

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001017	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/04/2014
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NAME OF PROVIDER OR SUPPLIER MUNCIE EYE SPECIALISTS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N TILLOTSON AVE MUNCIE, IN 47304
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Q000000	The visit was for a re-certification survey. Facility Number: 005398 Survey Date: 6/2/2014 through 6/4/2014 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 06/09/14	Q000000		
Q000083	416.43(d) PERFORMANCE IMPROVEMENT PROJECTS (1) The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations. (2) The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results Based on document review and interview, the center failed to develop and conduct a recent performance	O000083	Performance Improvement projects will be conducted annually upon the scope and complexity of the ASC's	07/13/2014

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>improvement (PI) project based upon a potential or identified concern and associated with improved health outcomes and patient safety.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 6-02-14 at 930 hours, staff A1 was requested to provide documentation of a current performance improvement project and none was provided prior to exit from the center. 2. The 8-06-13 Committee Minutes as a Whole included PI project documentation begun in 2011 based on a low return rate of Patient Satisfaction Surveys. The project indicated that the center met its goal return rate of 20% from the 2nd quarter 2012 through the 2nd quarter 2013. The 8-06-13 minutes included PI project documentation of pre-operative antibiotic administration. The documentation indicated that it was the fourth antibiotic timing study conducted and indicated that the center met its goal rate of 100% for 2012 through 2nd quarter 2013. No evidence of additional activity was observed in committee minutes dated 11-11-13 and 3-04-14 or provided prior to exit. 3. The 5-07-13 Committee Minutes as a Whole included documentation of a PI 		<p>services & operations. Documentation will include the reason(s) for implementing the projects, and a description of the project's results. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p>	

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Q000105	<p>project begun in 2011 based upon a delay in OR procedure starting time, delay in OR room turnover, a ripple effect on clinic patients, delay of surgeon to follow in OR room and room staff not getting a lunch break. The documentation indicated a 1st quarter 2013 action of creating a surgery day for each surgeon and no evidence of a response was documented in the committee minutes dated 8-06-13, 11-11-13 or 3-4-14.</p> <p>4. During an interview on 6-04-14 at 1215 hours, staff A1 confirmed that the center had conducted the same three PI projects since 2011 and confirmed that no new PI project or study had been conducted in the past 12 months.</p> <p>416.44(c) EMERGENCY EQUIPMENT The ASC medical staff and governing body of the ASC coordinates, develops, and revises ASC policies and procedures to specify the types of emergency equipment required for use in the ASC's operating room. The equipment must meet the following requirements:</p> <p>(1) Be immediately available for use during emergency situations. (2) Be appropriate for the facility's patient population. (3) Be maintained by appropriate personnel. Based on observation, document review, and interview, the medical staff and</p>	Q000105	Code cart contents will reflect	07/10/2014			

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	<p>governing body failed to ensure the checking of expiration dates for emergency supplies found in the emergency code cart.</p> <p>Findings:</p> <p>1. At 3:50 PM on 6/3/14, while on tour of the post op area of the surgery center in the company of staff member #50, the patient care manager, it was observed in the emergency code cart that the following supplies were expired:</p> <p>a. One 7.5 Kendall trach tube that expired 12/2002.</p> <p>b. Two Braun IV (intravenous) administration sets that expired 9/20/12.</p> <p>2. Review of the "Crash Cart" check list indicated:</p> <p>a. So far in 2014, the crash cart was noted as having been checked by nursing staff every month January through May.</p> <p>b. On page 2, the 7.5 trach tube was noted with nursing initials as being "present", but no expiration dates were listed for the trach tubes.</p> <p>c. On page 4, the IV administration sets are noted with nursing initials as being "present", but no expiration dates were listed for the IV sets.</p> <p>3. Interview with staff member #50, the patient care manager, at 4:00 PM on 6/3/14 indicated:</p>		<p>expiration dates by July 10, 2014. Staff will be inserviced on applying expiration dates on items in code cart & reviewed periodically. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p>				

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Q000162	<p>a. Expiration dates for supplies were not listed on the crash cart list of medications and supplies.</p> <p>b. Nursing staff have just been noting the presence of supplies in the crash cart and not checking the expiration dates on them.</p> <p>416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</p> <ul style="list-style-type: none"> (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the</p>	O000162	Medical Records must be accurate, legible, & promptly completed.	07/10/2014			

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	<p>accuracy of medical records for 5 of 16 records reviewed (pts. #9, #10, #11, #13 and #14).</p> <p>Findings:</p> <p>1. Review of the policy and procedure, "Medical Records - General", policy number 4.01, with a most recent revised date of 2-14, indicated:</p> <p>a. Under "Policy", it reads: "A medical record shall be maintained for each patient, which is accurate, legible, complete...".</p> <p>2. Review of patient medical records indicated:</p> <p>a. Pt. #9 had:</p> <p>I. A sticker on the front of the medical record that read "Advance Directives", which means that the patient has initiated advance directives.</p> <p>II. Documentation in the medical record that read: "Patient Rights: the patient DOES NOT have an advanced directive...".</p> <p>b. Pt. #10 had:</p> <p>I. A time of 9:43 AM for the first post op assessment on 3/24/14, that the IV (intravenous) was removed at 9:50 AM, and that the patient was discharged at 10 AM (on the post op assessment form--no form number or identification).</p> <p>II. A surgery start time of 9:51 AM and a surgery stop time of 9:59 AM listed</p>		<p>Clocks were all synchronized & staff reminded to watch the correct time when documenting; advanced directives completeness on charts was reviewed with ASC staff; allergy documentation was reviewed with ASC & Clinic staff on documentation from clinic; operative record pathology specimen was reviewed with surgeon and advised to properly review each operative record for accuracy. Staff & physicians will be inserviced on proper accuracy & completion by July 10, 2014. Items will be periodically reviewed with all staff involved. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p>				

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	<p>on the "Anesthesia Form" and the "Operative Record" form.</p> <p>c. Pt. #11 had:</p> <p>I. "Morphine" listed as an Allergy on the "Procedural History & Physical" Form and the "Pre Op Assessment form.</p> <p>II. "No known allergies" noted in two different "chart notes" in the medical record.</p> <p>d. Pts. #13 and #14 had:</p> <p>I. Documentation by nursing on the Operative Record" form that the "Specimen" was "exempt".</p> <p>II. An operative report where the physician indicated a "Specimen" was "Sent to pathology".</p> <p>3. At 9:45 AM on 6/4/14, an interview with staff member #50, the patient care manager, indicated:</p> <p>a. The medical records listed in 2. above were inaccurate as written.</p> <p>b. No specimens were sent for pts. #13 and #14.</p> <p>c. Per staff interview with the surgical staff involved with the cases, the type of surgery (2nd stage Hughes procedure) does not require a specimen to be sent to pathology.</p> <p>c. It was thought that the physician for pts. #13 and #14 used a "template" in which the "Specimen sent to pathology" area is a "default" and that the physician forgot to delete that notation.</p>			
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Q000181	<p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the implementation of the policy related to the authentication of standing orders for 1 of 1 chart of a transferred patient (pt. #1).</p> <p>Findings: 1. Review of the policy titled, "Standing Orders", policy number 6.1, with a reviewed date of 3-13, indicated: a. Under "Practice and Procedures", it reads: "...3. Pre-operative standing orders can be maintained on file in the Center and initiated verbally by the physician in which case they must be signed by the physician the day of surgery;...".</p> <p>2. Review of patient medical records indicated that patient #1: a. Was admitted for left cataract surgery on 11/27/13. b. Had pre op eye medications (drops) given and a saline lock initiated.</p>	O000181	The ASC will ensure that all standing orders will be signed by the physician the day of surgery. Staff & physicians will be inserviced on proper accuracy & completion bu July 10, 2014. Good communication will be maintained with physicians for proper compliance. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	07/10/2014

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Q000224	<p>c. Was taken to the surgery suite but transferred to a local hospital prior to the surgical procedure.</p> <p>d. Lacked authentication of pre op orders, by the physician, that were completed by nursing personnel.</p> <p>3. At 3:25 PM on 6/2/14, interview with staff member #50, the patient care manager, it was indicated that:</p> <p>a. The physician had not authenticated the standing orders present in the patient's medical record.</p> <p>b. It was thought that the standing orders didn't need to be authenticated since the surgery was canceled.</p> <p>416.50(c)(1)(2)(3) ADVANCED DIRECTIVES The ASC must comply with the following requirements:</p> <p>(1) Provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.</p> <p>(2) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care.</p>						

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	<p>(3) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure that the advance directives policy was implemented for 8 of 8 records for physician #55 (pts. #3, #4, #5, #6, #7, #8, #13, and #14).</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of the facility policy, "Advanced Directives", Policy number 1.21, with a revised date of 4-12, indicated: <ol style="list-style-type: none"> Under "Practice and Procedures", it reads: "1. Center staff will ask the patient or their representative in advance of the date of the procedure if an advanced directive exists..." Review of patient medical records #3, #4, #5, #6, #7, #8, #13, and #14 had no documentation indicating whether or not these patients had initiated an advance directive. At 3:25 PM on 6/2/14, interview with staff member #50, the patient care manager, indicated: <ol style="list-style-type: none"> There is no documentation in the medical records, for the 8 patients listed in 2. above, regarding whether or not they 	O000224	The ASC will ensure that proper documentation of advance directives will be in a prominent part of the patient's medical record by July 10, 2014. Proper documentation will be reflected on these charts & periodically reviewed with physicians office. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	07/10/2014

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Q000226	<p>have completed advance directives.</p> <p>b. Physician #55 doesn't use the electronic medical record system used by the other physicians, so that the question of whether or not a patient has an advance directive is not populated on the medical records used by physician #55.</p> <p>c. Another method of capturing this data, regarding a patient's having an advance directive or not, needs to be implemented by the facility.</p> <p>416.50(d)(1), (2), & (3) GRIEVANCES - MISTREATMENT, ABUSE The following criteria must be met:</p> <p>(1) All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented.</p> <p>(2) All allegations must be immediately reported to a person in authority in the ASC.</p> <p>Only substantiated allegations must be reported to the State authority or the local authority, or both.</p> <p>Based on document review and interview, the center failed to ensure that all allegations of abuse, neglect, or mistreatment which are alleged to have occurred at the ASC will be documented</p>	O000226	Policy 1.20 Rights of Patients read verbatim to the regulation on II but that IV was missing and therefore added; updated to reflect only substantiated	07/10/2014

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Q000241	<p>and substantiated allegations will be reported to the State and/or the local authority.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Rights of Patients (approved 12-13) failed to indicate a provision for documenting all allegations involving mistreatment, neglect, verbal, mental, sexual, or physical abuse alleged to have occurred at the ASC and failed to indicate a provision that only substantiated allegations will be reported to the State and/or the local authority. During an interview on 6-04-14 at 1410 hours, staff A1, Administrator, confirmed that the policy/procedures lacked the indicated provisions. <p>416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on observation, manufacturer's recommendations review, contracted housekeeper file review, and staff interview, the infection control</p>	O000241	<p>allegations will be reported to the State and/or local authority. The ASC Patient Care Manager will present to the medical staff by July 10, 2014 this updated policy for approval and then to the governing board for approval. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p> <p>The ASC will provide a functional & sanitary environment for the provision of surgical services by adhering to professionally</p>	07/10/2014	

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	<p>committee failed to ensure that training and re-education of the housekeeper in February, 2014, was effective, failed to ensure that nursing staff followed the surgical attire policy for one staff member observed (N3) and failed to maintain its operating rooms (OR) and patient care areas in a sanitary manner for 2 of 2 OR rooms and the pre and post-op areas of the center.</p> <p>Findings:</p> <p>1. At 5:00 PM on 6/2/14, while on tour of the surgery area in the company of staff members #50, the patient care manager, and #52, the contracted housekeeper, it was observed in the housekeeping closet that:</p> <ul style="list-style-type: none"> a. Expose II 256 was the product being used for cleaning and mopping and was a container made for a wall mounted dispersion system. b. The Expose bottle indicated dilution was to be a "1:256 solution". c. There were no measuring cups, or other devices for measuring, present to assure that a proper dilution of the Expose product is provided. d. A 32 oz spray bottle was present and used for cleaning surfaces. e. There was only one string, microfiber, mop head present in the housekeeping closet. <p>2. Interview with staff member #52, the contracted housekeeper, at 5:10 PM on 6/2/14, indicated:</p> <ul style="list-style-type: none"> a. While pointing to the numbers on the side of the spray bottle, the housekeeper indicated that 3 to 6 ounces of Expose is placed in both the 32 ounce bottle, and in the mop bucket, prior to adding water. b. It was unknown what the correct dilution rate 		<p>acceptable standards of practice. The infection control committee will ensure that training & re-education of the housekeeper will be effective (proper mop head usage, proper chemical usage/mixing), and that nursing staff will follow the surgical attire policy and that the operating rooms & patient care areas will be maintained in a sanitary manner. The housekeepers cleaning schedule was updated to reflect designated duties for proper cleaning. Inservice with housekeeper will be accomplished by July 10, 2014. Inservice with staff on proper surgical attire, policy 5.04, will be accomplished by July 10, 2014. Will be periodically reviewed with staff involved. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p>				

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	<p>for Expose was, per the manufacturer's recommendation.</p> <p>c. It was unknown how many gallons the mop bucket held, staff member #52 stated they fill the bucket "1/2 full" of water and add the same amount of Expose (3 to 6 ounces) in 1/2 bucket of water.</p> <p>d. The Expose product kill time is "3 minutes".</p> <p>e. One mop head is used to mop both OR (operating room) suites, the surgical hallway, and the pre/post op area.</p> <p>f. The contracted laundry service doesn't return the mop heads, so that only one is usually present for use.</p> <p>g. This staff member sometimes brings other microfiber mop heads in and then takes them home for laundering.</p> <p>3. At 5:25 PM on 6/2/14, interview with staff member #50, the patient care manager, it was indicated that:</p> <p>a. This staff member thought the problem of missing, or not enough, mop heads "had been fixed".</p> <p>b. This staff member was unaware that the housekeeper was using only one mop head for the whole surgery center.</p> <p>c. This staff member was unaware that some mop heads were being taken home for home laundering.</p> <p>4. At 3:30 PM on 6/3/14, while on tour of the surgery center in the company of staff member #50, the patient care manager, it was observed that:</p> <p>a. The mop bucket holds 6 gallons of water if filled completely (3 gallons = 1/2 bucket).</p> <p>5. Review of manufacturer's dilution recommendations indicated that:</p> <p>a. A 1:256 dilution is created with 1/2 ounce of</p>			

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	<p>product per gallon of water.</p> <p>b. The kill time for the Expose product is 10 minutes to kill all organisms.</p> <p>6. Review of the employee file for staff member #52 (also N15) indicated:</p> <p>a. An annual "Review proper cleaning to infection control regulations" was done 2/3/14.</p> <p>b. The first item of review was: "Reviewed disinfectant used, proper mixing, kill time required".</p> <p>7. At 9:20 AM on 6/3/14, interview with staff member #50, the patient care manager, indicated:</p> <p>a. The training done 2/3/14 was ineffective as it was unknown what the dilution rate for the Expose product was.</p> <p>b. There was no measuring device present for use in diluting the Expose in the spray bottle and the mop bucket.</p> <p>c. Monitoring of the contracted housekeeper is ineffective as it was unknown that the housekeeper was:</p> <p>I. Unaware of the product kill time.</p> <p>II. Using one mop head for the total surgery center floor plan.</p> <p>III. Improperly mixing/diluting the Expose product.</p> <p>8. Review of the policy and procedure, "Dress Requirements", policy number 5.04, with a date of 4-10, indicated:</p> <p>a. Under "Practice and Procedures", it reads: "...4. All personnel working in the OR (operating room) should remove jewelry from hands. Other jewelry, i.e. watches, earrings, bracelets, necklaces, piercings, should be removed or totally confined within the scrub attire to prevent contamination to the sterile field...".</p> <p>9. At 3:02 PM on 6/2/14, while observing a</p>			

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	<p>patient in OR room #1, it was observed through the connecting window, that staff member N3, a certified scrub tech, had earrings present that were not confined within the surgical cap while a surgical procedure was in process.</p> <p>10. At 3:02 PM on 6/2/14, staff member #50, the patient care manager, agreed that staff member N3 did not have their earrings confined, as per facility policy requirements.</p> <p>11. The policy/procedure Housekeeping Services (approved 12-13) indicated the following: "The cleaning procedures for the Center are provided below...Operating Rooms ...(daily) ...High dust fixtures, cabinets, equipment ...Dust air vents ...Spot clean doors, doorframes ..."</p> <p>12. During an observation on 6-03-14 at 1505 hours, the following condition was observed in OR room 2: accumulated dust and particulate material was observed on the grille of the (2) 18" return air ducts.</p> <p>13. During an observation on 6-03-14 at 1515 hours, the following conditions were observed in OR room 1: accumulated dust and particulate material was observed on the grille of the (2) 18" return air ducts. Accumulated dust and particulates were also observed on the top surface of the anesthesia machine and the upper ledge of the wall-mounted xray</p>			

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	<p>film viewer.</p> <p>14. During an interview on 6-03-14 at 1515 hours, staff A1, Administrator, confirmed that the OR room conditions were unsanitary and had not been properly maintained.</p> <p>15. During an observation on 6-03-14 at 1530 hours, the following conditions were observed in the restricted area hallway outside of OR room 2: the south end double doorway was observed with accumulated dust and debris in the corners of the threshold. The midline door weather stripping was observed to be incompetent and the nearby 24" by 48" overhead lighting diffuser was observed to contain the remains of approximately 15 insects.</p> <p>16. During an interview on 6-03-14 at 1530 hours, staff A1, Administrator, confirmed that the doorway and lighting fixture conditions were unsanitary and had not been properly maintained.</p> <p>17. During an observation on 6-03-14 at 1548 hours, the following condition was observed in the post-op area: a 24" square ventilation return grille was observed with a heavy accumulation of dust and particulate material.</p>						

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S000000	<p>18. During an observation on 6-03-14 at 1550 hours, the following condition was observed in the pre-op area: (four) 6" by 24" ventilation return grilles located on the wall over the patient carts were observed with an accumulation of dust and particulate material and the lower edge of a large round window opening over the area was observed with an accumulation of dust projecting onto the vertical wall below.</p> <p>19. During an interview on 6-03-14 at 1550 hours, staff A1, Administrator, confirmed that the window and ventilation grille conditions were unsanitary and had not been properly maintained.</p> <p>The visit was for a licensure survey.</p> <p>Facility Number: 005398</p> <p>Survey Date: 6/2/2014 through 6/4/2014</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN</p>	S000000		

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S000122	<p>Public Health Nurse Surveyor</p> <p>QA: claughlin 06/09/14</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body.</p> <p>Based on document review and interview, the governing board failed to review and approve the medical staff bylaws within the past three years.</p> <p>Findings:</p> <p>1. On 6-02-14 at 0930 hours, staff A1 was requested to provide documentation indicating governing board approval of the medical staff bylaws, rules and regulations and none was provided prior to exit.</p> <p>2. The medical staff special committee meeting minutes dated 10-16-13 indicated that the medical staff met and unanimously re-approved their medical</p>	S000122	The Governing Board is responsible for approving the medical staff bylaws and rules. The ASC Patient Care Manager will present to the governing board the bylaws and rules for approval by July 10, 2014 with proper documentation in minutes. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	07/10/2014

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S000166	<p>staff bylaws.</p> <p>3. The governing board meeting minutes dated 12-10-13, 3-19-14 and 4-29-14 failed to document that the governing board had reviewed and approved the medical staff bylaws.</p> <p>4. During an interview on 6-03-14 at 1030 hours, staff A2 confirmed that the governing board minutes lacked documentation of board approval for its medical staff bylaws.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the governing board failed to ensure that the advance directives policy was implemented for 8 of 8 records for physician #55 (pts. #3, #4, #5, #6, #7, #8, #13, and #14).</p>	S000166	The ASC will ensure that proper documentation of advance directives will be in a prominent part of the patient's medical record by July 10, 2014. The ASC patient care manager will be responsible for completion, implementation &	07/10/2014	

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	<p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility policy, "Advanced Directives", Policy number 1.21, with a revised date of 4-12, indicated: <ol style="list-style-type: none"> a. Under "Practice and Procedures", it reads: "1. Center staff will ask the patient or their representative in advance of the date of the procedure if an advance directive exists..." 2. Review of patient medical records #3, #4, #5, #6, #7, #8, #13, and #14 had no documentation indicating whether or not these patients had initiated an advance directive. 3. At 3:25 PM on 6/2/14, interview with staff member #50, the patient care manager, indicated: <ol style="list-style-type: none"> a. There is no documentation in the medical records, for the 8 patients listed in 2. above, regarding whether or not they have completed advance directives. b. Physician #55 doesn't use the electronic medical record system used by the other physicians, so that the question of whether or not a patient has an advance directive is not populated on the medical records used by physician #55. c. Another method of capturing this data, regarding a patient's having an advance directive or not, needs to be 		monitoring for compliance.	

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S000328	<p>implemented by the facility.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on document review and interview, the center failed to document an appropriate action in response to an opportunity for improvement identified through the Quality Assurance (QA) program.</p> <p>Findings:</p> <p>1. On 6-02-14 at 0930 hours, staff A1 was requested to provide documentation of QA committee recommendations and actions implemented in response to services and functions reviewed through the program and none was provided prior to exit.</p>	S000328	<p>Performance Improvement projects will be conducted annually upon the scope and complexity of the ASC's sevicees & operations. Documentation will include the reason(s) for implementing the projects, and a description of the project's results. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p>	07/13/2014			

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S000444	<p>2. The 2013 and 2014 QA committee portion of the Committee Meeting Minutes as a Whole dated 5-7-13, 8-6-13, 11-11-13 and 3-4-14 failed to indicate documentation of an issue, concern, problem or area for improvement identified through the QA program and failed to indicate a committee recommendation or corrective action with ongoing monitoring of the action for its effectiveness. The minutes lacked documentation of a committee action or finding in response to areas presented (ex.- incident reports, medical records review) at each meeting.</p> <p>3. During an interview on 6-03-14 at 1245 hours, staff A1 confirmed that the QA committee/Committee Meeting Minutes as a Whole lacked documentation of an action in response to identified concerns.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</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</p>						

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	<p>infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on policy and procedure review, observation, and staff interview, the infection control committee failed to ensure that nursing staff followed the surgical attire policy for one staff member (N3) observed.</p> <p>Findings:</p> <p>1. Review of the policy and procedure, "Dress Requirements", policy number 5.04, with a date of 4-10, indicated:</p> <p>a. Under "Practice and Procedures", it reads: "...4. All personnel working in the OR (operating room) should remove jewelry from hands. Other jewelry, i.e. watches, earrings, bracelets, necklaces, piercings, should be removed or totally confined within the scrub attire to prevent contamination to the sterile field...".</p> <p>2. At 3:02 PM on 6/2/14, while observing a patient in OR room #1, it was observed through the connecting window, that staff member N3, a certified scrub tech, had earrings present that were not confined within the surgical cap while a surgical procedure was in process.</p>	S000444	Inservice with staff on proper surgical attire will be accomplished by July 10, 2014 and reviewed periodically. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	07/10/2014

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S000612	<p>3. At 3:02 PM on 6/2/14, staff member #50, the patient care manager, agreed that staff member N3 did not have their earrings confined, as per facility policy requirements.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the accuracy of medical records for 5 of 16 records reviewed (pts. #9, #10, #11, #13 and #14).</p> <p>Findings: 1. Review of the policy and procedure, "Medical Records - General", policy number 4.01, with a most recent revised date of 2-14, indicated: a. Under "Policy", it reads: "A medical record shall be maintained for each patient, which is accurate, legible,</p>	S000612	Medical Records must be accurate, legible, & promptly completed. Staff & physicians will be inserviced on proper accuracy & completion by July 10, 2014 and reviewed periodically. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	07/10/2014

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	<p>complete...".</p> <p>2. Review of patient medical records indicated:</p> <p>a. Pt. #9 had:</p> <p>I. A sticker on the front of the medical record that read "Advance Directives", which means that the patient has initiated advance directives.</p> <p>II. Documentation in the medical record that read: "Patient Rights: the patient DOES NOT have an advanced directive...".</p> <p>b. Pt. #10 had:</p> <p>I. A time of 9:43 AM for the first post op assessment on 3/24/14, that the IV (intravenous) was removed at 9:50 AM, and that the patient was discharged at 10 AM (on the post op assessment form--no form number or identification).</p> <p>II. A surgery start time of 9:51 AM and a surgery stop time of 9:59 AM listed on the "Anesthesia Form" and the "Operative Record" form.</p> <p>c. Pt. #11 had:</p> <p>I. "Morphine" listed as an Allergy on the "Procedural History & Physical" Form and the "Pre Op Assessment form.</p> <p>II. "No known allergies" noted in two different "chart notes" in the medical record.</p> <p>d. Pts. #13 and #14 had:</p> <p>I. Documentation by nursing on the "Operative Record" form that the</p>			

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S000616	<p>"Specimen" was "exempt".</p> <p>II. An operative report where the physician indicated a "Specimen" was "Sent to pathology".</p> <p>3. At 9:45 AM on 6/4/14, an interview with staff member #50, the patient care manager, indicated:</p> <p>a. The medical records listed in 2. above were inaccurate as written.</p> <p>b. No specimens were sent for pts. #13 and #14.</p> <p>c. Per staff interview with the surgical staff involved with the cases, the type of surgery (2nd stage Hughes procedure) does not require a specimen to be sent to pathology.</p> <p>c. It was thought that the physician for pts. #13 and #14 used a "template" in which the "Specimen sent to pathology" area is a "default" and that the physician forgot to delete that notation.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p>						

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	<p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to ensure the implementation of the policy related to the authentication of standing orders for 1 of 1 chart of a transferred patient (pt. #1).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the policy titled, "Standing Orders", policy number 6.1, with a reviewed date of 3-13, indicated: <ol style="list-style-type: none"> a. Under "Practice and Procedures", it reads: "...3. Pre-operative standing orders can be maintained on file in the Center and initiated verbally by the physician in which case they must be signed by the physician the day of surgery;...". 2. Review of patient medical records indicated that patient #1: <ol style="list-style-type: none"> a. Was admitted for left cataract surgery on 11/27/13. b. Had pre op eye medications (drops) given and a saline lock initiated. c. Was taken to the surgery suite but transferred to a local hospital prior to the 	S000616	The ASC will ensure that all standing orders will be signed by the physician the day of surgery. Staff & physicians will be inserviced on proper accuracy & completion by July 10, 2014. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	07/10/2014			

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S001142	<p>surgical procedure.</p> <p>d. Lacked authentication of pre op orders, by the physician, that were completed by nursing personnel.</p> <p>3. At 3:25 PM on 6/2/14, interview with staff member #50, the patient care manager, it was indicated that:</p> <p>a. The physician had not authenticated the standing orders present in the patient's medical record.</p> <p>b. It was thought that the standing orders didn't need to be authenticated since the surgery was canceled.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)</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>(1) No condition in the center or on the grounds may be maintained which may be conducive to the harboring or breeding of insects, rodents, or other vermin.</p> <p>Based on observation and interview, the center failed to assure that its operating rooms (OR) and restricted areas were maintained free of insects and related</p>	S001142	The condition of the physical plant & the overall center environment must be developed & maintained in such a manner that the safety &	07/10/2014			

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S001146	<p>contaminants for 1 of 3 areas (restricted surgical hallway) at the center.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation on 6-03-14 at 1530 hours, the following condition was observed in the south end of the restricted area hallway outside of OR room 2: the midline double door weather stripping was observed to be incompetent and the nearby 24" by 48" overhead lighting diffuser was observed to contain the remains of approximately 15 insects. 2. During an interview on 6-03-14 at 1530 hours, staff A1 confirmed that the lighting fixture infestation and associated doorway condition was unsanitary and confirmed that the restricted hallway area had not been properly maintained. <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</p>		<p>well-being of patients are assured, ie: no condition in the center or on the grounds may be maintained which may be conducive to the harboring or breeding of insects, rodents, or other vermin. The overhead lights were cleaned of the dead insects on June 3, 2014. This area will be maintained monthly per Housekeeping service. The buildings owner was notified of the need to apply competent weather stripping on 6-4-2014. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p>				

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	<p>maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, document review, and interview, the facility failed to ensure the safety of patients as related to expired products in the code/crash cart and the checking of expiration dates for emergency supplies found therein, and related to expired lab tubes in the post op area of the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. At 3:40 PM on 6/3/14, while on tour of the post op area of the surgery center in the company of staff member #50, the patient care manager, it was observed in drawers behind the nursing station: <ol style="list-style-type: none"> a. 4 purple top lab tubes that expired 11/13. b. 5 red top lab tubes (SST tubes) that expired 5/14. c. 6 red top lab tubes that expired 4/14. 2. At 3:50 PM on 6/3/14, while on tour of the post op area of the surgery center in the company of staff member #50, the patient care manager, it was observed in the emergency code cart that the following supplies were expired: <ol style="list-style-type: none"> a. One 7.5 Kendall trach tube that expired 12/2002. b. Two Braun IV (intravenous) administration sets that expired 9/20/12. 	S001146	Code cart contents will reflect expiration dates of items by July 10, 2014 and vacutainer tubes will be monitored for expiration dates. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	07/10/2014

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	<p>3. Review of the "Crash Cart" check list indicated:</p> <p>a. So far in 2014, the crash cart was noted as having been checked by nursing staff every month January through May.</p> <p>b. On page 2, the 7.5 trach tube was noted with nursing initials as being "present", but no expiration dates were listed for the trach tubes.</p> <p>c. On page 4, the IV administration sets are noted with nursing initials as being "present", but no expiration dates were listed for the IV sets.</p> <p>3. Interview with staff member #50, the patient care manager, at 4:00 PM on 6/3/14 indicated:</p> <p>a. Expiration dates for supplies were not listed on the crash cart list of medications and supplies.</p> <p>b. Nursing staff have just been noting the presence of supplies in the crash cart and not checking the expiration dates on them.</p> <p>c. Lab tubes are not listed on the crash cart checklist, but nursing is to clean cabinets and drawers on a monthly basis and should have been checking expiration dates while doing that cleaning.</p>			

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S001164	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</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>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule.</p> <p>Based on document review, observation and interview, the center failed to ensure that its patient care equipment was maintained in accordance with manufacturer's recommendations for 1 of 2 defibrillators available for use at the center.</p> <p>Findings:</p> <p>1. The Physio-Control Lifepak 9P Defibrillator service manual (1993) indicated the following under Basic Operations: "Batteries should be</p>	S001164	<p>All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule. The Lifepak 9 Defibrillator battery will be replaced every 2 years as a preventive maintenance measure per manufacturer guidelines & reflected on code cart documentation. The battery was replaced 7/1/14. The ASC patient</p>	07/10/2014
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S001172	<p>replaced every two years as a preventive maintenance measure."</p> <p>2. During a tour on 6-3-14 at 1550 hours, the following condition was observed in the patient recovery area: a Lifepak 9 defibrillator battery with an effective service date of 1-26-2010.</p> <p>3. During an interview on 6-3-14 at 1550 hours, staff A1 confirmed that the defibrillator had not been maintained in accordance with the manufacturer's recommendations.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)</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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: Based on document review, observation and interview, the center failed to maintain its operating rooms (OR) and</p>	S001172	<p>care manager will be responsible for completion, implementation & monitoring for compliance.</p> <p>The ASC will provide a functional & sanitary environment for the provision of surgical services by</p>	07/10/2014			

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	<p>patient care areas in a clean and sanitary manner for 2 of 2 OR rooms and the pre and post-op areas of the center.</p> <p>Findings:</p> <p>1. The policy/procedure Housekeeping Services (approved 12-13) indicated the following: "The cleaning procedures for the Center are provided below...Operating Rooms...(daily) ...High dust fixtures, cabinets, equipment ...Dust air vents ...Spot clean doors, doorframes ..."</p> <p>2. During an observation on 6-03-14 at 1505 hours, the following condition was observed in OR room 2: accumulated dust and particulate material was observed on the grille of the (2) 18" return air ducts.</p> <p>3. During an observation on 6-03-14 at 1515 hours, the following conditions were observed in OR room 1: accumulated dust and particulate material was observed on the grille of the (2) 18" return air ducts. Accumulated dust and particulates were also observed on the top surface of the anesthesia machine and the upper ledge of the wall-mounted xray film viewer.</p> <p>4. During an interview on 6-03-14 at</p>		<p>adhering to professionally acceptable standards of practice. The infection control committee will ensure that training & re-education of the housekeeper will be effective and that the operating rooms & patient care areas will be maintained in a sanitary manner. The housekeepers cleaning schedule was updated to reflect designated duties for proper cleaning. Inservice with housekeeper will be accomplished by July 10, 2014 and reviewed periodically. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p>		

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	<p>1515 hours, staff A1 confirmed that the OR room conditions were unsanitary and had not been properly maintained.</p> <p>5. During an observation on 6-03-14 at 1530 hours, the following condition was observed in the restricted area hallway outside of OR room 2: accumulated dust and debris in the corners of the south doorway threshold.</p> <p>6. During an interview on 6-03-14 at 1530 hours, staff A1 confirmed that the doorway condition was unsanitary and had not been properly maintained.</p> <p>7. During an observation on 6-03-14 at 1548 hours, the following condition was observed in the post-op area: a 24" square ventilation return grille was observed with a heavy accumulation of dust and particulate material.</p> <p>8. During an observation on 6-03-14 at 1550 hours, the following condition was observed in the pre-op area: (four) 6" by 24" ventilation return grilles located on the wall over the patient carts were observed with an accumulation of dust and particulate material and the lower edge of a large round window opening over the area was observed with an accumulation of dust projecting onto the vertical wall below.</p>						

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S001174	<p>9. During an interview on 6-03-14 at 1550 hours, staff A1 confirmed that the window and ventilation grille conditions were unsanitary and had not been properly maintained.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following:</p> <p>(A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice. Based on observation, manufacturer's recommendations review, contracted</p>	S001174	The ASC will provide a functional & sanitary environment for the	07/10/2014

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	<p>housekeeper file review, and staff interview, the facility failed to ensure that training and re-education of the housekeeper in February, 2014, was effective.</p> <p>Findings:</p> <p>1. At 5:00 PM on 6/2/14, while on tour of the surgery area in the company of staff members #50, the patient care manager, and #52, the contracted housekeeper, it was observed in the housekeeping closet that:</p> <p>a. Expose II 256 was the product being used for cleaning and mopping and was a container made for a wall mounted dispersion system.</p> <p>b. the Expose bottle indicated dilution was to be a "1:256 solution".</p> <p>c. There were no measuring cups, or other devices for measuring, present to assure that a proper dilution of the Expose product is provided.</p> <p>d. A 32 oz spray bottle was present and used for cleaning surfaces.</p> <p>e. There was only one string, microfiber, mop head present in the housekeeping closet.</p> <p>2. Interview with staff member #52, the contracted housekeeper, at 5:10 PM on 6/2/14, indicated:</p> <p>a. While pointing to the numbers on the side of the spray bottle, the housekeeper</p>		<p>provision of surgical services by adhering to professionally acceptable standards of practice. The infection control committee will ensure that training & re-education of the housekeeper will be effective and that the operating rooms & patient care areas will be maintained in a sanitary manner. The housekeepers cleaning schedule was updated to reflect designated duties for proper cleaning. Inservice with housekeeper will be accomplished by July 10, 2014. Cleaning agent Epose II 256 instructions for using was obtained & gone over with the Housekeeper on June 4, 2014. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p>				

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	<p>indicated that 3 to 6 ounces of Expose is placed in both the 32 ounce bottle, and in the mop bucket, prior to adding water.</p> <p>b. It was unknown what the correct dilution rate for Expose was, per the manufacturer's recommendation.</p> <p>c. It was unknown how many gallons the mop bucket held, staff member #52 stated they fill the bucket "1/2 full" of water and add the same amount of Expose (3 to 6 ounces) in 1/2 bucket of water.</p> <p>d. The Expose product kill time is "3 minutes".</p> <p>e. One mop head is used to mop both OR (operating room) suites, the surgical hallway, and the pre/post op area.</p> <p>f. The contracted laundry service doesn't return the mop heads, so that only one is usually present for use.</p> <p>g. This staff member sometimes brings other microfiber mop heads in and then takes them home for laundering.</p> <p>3. At 5:25 PM on 6/2/14, interview with staff member #50, the patient care manager, it was indicated that:</p> <p>a. This staff member thought the problem of missing, or not enough, mop heads "had been fixed".</p> <p>b. This staff member was unaware that the housekeeper was using only one mop head for the whole surgery center.</p> <p>c. This staff member was unaware that</p>			

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	<p>some mop heads were being taken home for home laundering.</p> <p>4. At 3:30 PM on 6/3/14, while on tour of the surgery center in the company of staff member #50, the patient care manager, it was observed that:</p> <p>a. The mop bucket holds 6 gallons of water if filled completely (3 gallons = 1/2 bucket).</p> <p>5. Review of manufacturer's dilution recommendations indicated that:</p> <p>a. A 1:256 dilution is created with 1/2 ounce of product per gallon of water.</p> <p>b. The kill time for the Expose product is 10 minutes to kill all organisms.</p> <p>6. Review of the employee file for staff member #52 (also N15) indicated:</p> <p>a. An annual "Review proper cleaning to infection control regulations" was done 2/3/14.</p> <p>b. The first item of review was: "Reviewed disinfectant used, proper mixing, kill time required".</p> <p>7. At 9:20 AM on 6/3/14, interview with staff member #50, the patient care manager, indicated:</p> <p>a. The training done 2/3/14 was ineffective as it was unknown what the dilution rate for the Expose product was.</p> <p>b. There was no measuring device</p>			

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	<p>present for use in diluting the Expose in the spray bottle and the mop bucket.</p> <p>c. Monitoring of the contracted housekeeper is ineffective as it was unknown that the housekeeper was:</p> <p>I. Unaware of the product kill time.</p> <p>II. Using one mop head for the total surgery center floor plan.</p> <p>III. Improperly mixing/diluting the Expose product.</p>						