

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001015	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/11/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 005396</p> <p>Survey Date: 9/10/13 through 9/11/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 09/16/13</p>	S000000		
S000010	<p>410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a)</p> <p>Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules.</p> <p>Based on document review, the facility failed to comply with all</p>	S000010	1. Our Human Resources department started doing a Nurse Aid Registry query on all new	09/17/2013

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>applicable state laws for 2 of 2 unlicensed Clinical Technician employee files that were reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. IC 16-28-13-4: a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law. 2. Review of employees #17 and #18 employee files indicated that they were hired 3/2007 and August 2007 respectively as Clinical Technicians. The employees' personnel files lacked documentation of a nurse aide registry report. The two Clinical Technicians were not certified. 		<p>hires in 2008. The HR department did the query on all employees hired before that year after the deficiency was received. This was completed on 9/17/2013. 2. This query will be added to the Center's New Employee Checklist 3. Responsible Person: Clinical Director</p>	

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S000432	<p>3. The Clinical Technician's job description indicated the staff member provides support to the Registered Nurses in direct patient care.</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 policy review, facility document review, and interview, the infection control committee failed to ensure the facility was cleaned according to standard of practice and the contracted housekeeping staff used the proper cleaning products according to manufacturer instructions.</p> <p>Findings included:</p>	S000432	<p>1. The contracted cleaning company will revise their "Operating Room Cleaning Tasks" checklist to include "mopping floors during terminal cleaning". All personnel will be instructed to use a clean mop head for each Operating Room. Wexcide is the disinfectant used currently by the contracted cleaning company. This is approved for use by the Center.</p>	10/11/2013

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	<p>1. The facility policy "Infection Control Policy", last reviewed 01/14/13, indicated, "4. Floors will be mopped between cases as needed with a clean mop head. Procedure: a germicidal solution will be mixed in accordance with the manufacturer's guidelines for walls and floors. ...6. At the end of each day, the operating rooms will be terminally cleaned."</p> <p>2. Review of the "Operating Room Cleaning Job Description", signed on 08/20/12 by the contracted housekeeping staff member #A20, the staff member who cleaning the surgical area and operating rooms, indicated step by step cleaning directions, but failed to list mopping of the operating rooms. The document also listed Virex, or similar quaternary based disinfectant product approved for use in medical facilities, as one of the required supplies.</p> <p>3. At 10:00 AM on 09/11/13, the director of operations of the contracted cleaning company, #A23, was interviewed. He/she indicated staff member #A20 received training by the company and also on the job training at the facility. He/she indicated he/she also observed the staff member to ensure all policies were followed. He/she</p>		<p>2. These changes will be audited biannually during the Infection Control Officer's cleaning observation. 3. Responsible Person: Infection Control Officer</p>	

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	<p>indicated Virex was only used for the operating room and was kept in the 2nd floor closet, but he/she did not bring the keys to unlock the closet. He/she indicated the operating rooms were mopped nightly and the mop heads and mop water were changed every three rooms.</p> <p>4. At 10:55 PM on 09/11/13, staff member A#23 indicated he/she had called the vice president of the cleaning company, #A24, who indicated the chemical used in the operating rooms was 256 C, not Virex as he/she had indicated.</p> <p>5. At 3:25 PM on 09/11/13, staff members #A1 and A4 indicated they did not know the specific chemicals used by the cleaning company and their standard of practice was for a new mop head to be used on each operating room. They acknowledged the director of operations was unsure of the correct chemicals and practices.</p>			

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S000434	<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.</p> <p>Based on observation, policy review, and interview, aseptic technique and universal precautions were not observed in the operating room.</p> <p>Findings included:</p> <p>1. During the case observation in operating room #3, between 1:20 PM and 2:00 PM on 09/10/13, the following observations were made:</p> <p>A. Staff member #A10 intubated the patient without wearing gloves, then immediately replaced the laryngoscope handle back in the drawer of the anesthesia cart with clean supplies.</p> <p>B. Staff member #A10 removed medications and syringes from supplies in the anesthesia cart without performing any hand hygiene since intubating the patient.</p>	S000434	<p>1. The Anesthesia Infection Control Policy will be reviewed at their Quarterly Anesthesia QA Meeting. 2. This will be monitored through monthly hand hygiene observations. 3. Responsible Person: Infection Control Officer</p>	10/16/2013

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S000442	<p>2. The facility anesthesia policy "Infection Control Policy:, last reviewed 01/14/13, indicated, "1. Personnel- ...E. Will comply with Universal Precautions:</p> <p>1. Wear gloves for any patient contact involving bodily fluids. Change gloves between patients."</p> <p>3. At 2:15 PM on 09/10/13, staff member #A4 confirmed Universal Precautions were not observed and acknowledged there was the risk of cross contamination with the supplies in the anesthesia cart.</p> <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 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</p>	S000442	1. Contracted cleaning company has been informed of	10/11/2013

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	<p>staff interview, the facility failed to monitor the immune status for 2 of 2 housekeeper workers related to Rubella, Rubeola, Varicella (#20, #21).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Employee Occupational Health Service Program (Last approved 1/14/13) states, "All applicants and contracted employees selected to fill Community positions will be scheduled for a pre placement screening to include urine drug screening, serological testing to establish immunity to Rubella, Rubeola, Mumps and Varicella, TB testing, completions of a health history." 2. At 3:15 PM on 9/10/2013, staff member #1 confirmed the two contracted housekeepers do not have the required health screenings as defined in the surgery center's policy. 3. At 10:30 AM on 9/11/2013, 		<p>immunization requirements. 2. These employee files will be reviewed annually at the same time the Center's employee files are reviewed. 3. Responsible Person: Clinical Director</p>		

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S000480	<p>staff member #23 indicated his/her company only requires TB testing and no other immunization was required.</p> <p>4. Staff member #20 health care record provided did not identify the staff member was screened for Rubella or Rubeolla.</p> <p>5. Staff member #21 health care record provided did not identify the staff member was screened for Rubella, Rubeolla, and Varicella.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(2)(i)(1)(A)</p> <p>(i) The center, whether it operates its own laundry or uses outside laundry service, shall ensure that the laundry process complies with a recognized laundry standard as follows:</p> <p>(1) Clean linen must be separated from soiled linen at all times as follows:</p> <p>(A) Contaminated linens must be clearly identified and bagged.</p>			

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	<p>Based on observation, interview, and policy review, the infection control committee failed to ensure the facility's clean linen was stored to prevent cross-contamination.</p> <p>Findings included;</p> <ol style="list-style-type: none"> At 2:20 PM on 09/10/13, accompanied by staff member #A4, a room that was labeled with a biohazard symbol and the sign "Trash/Soiled Linen" was inspected. The room contained a rolling bin with bags of soiled linen, boxes of biohazard material for pick-up, and a rolling bin with wrapped packages of clean linen. At 2:20 PM on 09/10/13, staff member #A4 indicated the clean linen was delivered to the room daily and picked up by the staff for use in the patient care areas. The facility policy "Infection Control Policy", last reviewed 01/14/13, indicated, "H. Linen: 1. Linen will be handled in a method that prevents cross-contamination and promotes confinement and containment of microorganisms. 2. Clean linen is received and distributed to designated area in covered containers to prevent contamination. 3. Soiled linen is 	S000480	<ol style="list-style-type: none"> The contracted linen company was notified on 9/17/2013 to start delivering clean linen through a different door which will keep the clean linen from soiled linen at all times. All support technicians have been instructed of this change. Responsible Person: Infection Control Officer 	09/23/2013

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S000670	<p>contained in a bag impervious to moisture and when full is closed and transported to the soiled holding area."</p> <p>4. The facility policy "Hazardous Waste Management", last reviewed 01/14/13, indicated, "F. Storage: 1. The area where hazardous wastes are stored is designated for this purpose and marked with the universal biohazard symbol. 2. The area is accessible only to personnel trained in the handling of waste material and is locked or otherwise secured to eliminate access by or exposure to the general public."</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAc 15-2.5-3(f)(12)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(12) Final progress note, including instructions to the patient and family, with dismissal diagnosis.</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure 2 of 2 transferred patients (#P10 and P12) had a final progress note or discharge summary and failed to ensure 6 of 12 patients who were discharged after their procedure or the next morning (#P1, P2, P3, P8, P9, and</p>	S000670	1 The Medical Staff of the Center will be notified by mail of the ISDOH deficiency. The letter will state that a "final progress note" is required by the physician to explain the course of treatment for patients that are transferred to an alternate facility. The Center's policy "Discharge Instructions, Communication Of" will be	10/11/2013

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	<p>P13) had complete discharge instructions.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The facility policy "Transfer of ISCS Patient to Hospital", last reviewed 01/14/13, indicated, "D. Physician Orders and Discharge Summary are to be written by physician prior to discharge. A copy of the same is to be transferred with the patient." The facility policy "Discharge Criteria", last reviewed 01/14/13, indicated, "B. Review written and/or verbal discharge instructions with patient and/or patient representative. Patients should have a copy of all written discharge instructions. This shall include general discharge instructions from the Center and discharge instructions from the physician performing the procedure." The medical record for patient #P10, who had a procedure performed on 01/28/13 and was then transferred to the hospital, lacked documentation of a discharge summary or final progress note by the physician to explain the course of treatment. The medical record for patient #P11, 		<p>updated to include "Discharge instructions shall address when the patient is to follow up with their surgeon post-operatively". Nursing will be educated on the change at a Staff Meeting on October 16, 2013. 2. The Center's Medical Records Consultant will include these requirements in her audit the last quarter of 2013. 3. Responsible Person: Clinical Director</p>	

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	<p>who had a procedure performed on 02/13/13 and was then transferred to the hospital, lacked documentation of a discharge summary or final progress note by the physician to explain the course of treatment.</p> <p>5. The medical record for patient #P1, a pediatric patient who had a procedure on 04/18/13, lacked information in the areas, "Your first post-operative visit is scheduled for" and "Please call the office to schedule an appointment for", on the Post-Operative Instructions for Myringotomies form that was in the record.</p> <p>6. The medical record for patient #P2, a pediatric patient who had a procedure on 03/06/13, lacked information in the areas, "Your first post-operative visit is scheduled for" and "Please call the office to schedule an appointment for", on the Post-Operative Instructions for Myringotomies form that was in the record.</p> <p>7. The medical record for patient #P3, a pediatric patient who had a procedure on 03/14/13, lacked information in the areas, "Your first post-operative visit is scheduled for" and "Please call the office to schedule an appointment for", on the Post-Operative Instructions for</p>			

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	<p>Myringotomies form that was in the record.</p> <p>8. The medical record for patient #P8, who had a procedure on 03/05/13 and stayed overnight, lacked discharge information regarding a follow-up appointment or instructions regarding when to call the physician for an appointment.</p> <p>9. The medical record for patient #P9, who had a procedure on 06/17/13 and stayed overnight, lacked discharge information regarding a follow-up appointment or instructions regarding when to call the physician for an appointment.</p> <p>10. The medical record for patient #P13, an adult patient who had a procedure on 05/09/13 and was discharged, lacked discharge information regarding a follow-up appointment or instructions regarding when to call the physician for an appointment.</p> <p>11. At 3:25 PM on 09/11/13, staff members #A1 and A3 indicated instructions of when to call the doctor would be given verbally by the nurse or physician if a follow-up appointment was not made, but confirmed the lack of</p>			

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S001010	<p>documentation regarding this.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</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>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, policy review, and interview, the facility failed to follow their policies regarding multi-dose vials in the pre-op and surgical areas.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the pre-op area at 12:30 PM on 09/10/13, accompanied by staff member #A4, an open, 10 ml. (milliliter) vial of Lidocaine for IV (intravenous) starts was observed with two dates, 9/10/13 and 10/10/13, written on the vial. During the tour of the anesthesia room at 12:50 PM on 09/10/13, accompanied by staff members #A4 and A11, a 10 ml. vial of Kenalog and a 10 ml. vial of Lidocaine, both open, but not dated, were observed in the top drawer of the block cart. During the tour of the surgical area at 1:10 PM on 09/10/13, accompanied by staff member 	S001010	<ol style="list-style-type: none"> All Surgery Center policies regarding multi-dose containers will state "Injectable medications in multi-dose containers will be dated 28 days from the time they are opened. This date will be the discard date unless the manufacturer's expiration date preceeds the opened date. The policies will be reviewed at staff meetings and Anesthesia QA Meeting. Responsible Person: Infection Control Officer This will be audited during the monthly expiration date checks. 	10/16/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001015	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/11/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY SURGERY CENTER SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227
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	<p>#A4, the following items were observed in the medication refrigerator:</p> <p>A. An open 3 ml. vial of Humulin R insulin with the date of 8/13/13 written on it.</p> <p>B. An open 3 ml. vial of Humalog insulin with the date of 8/19/13 written on it.</p> <p>C. A 3 ml. vial of Humulin R insulin, open, but not dated.</p> <p>D. Three of three open, but not dated, containers of Proparacaine eye drops.</p> <p>4. At 1:10 PM on 09/10/13, staff member #A4 indicated the eye drops were multi-use and should be dated and the other dates were the discard dates.</p> <p>5. During the case observation in OR (operating room) #3 at 1:30 PM on 09/10/13, an open 10 ml. vial of Succinylcholine was observed in the top drawer of the anesthesia cart with a date written on it, but the date was illegible.</p> <p>6. At 1:30 PM on 09/10/13, staff member #A4 confirmed the discard date on the Succinylcholine could not be determined.</p> <p>7. At 1:55 PM on 09/10/13, OR #4 was inspected with staff member #A4 and one 20 ml. vial of Lidocaine and one 10 ml. vial of Succinylcholine were observed open, but not dated, in the top drawer of the anesthesia cart.</p> <p>8. The facility policy "Multi-Dose Meds and IV Solutions", revised 01/10/12, indicated, "7. All opened injectable medications will be discarded at the end of each day."</p> <p>9. The facility anesthesia policy "Infection Control Policy", last reviewed 01/14/13, indicated, "B. Injectable medications in multi-dose containers will be dated 28 days from</p>			

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	<p>the time they are opened."</p> <p>10. The facility anesthesia policy "Multi-Dose Meds and IV Solutions", last reviewed 01/14/13, indicated, "3. All opened multi-dose medication vials will be discarded at the end of each month."</p> <p>11. At 2:30 PM on 09/10/13, staff members #A1 and A4 confirmed the medications were not marked according to policy and also confirmed the conflicting policy information.</p>			