

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001113	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/09/2016
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NAME OF PROVIDER OR SUPPLIER  CENTER FOR SPECIAL SURGERY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 8805 N MERIDIAN ST INDIANAPOLIS, IN 46260
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S 0000  Bldg. 00	This visit was for a State licensure survey.  Facility Number: 003032  Survey Date: 03-07/09-2016  QA: cjl 04/12/16	S 0000		
S 0156  Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E)  Require that the chief executive officer develop and implement policies and programs for the following:  (E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.  Based on document review, observation and interview, the chief executive officer failed to ensure a job description for 2 of 2 housekeepers (N5, N6).	S 0156	The facility is changing janitorial service effective 6/1/2016. The nurse manager will insure that job descriptions for each new housekeeper will be reviewed and	06/01/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Findings Include:</p> <ol style="list-style-type: none"> <li>Review of policy/procedure Policy NO: 113 indicated on page 4 the following: To facilitate attainment of the Center's mission, goals, and objectives, The Center's Director will maintain the following documents: <ul style="list-style-type: none"> <li>Job descriptions for each employee that outlines qualifications commensurate with the responsibilities and authority as well as privileges of employment. The appropriate job description will be shown to each employee either prior to or at the time of employment.</li> </ul> <p>This policy/procedure was last reviewed/ revised on 1-4-02.</p> </li> <li>Review of personnel files indicated a lack of documentation related to job descriptions for housekeeper N5 and N6.</li> <li>Interview on 3-9-2016 at 1150 hours with RN (Registered Nurse) N1, Nurse Manager/Infection Control confirmed the finding that a job description was lacking for housekeepers N5 and N6.</li> </ol>		<p>signed on or prior to 6/1/2016. The facility was unable to change vendors prior to this date due to a contractual obligation. The nurse manager will review personnel files on every new housekeeper in the future to insure there is a valid job description.</p>	

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S 0172  Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review, observation and interview, the chief executive officer failed to maintain personnel records for each employee as related to post offer physicals for 2 of 4 RNs (Registered Nurses), RN N2 and RN N3.</p> <p>Findings Include:</p> <p>1. Review of policy/procedure HEALTH ASSESSMENT on page 4 indicated the following; POLICY: New employees are required to complete a health assessment prior to work.</p> <p>2. Review of personnel files indicated a lack of a completed post offer physical for RN N2 and RN N3.</p>	S 0172	A provider signature was obtained for the two deficient health assessments. The nurse manager will ensure that all future new employees have a completed health assessment signed by a provider prior to assuming any work duties.	03/16/2016

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S 0432 Bldg. 00	<p>3. Interview on 3-7-2016 at 1420 hours with RN N1, Nurse Manager/Infection Control, confirmed the fact that the post offer physicals for RN N2 and RN N3 lacked a provider signature.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review, observation and interview, the infection control committee failed to ensure cleaning of 2 wall vents in the operating room.</p> <p>Findings Include:</p> <p>1. Review of policy/ procedure ENVIRONMENTAL CLEANING/ STERILIZING on page 1 indicated the following; ENVIRONMENTAL CLEANING</p>	S 0432	Beginning immediately after the survey and continuing through the end of May the nurse manager has been/will be monitoring dust on the vents and horizontal surfaces. The facility will be using a new janitorial service effective 6/01/2016. The facility was unable to change vendors sooner due to a contractual obligation. To coincide with the change in janitorial service, a log book will be established where staff be able to record any concerns with the terminal cleaning and specifically dust accumulation.	06/01/2016

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S 0442  Bldg. 00	<p>For this instrument, the following definitions refer to environmental cleaning: Terminal cleaning is the use of mechanical friction with a facility-approved agent to clean: 3. Ventilation faceplates</p> <p>This policy/procedure was last reviewed/ revised on 9-24-13.</p> <p>2. While on tour on 3-8-2016 at 1418 hours with RN (Registered Nurse) N1, Nurse Manager/Infection Control, it was observed that the 2 wall vents in the operating room had heavy dust on them.</p> <p>3. Interview on 3-8-2016 at 1418 hours with RN N1 confirmed the finding.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease</p>		<p>This log will be available to both administration and the janitorial service. Also "visible dust accumulation" will be added to the QA indicators to monitor the janitorial service. The next Governing Body meeting will be in June and that indicator will be approved at that time. The QA measures are reviewed by both the nurse manager and the administrator.</p>				

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	<p>history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on document review, observation and interview, the Infection Control Committee failed to determine the communicable disease history of new hire personnel for 3 of 11 personnel files reviewed: N4,Certified Surgical Tech (CST) and files P1 and P2, both radiology techs.</p> <p><input type="checkbox"/></p> <p>Findings include:</p> <p><input type="checkbox"/></p> <p>1. Review of a policy/procedure entitled Infection Control Program, approved 03-03-2015, indicated "COMPONENTS OF THE INFECTION CONTROL PROGRAM: <u>RESPONSIBILITY</u>: The governing board has approved the adherence to nationally recognized infection control guidelines as outlined by i.e. CDC (Centers for Disease Control)."</p> <p><input type="checkbox"/></p> <p>2. Review of CDC Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), Recommendations and Reports, November 25, 2011/60(RR07); 1-45, Section Varicella Recommendations vaccination, indicated the following; "Health-care institutions should ensure</p>	S 0442	<p>The nurse manager/infection control officer will update the policy and procedure to be consistent with a nationally recognized standard. The facility will now require documentation of immunization, documentation of illness, or titres for varicella. The nurse manager will ensure that this is obtained for existing and new employees. Due to our facility not being linked to the Survey Report System, our Plan of Correction for Deficiencies was not received until 5/06/2013. Due to the complexity of requesting this information from outside sources, the facility will require this documentation by 6/13/2016. The new policy will be reviewed at the June Governing Body meeting.</p>	06/13/2016

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	<p>that all HCP (health care personnel) have evidence of immunity to varicella. This information should be documented and readily available at the work location. HCP without evidence of immunity to varicella should receive 2 doses of Varicella vaccine administered 4-8 weeks apart. If &gt;8 weeks elapse after the first dose, the second dose may be administered without restarting the schedule. Recently vaccinated HCP do not require any restriction in their work activities; however, HCP who develop a vaccine-related rash after vaccination should avoid contact with persons without evidence of immunity to varicella who are at risk for severe disease and complications until all lesions resolve (i.e., are crusted over) or, if they develop lesions that do not crust (macules and papules only), until no new lesions appear within a 24-hour period."</p> <p>3. Review of a facility policy entitled HEALTH ASSESSMENT, approved 03-03-2015, indicated "As part of the assessment, the infectious disease and immunization history form will be completed." <input type="checkbox"/></p> <p>4. Review of personnel files indicated no authenticated documentation of immunity to Varicella for N4, CST, and P1 and P2, radiology techs.</p>			

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S 1154 Bldg. 00	<input type="checkbox"/> <p>5. Interview on 2/3/16 at 1345 hours of RN N1, Nurse Manager/Infection Control Coordinator, confirmed the file for RN N6 lacked authenticated documentation for Varicella immunity.</p> <p>6. Interview of employee #A1, Administrator, on 03-08-2016 at 11:00 am, confirmed files P1 and P2 had no authenticated documentation of Varicella immunity and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(C)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Operational and maintenance control records must be established and analyzed at least triennially. These records must be readily</p>				

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	<p>available on the premises.</p> <p>Based on document view and interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 3 (heating, ventilation and air conditioning) of 6 systems of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On 03-07-2016 at 9:30 am, employee #A1, Administrator, was requested to provide documentation of the operational and maintenance control records for the heating, ventilation, air conditioning, emergency generator, smoke detector and fire alarm systems having been analyzed at least triennially to determine if the process used to conduct the preventive maintenance was current and in accordance with manufacturer's recommendations.</li> <li>2. Review of facility documents indicated there was no documentation for the heating, ventilation and air conditioning systems having been analyzed at least triennially to determine if the process used to conduct the preventive maintenance was current and in accordance with manufacturer's recommendations.</li> <li>3. Interview of employee #A1, on</li> </ol>	S 1154	<p>The administrator will meet with a representative of the HVAC vendor to determine if the process used to conduct the preventative maintenance is current and in accordance with the manufacture's recommendations. HVAC will be added to the triennial maintenance review. Due to our facility not being linked to the Survey Report System, our Plan of Correction for Deficiencies was not received until 5/06/2013. Due to the need to schedule this with an outside organization and some additional scheduling constraints, this review will be completed by 6/13/2016.</p>	06/13/2016	

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S 1168 Bldg. 00	<p>03-09-2106 at 10:20 am, confirmed there was no above-requested documentation. The employee indicated the facility interpreted the triennial review to mean a review of maintenance activity for the past 3 years to notice any patterns relative to unusual wear and tear. No other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</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>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the facility failed to document a current electrical check for 2</p>	S 1168	Trimedx will perform an electrical inspection on the the deficient equipment. The administrator will ensure that this equipment is	06/13/2016

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	<p>(anesthesia machine and sterilizer) of 11 pieces of clinical equipment, and did not perform a triennial review for 2 (emergency call code system and radiology equipment) of 9 pieces of clinical equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. On 03-07-2016 at 9:30 am, employee #A1, Administrator, was requested to provide documentation of a triennial review to determine if the process used to conduct the preventive maintenance was current and in accordance with manufacturer's recommendations for 11 pieces of clinical equipment.</li> <li>2. Review of facility documents indicated there was no above-requested documentation for an anesthesia machine and sterilizer.</li> <li>3. Interview of employee #A1, on 03-08-2106 at 3:15 pm, confirmed there was no above-requested documentation. The employee indicated the facility interpreted the triennial review to mean a review of maintenance activity for the past 3 years to notice any patterns relative to unusual wear and tear. No other documentation was provided prior to exit.</li> </ol>		<p>added to the equipment inspected by Trimedx annually. Due to our facility not being linked to the Survey Report System, our Plan of Correction for Deficiencies was not received until 5/06/2013. Due to the need to schedule this with an outside organization, this inspection will be completed by 6/13/2016. In addition at the June Governing Body meeting, the manuals will be reviewed for the equipment to insure that the process used to conduct preventative maintenance is current and in accordance with manufacturer's recommendations . This equipment will be added by the administrator to the triennial maintenance review.</p>	

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S 1170 Bldg. 00	<p>4. On 03-07-2016 at 9:30 am, employee #A1 was requested to provide documentation of a of a current electrical check for 9 pieces of clinical equipment.</p> <p>5. Review of facility documents indicated there was no above-requested documentation of a current electrical check for an emergency call code system and radiology equipment.</p> <p>6. Interview of employee #A1, on 03-08-2106 at 3:15 pm, confirmed there was no documentation of a current electrical check for an emergency call code system and radiology equipment.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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</p>			

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	<p>serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to document defibrillator checks in accordance with the manufacturer's specification for 1 of 1 defibrillator.</p> <p>Findings include:</p> <p>1. Review of the CodeMaster XL Series Manual, indicated the facility was to perform Operational Checks, as follows:</p> <p><b>"Every Shift ...</b> [Check for various items as specified by the manufacturer]</p> <p><b>Every Day ...</b> [Check for various items as specified by the manufacturer]</p> <p>To check the instrument with the pads adapter cable, perform the following steps:</p> <p><b>Quick Pacer Functionality Test ...</b> [Check for various items as specified by the manufacturer]</p>	S 1170	The Emergency Cart Checklist was revised by the nurse manager to reflect the manufacturer's specifications outlined in the user's guide. The corresponding policy and procedure were also revised. Due to our facility not being linked to the Survey Report System, our Plan of Correction for Deficiencies was not received until 5/06/2013. These revisions were completed on 5/11/2016. The new policy will be reviewed at the June Governing Body meeting.	05/11/2016	

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	<p><b>Every Week ...</b> [Check for various items as specified by the manufacturer]</p> <p><b>Every Three Months ...</b> Have the cable set tested for electrical continuity every three months</p> <p>2. Review of facility POLICY NO: 321C, entitled Use and Care of CodeMaster XL DEFIBRILLATOR, approved 03-03-2015, indicated "LIST OF EQUIPMENT, USE AND CARE ... DEFIBRILLATOR TESTING ... DEFIBRILLATOR DAILY...". Under each category, there were several items listed as to when and how to check and test the defibrillator.</p> <p>3. Review of documents entitled EMERGENCY CART CHECKLIST for calendar year 2015, indicated it could not be determined if all the above checks were conducted, as required.</p> <p>4. Interview of employee #A2, Nurse Manager, on 03-09-2016 at 10:00 am, confirmed all the above and no other documentation was provided prior to exit.</p>			