

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000  Bldg. 00	This visit was for a State licensure survey.  Facility Number: 005405  Survey Date: 1/11/2016 to 1/12/2016  QA: cjl 02/16/16	S 0000		
S 0446  Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(x)  The infection control committee responsibilities must include, but are not limited to:  (E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:  (x) A program of linen management. Based on document review and interview, the center failed to implement its policy/procedures and monitor the	S 0446	2/22/2016 Laura Townsend, RN, Director of Surgical Services emailed Center's contracted laundry service to obtain proper	02/22/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>laundry service provider according to generally accepted industry standards through the infection control program.</p> <p>Findings include:</p> <p>1. The Centers for Disease Control and Prevention report titled Guidelines for Environmental Infection Control in Health-Care Facilities (2003) indicated the following: "The antimicrobial action of the laundering process results from a combination of mechanical, thermal, and chemical factors ...hot water provides an effective means of destroying microorganisms ...the use of chlorine bleach assures an extra margin of safety. A total available chlorine residual of 50-150 parts per million (ppm) is usually achieved during the bleach cycle ...the last of the series of rinse cycles is the addition of a mild acid (i.e., sour) to neutralize any alkalinity ...the rapid shift in pH from approximately 12 to 5 is an effective means to inactivate some microorganisms ..."</p> <p>2. The policy/procedure Laundry Services (approved 1-15) indicated the following: "The center shall maintain contracted Laundry Services and monitor such services so as to assure adequate supplies of linen that have been processed according to accepted</p>		<p>temperature and titration reports. Moving forward, the forms will now be obtained monthly, monitored monthly, and kept in the contracted service QA file. This information will also be presented at the quarterly Quality Assurance Committee and Infection Control Committee meetings and the minutes will reflect as such. Laura Townsend, RN, Director of Surgical Services will be responsible for this correction.</p> <p><b>Observations and Comment Report Committed to Quality and Service</b></p> <p>ACCOUNT: <b>Indiana University Health-Bloomington Hospital</b> SERVICE DATE: <b>1/15/16</b> Hours: <b>3</b></p> <p>ADDRESS: <b>640 South Morton St.</b> CITY: <b>Bloomington</b> STATE: <b>IN</b> PHONE: FAX : E-MAIL:</p> <p>CUSTOMER: <b>Scott Pannell GURTLER</b> REP.: <b>Jon Oren</b></p> <p>NO. OF REPORT COPIES: Account: <b>1</b> Gurtler: <b>1 NEXT PLANNED ROUTINE SERVICE: 2/26/2016</b></p> <p><b>SERVICE PERFORMED TODAY; AREAS NEEDING ATTENTION; COMMENTS:</b> &lt;Completed a regularly scheduled service visit today. &lt;Spoke with Scott P. upon entrance regarding: faulty steam</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/12/2016
NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	standards."  3. Review of the Infection Control (IC) committee minutes dated 1-27-15, 4-27-15, 7-28-15 and 10-27-15 failed to indicate that Temperature and Titration reports were obtained from the contracted laundry service and periodically reviewed and reported to the committee to ensure the linen was processed according to accepted standards.  4. During an interview on 1-12-16 at 1145 hours, the director of surgical services, staff A1 confirmed the center was not receiving temperature and titration reports from the contracted laundry service and confirmed the IC and Quality Assurance committee minutes lacked documentation that the reports were monitored or reviewed.		regulator valve, high water level in washer extractor #1. Observations/Actions: <Completed a cost and inventory report for period 11/25-01/15. Numbers are within parameters for proper dispensing. Please see attached report. <Titrated formula 04 Bath Blankets in the tunnel washer. Numbers are within parameters for cleanliness and stain removal. Please see attached. <Water level in washer extractor was increasing above glass at times. The reason for this is unknown. Scott checked drains and fill valves, which appear to be working properly. Thank you! Jon Oren  <b>Sign &amp; Date: Service Representative:</b> <i>Jon Oren Customer: Scott Pannell</i> <b>Gurtler Industries, Inc.</b> 15475 S. LaSalle St. S. Holland, IL. 60473 1 - 800 - NDT - 7300  <b>Safety, Water, Wash and Dispensing Equipment, Garment Report Committed to Quality and Service</b>  ACCOUNT: <b>Indiana University Health-Bloomington Hospital</b> SERVICE DATE: <b>1/15/16</b> Hours: 3  ADDRESS: 640 South Morton St. CITY: Bloomington STATE: IN  CUSTOMER: <b>Scott Pannell</b> GURLER REP.:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>Jon Oren</p> <p>NUMBER OF REPORT COPIES: Account: 1 Gurtler:</p> <p><b>1 NEXT PLANNED ROUTINE SERVICE:</b></p> <p><b>SAFETY ITEMS AND CHEMICAL STORAGE CONDITIONS</b></p> <p>SUPPLY STORAGE AREA SUPPLY AREA Disp. Personal Protection Equipment - PPE GENERAL SAFETY</p> <p>Leaks Clean Lines Leaks Clean Lines Shields Apron Goggles Gloves Eye wash avail? MSDS's Dry floors?</p> <p>Neat? Other None Yes OK None Yes OK Yes No No Yes Yes Yes Yes Yes</p> <p><b>WATER AND CHEMICAL CONDITIONS</b></p> <p>Temp. Hardness Alkalinity Chlorine Iron BLEACH CONCENTRATIONS by WEIGHT (°F) (grains) (ppm @ Na2O) (ppm av. Cl) (ppm @Fe) Raw % 11% Stock %</p> <p>COLD WATER 54 °F 1 grains 22 ppm 0.0 ppm Heat Reclamation System</p> <p>TEMPERED 54 °F 1 grains 22 ppm 0.0 ppm A. Pit Temperature</p> <p>REUSE WATER B. Preheated Temperature</p> <p>OTHER C. Sewered Temperature</p> <p>OTHER D. Approach (A-B)</p> <p><b>SUPPLY DISPENSER CONDITION AND SERVICE</b></p> <p>Dispenser TYPE To No. Work Clean Shield Calibrate Tubing SERVICE PERFORMED</p> <p>No. Washer OK? Disp.? OK? Pumps? OK? OR PROBLEMS NOTED WITH DISPENSERS</p> <p>1 Knight Trak II 1 Yes Yes Yes Yes Yes Working well.</p> <p>2 Knight Trak II 2 Yes Yes Yes Yes Yes Working well.</p> <p>3 GRIP IV 3 Yes Yes Yes Yes Yes Working well.</p> <p>4 Knight Trak II 4 Yes Yes Yes Yes Yes Working well.</p> <p>5 6 7</p> <p><b>WASH EQUIPMENT CONDITION</b></p> <p>WASHER MAKE AND CAPACITY DRAIN HOT COLD STEAM STARCH WASH RINSE LOW MED.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>HIGH TEMP. CHART COND. NO. VALVE INLET INLET INLET LEVEL LEVEL LEVEL THERM THERM THERM GAUGEPROCESSOR COND.</p> <p>1 Milnor 110# WE OK OK</p> <p>2 Milnor 110# WE OK OK</p> <p>3 Milnor 8 Mod CBW OK NA OK NA OK NA OK NA OK OK OK OK</p> <p>4 UniMac 85 OK OK</p> <p>5 6 7 Press QUALITY GENERAL COMMENTS:</p> <p><i>Sign &amp; Date: Service Representative: Customer: Gurtler Industries, Inc. 15475 S. LaSalle St. S. Holland, IL. 60473 1 - 800 - NDT - 7300</i></p> <p><i>Inventory Report for Indiana University Health-Bloomington Hospital Committed to Quality and Service</i></p> <p>CUSTOMER: Scott Pannell SERVICE DATE: 1/15/16 Hours: 4 ADDRESS: 640 South Morton St. CITY: Bloomington STATE: IN</p> <p><b>INVENTORY STATUS FOR INDIANA UNIVERSITY HEALTH-BLOOMINGTON HOSPITAL</b></p> <p>Work Days PER WEEK: 5 Inventory Dates- START: 11/25/15 END: 1/15/16 Production Days: 38 days</p> <p>Product Name Supply Cost per Start Inv. Shipment End Inv. Amount Total Average Usage Days of unit gal or lb 11/25/15 In Period 1/15/16 Used Cost per day per cwt. Product Left *</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p><b>PULSE ULTRA(tote)</b> gal-275 \$5.35 669 413 256 \$1,369.34 6.7 10.7 oz. 61.3 days</p> <p><b>PULSE ADVANCE(tote)</b> gal-275 \$9.65 490 408 81 \$784.81 2.1 3.4 oz. 190.9 days</p> <p><b>NDT TUNNEL SOUR (55)</b> gal-55 \$15.36 68 46 22 \$342.91 0.6 .9 oz. 77.6 days</p> <p><b>BLEACH(15) milnor</b> gal-15 \$2.92 22 30 25 27 \$79.57 0.7 1.1 oz. 34.5 days</p> <p><b>NDT NEUTRA-CLOR(15)</b> gal-15 \$8.84 14 11 3 \$28.29 0.1 .1 oz. 125.4 days</p> <p><b>GEO SOFT (15)</b> gal-15 \$13.87 5 15 8 12 \$168.10 0.3 .5 oz. 26.1 days</p> <p><b>POWER BLOCK(55)</b> gal-55 \$13.45 32 55 60 27 \$361.18 0.7 1.1 oz. 85.1 days</p> <p><b>NDT SOLVATE(15)</b> gal-15 \$14.65</p> <p><b>PEROXIDE(54)</b> gal-55 \$4.89 117 53 74 96 \$470.83 2.5 4.0 oz. 29.2 days</p> <p>*Days of product left does not take into account unusable product at the bottom of bulk tanks, day tanks, and drums. <b>Chemical Cost For 38 Days: \$3,605.04</b></p> <p><b>Production Days: 38 Value of In-stock Inventory: \$8,304.12</b> Milnor CBW 2,575 Proper Average Load Size 104 lb.</p> <p>Pounds Processed if Loaded to Capacity 267,800 Milnor 110# W/E 253</p> <p>Proper Average Load Size 78 lb.</p> <p>Pounds if Loaded to Capacity 19,648 Milnor 110# W/E 255</p> <p>Proper Average Load Size 78 lb.</p> <p>Pounds if Loaded to Capacity 19,816</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>UniMac 85# W/E</p> <p>Proper Average Load Size <b>63 lb.</b> Pounds if Loaded to Capacity</p> <p><b>Total Pounds Processed if Loaded to Proper Load Size: 307,264</b></p> <p><b>Actual or Assessed Pounds Processed For 38 Production Days: 307,264</b></p> <p><b>Difference Between Properly Loaded Weight and Actual or Assessed Weight:</b> <b>% Difference Between Properly Loaded Weight and Processed Weight:</b> <b>Chemical Cost Per CWT if Proper Load Size Maintained: \$1.173</b> <b>Chemical Cost Per CWT Based On Actual or Assessed Weight ( 100.00% of proper load capacity): \$1.173</b></p> <p>Gurtler Rep. Signature: <b>Jon Oren</b> Customer Signature: <b>Scott Pannell</b> <b>Gurtler Industries, Inc.</b> 15475 S. LaSalle St. S. Holland, IL. 60473 1 - 800 - NDT - 7300 <b>Indiana University Health-Bloomington Hospital Inventory Database</b> ADDRESS: 640 South Morton St. DATE LAST SAVED: 2/23/2016 12:39 PM</p> <p><b>Product Name Unit Supply End date: 12/8/2014</b> <b>End date: 1/21/2015 End date: 2/24/2015 End date: 3/25/2015 End date: 4/23/2015 End date: 5/22/2015</b> <b>End date: 7/6/2015 End date: 8/19/2015 End date: 9/24/2015 End date: 10/27/2015 End date: 11/25/2015</b></p> <p><b>Cost unit Inventory Prod. Used Inventory Prod. Used</b></p> <p><b>PULSE ULTRA(tote) \$5.35 gal-275 848 245 648 200</b> 452 197 289 163 136 153 1,086 150 867 219 632 236 430 201 264 166 669 145</p> <p><b>PULSE ADVANCE(tote) \$9.65 gal-275 344 92 257</b> 88 211 46 152 58 93 60 577 65 484 94 389 94 319 70 263 56 490 49</p> <p><b>NDT TUNNEL SOUR (55) \$15.36 gal-55 29 21 65 19</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			57 8 46 11 32 14 19 13 70 4 59 11 83 31 81 1 68 13  <b>BLEACH(15) milnor</b> \$2.92 gal-15 16 24 27 20 11 16 28 13 11 17 28 13 28 35 23 31 19 16 15 22 9  <b>NDT NEUTRA-CLOR(15)</b> \$8.84 gal-15 23 4 20 3 18 3 15 3 12 2 10 2 7 3 19 3 17 2 15 2 14 1  <b>GEO SOFT (15)</b> \$13.87 gal-15 19 12 8 27 12 11 3 9 10 8 17 8 17 15 20 12 9 11 15 9 5 10  <b>POWER BLOCK(55)</b> \$13.45 gal-55 27 18 65 16 49 17 36 12 25 12 68 12 49 19 31 18 72 14 45 27 32 13  <b>NDT SOLVATE(15)</b> \$14.65 gal-15 7 7 7 7 7 7  <b>PEROXIDE(54)</b> \$4.89 gal-55 64 93 97 20 86 63 80 59 79 1 77 55 49 81 69 86 73 50 74 52 117 62 \$9.11 gal-15  <b>Supply Cost For Period</b> \$3,503.28 \$2,979.86 \$2,375.67 \$2,245.69 \$1,952.47 \$2,229.51 \$3,132.53 \$3,254.03 \$2,889.72 \$2,257.22 \$2,096.27  <b>Pounds Processed For Period</b> 278,366 251,646 213,762 184,000 178,852 168,726 246,861 254,447 211,679 189,592 179,125  <b>Cost per CWT For Period</b> \$1.259 \$1.184 \$1.111 \$1.220 \$1.092 \$1.321 \$1.269 \$1.279 \$1.365 \$1.191 \$1.170  <b>Work Days For Period</b> 34 34 25 21 21 22 32 33 26 24 22  <b>FORMULA TITRATION RECORD SHEET</b> <i>Committed to Quality and Service</i>  Account: <b>Indiana University Health-Bloomington</b> Hospital Date: <b>1/15/2016</b> Gurtler Rep: <b>Jon Oren</b>  Address: <b>640 South Morton St.</b> City, St: <b>Bloomington, IN</b> Customer: <b>Scott Pannell</b>  <b>Washer: Make, Size, and Controls: Milnor 8 Module Condition:</b>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p><b>TITRATED: Mid cycle CYCLE TIME( h:m:s) 4 min</b> 26 sec 19 Wash Time: 35 min 28 sec</p> <p><b>No. : 4. Classification: Bath Blankets Lbs per Load: 100</b></p> <p><b>COMP ZONE FLOW TEMP LEVEL Active</b> Alkalinity @ Na2O pH ppm bleach SUPPLIES Wash #'s</p> <p><b>8 Total RATE (°F) WIER drops ppm oxygen</b> Quantity Product Titrated</p> <p>1 PRE-WASH 85 °F 12.0 1.0 drops 44.0 ppm 10.9 2.3 ppm 1.0 1.5 Pulse Ultra Pulse Advance</p> <p>2 MAIN-WASH(130) 130 °F 10.5 4.0 drops 176 ppm 11.1 67.5 ppm</p> <p>3 MAIN-WASH(160) 160 °F 11.0 5.0 drops 220 ppm 11.3 101 ppm 7.0/4.0 1.0 Pulse Ultra/Peroxide 30% Power Block</p> <p>4 MAIN-WASH 145 °F 11.5 3.0 drops 132 ppm 11.1 78.8 ppm</p> <p>5 MAIN-WASH(140) 20 140 °F 12.0 2.0 drops 88.0 ppm 10.8 56.3 ppm</p> <p>6 RINSE 95 °F 10.5 1.0 drops 44.0 ppm 10.6 22.5 ppm</p> <p>7 RINSE 25 80 °F 11.0 0.3 drops 13.2 ppm 10.2 11.3 ppm</p> <p>8 SOUR 90 °F 12.0 1.0 1.5 NDT Tunnel Sour Softener</p> <p>Wash Time in Tunnel: <b>35 min 28 sec</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0708 Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(3)</p> <p>The medical staff shall do the following:</p> <p>(3) Make recommendations to the governing body on the appointment or reappointment of the applicant for a period not to exceed two (2) years. Based on document review and interview, the Medical Staff failed to ensure credentialed practitioners were reappointed not to exceed 2 years for 6 of 6 physicians (#4, 5, 6, 7, 8 and 9).</p> <p>Findings includes:</p> <ol style="list-style-type: none"> <li>1. Review of Governing Board/Professional Staff minutes of January 29, 2013; stated, "Board approved a 36 month reappointment in lieu of a 24 month."</li> <li>2. Review of six physicians' (#4, 5, 6, 7, 8 and 9) Bloomington Surgery Center letter of reappointments indicated, "You have been granted privileges by the Governing Board, as of July 30, 2013, in anesthesiology and any related procedures for the term of three years."</li> <li>3. In interview at 1:15 PM on 1/11/2016, staff member #2 (Director of Surgical</li> </ol>	S 0708	<p>The Board of Directors held a special meeting, January 13, 2016, to discuss the findings regarding the noncompliant credentialing terms. It was unanimously decided to change the Medical Staff By-laws from triennial back to biannual. The re-credentialing paperwork process began immediately and the Board granted the Medical Staff temporary privileges. The final approval will take place at the next Board of Directors Meeting on April 26, 2016. The Medical Staff Bylaws will be reviewed and monitored yearly. Laura Townsend, RN, Director of Surgical Services will be responsible for this correction.</p> <p><b>BLOOMINGTON SURGERY CENTER BOARD OF DIRECTORS MEETING</b> <b>January 13, 2016</b> The following represents minutes of a special meeting of the Board of Directors for the Bloomington Surgery Center held on January 13, 2016. <b>Members: Others</b></p>	01/13/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Services) indicated the reappointment of physicians was changed from once every two years to once every three years.		<p><b>Present:</b> Chad Huck, O.D. Joseph Mackey, M.D. R. Daniel Grossman, M.D. Laura Townsend, R.N., Director of Surgical Services Charlene Allen, Business Manager Vickie Edington, Surgical Assistant R. Daniel Grossman, MD and Charlene Allen were in attendance via conference call <u>New Business</u> Laura reported upon review during the Indiana State Department of Health survey conducted on January 11-12, 2016, it was brought to our attention that the credentialing change from biannually to triennially does not comply with state regulations. This change was made during a 2013 Board of Directors meeting. It was discussed and unanimously decided that, in order to comply with regulations, the (re) credentialing process was to begin immediately for 2016 and the Medical Staff Bylaws be changed back to biannually. Temporary privileges have been granted to all medical staff until proper paperwork is obtained and approved. <u>Adjournment</u> There being no further business to come before the Board, the meeting was adjourned. From Policy and Procedure Book: The medical staff year for purposes of these bylaws shall commence on January 1 and end on December 31. Section 4. <u>Conditions and Duration of</u></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 1166 Bldg. 00	<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</p>		<p><u>Appointment</u> (a) Initial appointments and reappointments to the medical staff shall be made by the governing body. The governing body shall act on appointments, reappointments, or revocation of appointments after there has been a recommendation from the medical staff as provided in these bylaws. (See Article V.) (b) Appointments to staff shall be for a period of twenty-four (24) months. Initial appointments shall be provisional for the first period of twelve (12) months. (c) Appointments to the medical staff shall confer on the appointee only such clinical privileges as have been granted by the governing body, in accordance with these bylaws. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every medical staff member's</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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 observation, document review and interview, the facility failed to document evidence of preventive maintenance inspections on 4 wheelchairs, 2 surgical tables and a fire extinguisher.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>At 12:14 PM on 1/12/2016, the surgery center was toured. The lobby was observed with 4 wheelchairs and two surgical tables lacking any markings to identify when they were last inspected by the facility. A fire extinguisher located in the mechanical room had a monthly inspection tag on the extinguisher that contained no monthly inspections initialed by the inspector on the tag.</li> <li>In review of Bloomington Surgery Center Preventive Maintenance policy, the inspection frequency of wheelchairs, surgical tables, and fire extinguishers is monthly.</li> <li>Review of the preventive maintenance</li> </ol>	S 1166	<p>January 20, 2016, the Center's monthly preventive maintenance form was corrected to reflect each individual wheelchair, surgery cart, and fire extinguisher. The wheelchairs and carts were individually labeled to coincide with serial numbers and fire extinguishers with locations. An in-service was performed with the Center's Building and Grounds Coordinator to review the changes made to the form. The monthly tags on the fire extinguishers were also discussed with the Coordinator and these will be utilized moving forward. The preventive maintenance form will be completed monthly by the Building and Grounds Coordinator and Laura Townsend will review the log monthly to confirm it is being completed. Laura Townsend, RN, Director of Surgical Services will be responsible for this correction.</p> <p><b>WHEEL CHAIR NUMBERSERIAL NUMBERSIZE</b> WC 14S1502211767LG WC 24S1209101466MED WC 34S1507201022LG</p>	01/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>documentation for wheelchairs, surgical tables and fire extinguishers indicated the three months Preventive Maintenance Checklists in the fourth quarter of 2015 did not contain evidence of preventive maintenance for each individual wheelchairs, surgical tables and fire extinguishers.</p> <p>4. In interview at 1:05 PM on 1/12/2016, staff member #3 (Building and Grounds Coordinator) confirmed above and no other documentation was provided by exit.</p>		<p>WC 4 4S1503231180MED WC 54S1210020867MED WC 64S1303211178MED WC 7A04110388DYL <b>TRANSPORT CHAIR NUMBERSERIAL NUMBER</b> TC 111EKS022108 TC 25D1202000862 TC 3brown chair/no data TC 4brown chair/no data <b>SURGICAL CARTSSERIAL NUMBER</b> CART 12034614 CART 22034561 CART 32034558 CART 42034615 CART 5105035824 CART 62034559 CART 72034560 <b>EXTINGUISHERSLOCATION</b> FE 8Locker Rm Hall FE 10Employee Entrance Hall FE 11Sterile Corridor FE 12BSC Reception Desk FE 16Laser Room</p> <p><b>MONTHLY PREVENTIVE MAINTENANCE CHECKLIST</b></p> <p>Date_____</p> <p>Inspected By_____</p> <p>-</p> <p><b>Item</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p><b>Inspected</b></p> <p><b>Comments/Repairs, if applicable</b></p> <p>Lighting</p> <p>Bulbs</p> <p>Switch Plates</p> <p>In place/operational</p> <p>Outlet/Cover</p> <p>In place/operational</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<p>Outlets not overloaded</p> <p>GFIs Tested</p> <p>Electrical Cords</p> <p>Not frayed</p> <p>No extension cords</p> <p>Walls/Ceiling/Baseboards/Floors</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/12/2016
---	--	---	--

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 1174  Bldg. 00	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE,		No cracks/holes  No chipped paint  No mold  Wallpaper intact  Carpet dry and clean	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>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.</p> <p>Based on document review and interview, the center failed to implement its policy/procedure for environmental services (EVS) and ensure a safe and sanitary environment was maintained for patients and staff at the center. Findings include:</p> <p>1. The policy/procedure Housekeeping Services (approved 1-15) indicated the following: "The Director and appointed individual (s) ...are responsible for monitoring contracted housekeeping</p>	S 1174	Laura Townsend, Director of Surgical Services, contacted BJ Ross, owner of Indiana ProClean, the Center's contracted service for environmental cleaning. Mr. Ross provided the Center with a copy of the contracted service's training DVD to view. After review of the DVD, Laura Townsend found that it was acceptable as an introductory training for cleaning. A training session is scheduled for March 2, 2016 with the contracted service employee and Laura Townsend, Infection Control Officer. At this time, a	03/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>services that are provided to assure accepted levels of cleanliness ...Assure that contract housekeeping services are performed according to prescribed Procedures and Standards ...A contract Housekeeping Service company shall be provided with the appropriate procedural guidelines for cleaning all areas of the center. Such procedures to be considered an addendum to the contract ...Director of Surgical Services and facility appointed individual(s) shall confirm with contract company that their employees are instructed in proper procedures ...The Director of Surgical Services and facility appointed individual(s) shall monitor contract services and initiate corrective action if proper standards are not maintained."</p> <p>2. Review of the agreement with the EVS contracted service provider dated 1-2-14 failed to indicate the contracted service had been provided with any surgery center policy/procedures to establish the appropriate standards for cleaning all areas of the center including the operating rooms (ORs).</p> <p>3. On 1-11-16 at 1645 hours, the EVS company owner, CS10 confirmed that he/she had not received any policy/procedures from the center.</p>		<p>copy of the Center's policies and procedures will be presented to the employee. A competency form has been created and will be completed upon observation of the employee's work. This observation/competency form will be completed yearly and the service will be monitored randomly; this form will be kept in the contracted service QA file. Laura Townsend, RN, Director of Surgical Services will be responsible for this correction.</p> <p><b><u>Housekeeping/Terminal Cleaning Competencies</u></b> Name _____ "+" = Outstanding "-" = Met "✓" = Not Met Blank = Not Applicable Enter Date Proper attire and PPE used for cleaning in restricted, semi-restricted and non-restricted areas Prepares, handles, and stores EPA registered disinfectants according to manufacturers' guidelines Assembles, disassembles, cleans and disinfects cleaning equipment according to manufactures' guidelines Floors mopped and wet with disinfectant for the dwell time indicated on manufacturers' guidelines Cleaning progressed from cleanest to dirtiest areas of the floor, top to bottom, perimeter to center of room Cleans all exposed surfaces of carts/equipment cleaned</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>4. On 1-11-16 at 1640 hours, the EVS company owner CS10 and the EVS operations manager CS11 were requested to provide documentation indicating the training content provided to all EVS cleaning staff working at the center to establish the standards for cleaning the ORs and none was received prior to exit.</p> <p>5. On 1-11-16 at 1640 hours, the EVS company owner CS10 provided a single page document indicating that the OR cleaner, staff CS12, had viewed a video (DVD) titled 1055 Cleaning the Operating Room prior to providing cleaning services at the center. The EVS company owner CS10 confirmed that no documentation of the DVD training content including an outline was available and confirmed the training DVD was not available for viewing at the time of the interview.</p> <p>6. On 1-11-16 at 1645 hours, the director of surgery services and infection control nurse, staff A1 confirmed neither they (A1) or another center appointed individual had viewed the EVS training DVD titled 1055 Cleaning the Operating Room to determine if the training content was consistent with accepted standards of practice for OR cleaning and disinfecting and in compliance with center policy/procedures.</p>		<p>including casters and wheels Cleans the clean processing areas prior to dirty/decontamination area to reduce contaminating the clean areas Cleans all horizontal surfaces, along with high-touch surfaces, with EPA-registered disinfectant and clean low-lint cloth Proper trash removal demonstrated Follows standard precautions to prevent contact with blood, body fluids, or potentially infectious materials Performs proper hand hygiene before donning proper attire as well as after removing PPE Has understanding of Center policies regarding bloodborne pathogens and environmental cleaning Knows locations of eye wash stations and spill kit</p> <p><b>DISCUSSION PLAN FOR FUTURE DEVELOPMENT</b> DATE: Name of Contracted Service Employee: Name of</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/12/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  BLOOMINGTON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 W SECOND ST BLOOMINGTON, IN 47403
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7. On 1-11-16 at 1450 hours, the director of surgery services and infection control nurse, staff A1 confirmed neither they (A1) or another qualified center staff had directly observed the EVS staff CS12 when performing terminal OR cleaning to determine that EVS staff are instructed in proper procedures and ensure that acceptable levels of cleanliness are maintained at the center.		<p>Guide/Supervisor:</p> <p>Practice learning opportunities and competencies discussed: Action plan to maximize achievement of learning opportunities and competencies: Skills Identified: Date Agreed for further Development Success: Contracted Service Employee signature:</p> <p>_____ Guide signature:</p> <p>_____ -</p> <p><b>CONTINUED DEVELOPMENT</b></p> <p>Competencies Achieved: Further Development Identified: Strategies for achieving new competencies: Date Agreed for further Development Success: Contracted Service Employee signature:</p> <p>_____ Guide signature:</p> <p>_____ -</p>	