposure to the radiologic equipment. The badges will be read and replaced each quarter by an outside badge company. 6. Lead aprons will be provided for staff and physician use. At approximately 1300 hours on 12/29/2014, while observing a patient surgery, it was noted that two staff members that were in the room at the time of the C-arm use were not wearing lead aprons: the scrub nurse and the anesthesiologist. When other staff members removed their scrub gowns, it was observed that they were wearing lead aprons, but radiation badges were not visible. It was observed that radiation badges were available to staff members, in the area where lead aprons were stored. Staff member #1, administrator, 		<p>and the importance of radiation safety, even when using the mini c-arm in order to avoid this citation in the future. The administrator is responsible for this education and it will be completed by 3/27/2015. Random surveillance on radiation safety will be completed by the administrator to ensure compliance with P&P.</p>	

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	indicated that he/she wasn't aware that staff members weren't using the lead aprons and radiation badges, as per facility policy.				