

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001105	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/10/2014
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NAME OF PROVIDER OR SUPPLIER  SOUTH EMERSON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8141 S EMERSON AVE STE C INDIANAPOLIS, IN 46237
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002837</p> <p>Survey Date: 7/9/2014 through 7/10/2014</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 07/23/14</p>	S000000		
S000400	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on documentation review, observation and staff interview, the</p>	S000400	S400 Policy was updated to reflect AORN standards S400 New facility logs have been	08/05/2014

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>facility failed to meet the humidity levels of the Operating Rooms as defined by surgery center's policies.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. South Emerson Surgery Center Infection Control in the Operating Room policy (last approved 8/2011) indicated the humidity must be maintained between 50 to 60%.</li> <li>2. The 2014 RH of Anesthetizing Locations humidity log sheet revealed the 2 operating rooms humidity were recorded on a weekly basis. Operating Room #1 did not comply with the facility's humidity control parameters of 50 to 60 percent for 23 of the first 27 weeks in 2014 and Operating Room #2 did not comply for the first 24 of 27 weeks also.</li> <li>3. At 1:45 PM on 7/10/2014, staff member #10 indicated the surgery center's policies regarding</li> </ol>		<p>implemented for documentation purposes S400 Submitted to Board of Managers 08/06/2014 for approval Nurse Manager will be responsible for ongoing monitoring. Monitoring will be performed by Nurse Manager and evaluated at Q/A.</p>	

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S000432	<p>operating room's humidity was more stringent than the AORN guidelines. The staff member confirmed the surgery center operating rooms were not maintained at the humidity control range of 50 to 60 percent as per surgery center's policy.</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 observation, policy review, manufacturer's directions, and interview, the infection control committee failed to ensure the facility staff and the contracted housekeeping staff used the proper cleaning products according to</p>	S000432	S432 Housekeeping policies and procedures have been revised to include: S432 Surveillance of the contracted service has been addressed Staff members have been assigned with details of how we will be determining if services are being performed to code	08/05/2014

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	<p>manufacturer instructions and cleaned all surfaces as specified.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. During the observation of the operating room turn-over between cases at 12:30 PM on 07/09/14, the flat surfaces of the anesthesia machine and anesthesia cart were not cleaned or disinfected, nor were the towels on the surfaces changed.</li> <li>2. The facility policy "Housekeeping", last reviewed 08/05/11, indicated "In high-risk areas where heavy contamination is expected, such as toilets and sinks, or for blood or body fluid spills, a disinfectant such as 0.5% chlorine or 1% phenol should be added to the cleaning solution (or a hospital approved disinfectant). Using a disinfectant in addition to soap and water is also recommended in other high-risk areas such as operating rooms, pre- and postoperative recovery areas. ...it is important that housekeeping staff be trained to perform their assigned tasks and are supervised on a regular basis. ...Between each case, do the following: (SESC staff) ...Instrument table (mayo stand and carts) and other flat surfaces. Wipe all flat surfaces that have come in immediate contact with a patient or body</li> </ol>		<p>S432 Black light kit has been purchased as an extra measure to determine randomly determine if the cleaning task was performed S432 New logs were created to indicate person responsible for task with initials S432 Meeting with contracted services took place on Aug 1 to discuss education, training and approved chemicals to be used S432 Contracted services have supplied us with competency training on Infection Control and OSHA S432 Mixing devise will be installed by the end of month to eliminate incorrect ratios of detergent being used S432 Staff have been advised of MSDS use via internet and educated on cleaning products available for use S432 Use of cleaning products have been determined and outlined in policy and procedure S432 Contracted services has been informed that they are prohibited from bringing outside products not approved by SESC into the facility S432 New policy was presented to the Board of Managers on 08/06/14 Monitoring will be overseen by Nurse Manager and reported to at the Q/A meetings.</p>	

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	<p>fluids with a disinfectant cleaning solution."</p> <p>3. While in the surgical area at 1:10 PM on 07/09/14, a bucket with mop water was observed in the area. Staff member A9 indicated the solution was mixed with water with Bleach-Rite for a 1 to 6 ratio (1 part chemical to 6 parts water). The label on the container of Bleach-Rite indicated the chemical was ready-to-use and there were no dilution directions.</p> <p>4. The janitor's closet was observed with a caddy containing spray bottles of Lysol, Chlorox Bleach Cleaner, Glass-Plus, Method Shower Cleaner, and The Works toilet cleaner. At 3:00 PM on 07/09/14, staff member A1 indicated the housekeeping staff came after hours and he/she was not aware of what cleaning products they used.</p> <p>5. At 11:10 AM on 07/10/14, the binder from the contracted cleaning staff was reviewed and documentation indicated the operating rooms were cleaned with "Vindicator". Staff member A1 indicated he/she had never heard of that and there was no documentation of approval by the Infection Control Committee. He/she indicated there was no documentation of observations of the cleaning crew to ensure they used the proper chemicals</p>			

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S000444	<p>appropriately.</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 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 observation, policy review, and interview, the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks.</p> <p>Findings included:</p> <p>1. While observing in the pre-op area between 10:10 AM and 11:10 AM on 07/09/14, three different staff members were observed coming out of the surgical area, going to the nurses' station, and talking with patients with their surgical masks hanging around their necks, then returning to the surgical area. At 11:20 AM, the anesthesiologist, staff member A7, came out of an OR (Operating</p>	S000444	<p>Staff have been advised that upon leaving the surgical suite that all gloves and masks must be removed and new masks and gloves must be applied to re-enter surgical suite. See Memo Nurse Manager will monitor to ensure staff is following procedures. This will also be monitored at our Q/A meetings.</p>	07/31/2014

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S001010	<p>Room) suite with a surgical mask and gloves on, pulled the mask down around his/her neck, but left the gloves on, and went in to check the case observation patient in the block area prior to surgery. He/she then removed the gloves and performed hand hygiene, but pulled the same mask back up to treat the patient. At 1:30 PM, staff member A9 was observed going in to the employee lounge with a surgical mask hanging around the neck.</p> <p>2. The facility policy "Surgical Attire", last reviewed 08/05/11, indicated, "VI. Surgical Masks: ...c. A fresh, clean surgical mask should be worn for every procedure. ...d. Surgical masks should be discarded after each procedure."</p> <p>3. At 2:45 PM on 07/10/14, staff member A1 confirmed the facility followed AORN recommendations which indicated surgical masks were to be changed between cases and not worn around the neck or stored in pockets.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the</p>			

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	<p>following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, interview, and policy review, the facility failed to ensure all medications were stored, labeled, and discarded according to policy.</p> <p>Findings included:</p> <p>1. During the tour of the surgical area at 12:30 PM on 07/09/14, accompanied by staff member A1, the following items were observed in the top drawer of the anesthesia cart in Operating Room 1:</p> <p>A. A 10 ml. (milliliter) uncapped vial of Succinylcholine with an expiration date of 1 Apr. 2014.</p> <p>B. An opened, but not dated, 20 ml. vial of Labetalol.</p> <p>C. An opened, but not dated, 10 ml. vial of Phenylephrine HCl.</p> <p>D. A 10 ml. vial of Brevibloc with an expiration date of 05/2014.</p> <p>A plastic bin on the counter contained an open, but not dated, 30 ml. vial of Epinephrine and two open, but not dated, 50 ml. vials of Marcaine.</p>	S001010	S1146 Policy and Procedures have been updated to reflect multi-dose injections. S1146 Staff has been re-educated regarding open medication, dating vials and expiration dates. Staff will follow procedures as outlined and various checks will be performed by Mary Driskell, Nurse Manager.	08/13/2014

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	<p>2. At 12:30 PM on 07/09/14, staff member A1 indicated staff member A6 checked the medication in the anesthesia carts. Staff member A6 indicated the Succinylcholine had not been punctured even though it was uncapped and the Brevibloc was kept because the facility cannot get any more at this time.</p> <p>3. The facility policy "Medication Standards", last reviewed 08/05/11, indicated, "17. Multi-dose vials: ...d. Discard multidose vials when suspected or visible contamination occurs, when the manufacturer's stated expiration date is reached, or 28 days past the date opened. e. Date ALL multidose vials with the date you opened the vial. f. Discard undated vials."</p> <p>4. The facility policy "Monitoring Medication Outdates", last reviewed 08/05/11, indicated, "1. Nursing personnel will check department medication inventory monthly. All multi-dose vials will be dated upon opening and will be discarded after 28 days. ...3. Dispose of all medications that will be outdated during the current month."</p> <p>5. The facility policy "Maintaining Medication Par Levels", last reviewed</p>			

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S001146	<p>08/05/11, indicated, "7. Anesthesia care provider is responsible for restocking anesthesia carts at the end of each day. Expiration dates will be checked monthly."</p> <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 maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, documentation review, and staff interview, the facility failed to maintain the hospital environment and equipment in such a manner that the safety and well-being of patients, visitors, and/or staff are assured in four (4) instances: electrical room, main hallway, nutrition pantry and PACU (post anesthesia care unit).</p>	S001146	<p>S 1146 Garden tool and ceiling tiles were removed from the electrical room S 1146 Skids/Carts will be replaced with a shelving unit that will not impede the clearance for an exit hallway S1146 Delivery services has been advised not to place boxes outside the clearance space S1146 The CO2 tank was reconnected at inspection S1146 The blanket warmer electronic control module is broken at inspection the unit was unplugged and an out of service sign was placed S1146 We have contacted our service team to determine if the unit can be fixed or that it</p>	08/05/2014

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	<p>Findings included:</p> <ol style="list-style-type: none"> <li>At 11:40 AM on 7/10/2014, the main electrical room was observed with assorted electrical panels and transfer switches. The transfer switchers were observed with warning signs on them indicating possible electrical shocks and fire hazards. The room was storing assorted shipping boxes and assorted garden steel tools. The tools were observed leaning against one of the electrical panels, which could contribute to a fire hazard or electrical shocks.</li> <li>At 11:50 AM on 7/10/2014, the rear hallway of the surgery center was observed as the receiving/holding station for health care supplies that are delivered for the facility. Storage cart and skid was observed in the hallway for the facility to receive their boxes on. Before the medical supply company delivered the facility's order, the skid and cart were observed storing items from</li> </ol>		<p>needs to be disposed of S1146 New policy and procedure along with monitoring logs have been implemented with staff S1146 Mechanical department has been contacted again to determine if the warmer can be fixed or that it needs to be disposed of S1146 The solution bags will be dated and the policy will reflect the changes. All facility plan of corrections have taken place. Monthly walk through will be performed by Nurse Manager to double check that no violations are taking place and findings will be reported to the Q/A committee.</p>	

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	<p>previous weeks. After the company has delivered the order, it was 39 inches from the storage boxes to the wall. The restriction of the hallway access to the EXIT door would pose a concern in egress of an emergency evacuation of the building through the fire exit door.</p> <p>3. Life Safety Code NFPA 20/21.2.3.2 indicated the clear width of any corridor required for exit access shall not be less than 44 inches.</p> <p>4. At 12:30 PM on 7/10/2014, the nutrition pantry located in the PACU area was observed with an unsecured carbon dioxide tank which was connected to the fountain soda dispensing station.</p> <p>5. At 1:45 PM on 7/10/2014, staff member #10 indicated the surgery center complies with Life Safety Code regulations and confirmed the width from the supplies to the wall was not in compliance. The</p>			

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	<p>staff member confirmed the three instances observed during the environmental tour were not compliant.</p> <p>6. During the tour of the facility at 10:10 AM on 07/09/14, accompanied by staff member A1, a small warming unit containing blankets was observed in the PACU (post anesthesia care unit). The interior of the unit was very warm to touch and the digital temperature read-out on the outside read 193 with a dot between the 9 and the 3, but at the top of the numbers, not at the bottom like a decimal point. Staff member A1 indicated the warmer was not registering properly, but staff was told not to turn it off by biomed. There was no signage indicating the warmer was not working properly and should not be used.</p> <p>7. During the tour of the surgical area at 11:20 AM on 07/09/14, accompanied by staff member A1, a large 2-compartment warmer was observed with the top registering</p>			

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	<p>107 degrees F. (Fahrenheit) and the bottom registering 108 degrees F. The top portion contained ten 250 ml. (milliliter) bottles of 0.9 Normal Saline for irrigation. The bottom portion contained three 1000 ml. intravenous Lactated Ringers bags in plastic wrap and ten 3000 ml. Lactated Ringers irrigation solution in plastic wraps. None of the solutions were dated. Staff member A1 indicated all of the solutions were used for irrigation and they did not remain in the warmer long before they were used. He/she indicated he/she did not know manufacturer's recommendations regarding temperature and length of time in the warmer. He/she indicated the temperature range of "90- 111 degrees" on the log sheet came from the manufacturer.</p> <p>8. The temperature monitoring logs for the warmer in the OR (Operating Room) for June and July 2014 indicated the temperatures ranged between 100</p>			

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	<p>and 115 degrees F.</p> <p>9. At 9:45 AM on 07/10/14, staff member A1 provided documentation dated July 10, 2014 from Baxter, the fluid manufacturer which indicated, "This is the information you have requested regarding the intentional warming of both irrigation and intravenous solutions in plastic bag containers and irrigation solutions in plastic pour bottle containers manufactured by Baxter Healthcare Corporation (Baxter). ...IV solutions of volumes 150 ml. or greater can be warmed in their plastic overpouches to temperatures not exceeding 40 degrees C. (104 degrees F.), and for a period no longer than 14 days. ...Warming of Irrigation Solutions in Plastic Pour Bottles: ... (1) Solutions can be warmed to temperatures not exceeding 50 degrees C (122 degrees F) and for a period no longer than 60 days."</p> <p>10. When temperature monitoring</p>			

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NAME OF PROVIDER OR SUPPLIER  SOUTH EMERSON SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8141 S EMERSON AVE STE C INDIANAPOLIS, IN 46237
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	<p>logs for the warmer in PACU were requested, staff member A10 provided the log for June 2014 which indicated the temperature ranged between 90 and 98 degrees F. and each day was initialed by staff member A10. When questioned, at 11:25 AM on 07/10/14, about whether he/she actually worked every day, staff member A10 indicated he/she did not, but other staff members actually checked the temperature and let him/her know what it was.</p> <p>11. At 1:30 PM on 07/10/14, staff member A10 indicated the PACU warmer had been having problems right after staff returned from the Memorial Day holiday; however, there was no signage on the warmer, blankets were still in the warmer, and the temperature log for June indicated the temperatures were in the acceptable range. Work Order documentation indicated service was requested on 06/19/14.</p>			

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	12. The facility policy "Blanket and Solution Warming Cabinet Temperature", last reviewed 08/05/11, indicated, "Procedure: 1. The warming cabinet temperature should be checked at regular intervals and documented on a temperature log. 2. If solution is stored in the warming cabinet, the cabinet should be labeled with safe temperature range of 90 to 111 degrees. 3. The responsibility for setting, maintaining, and monitoring warmers should be assigned to specific department's staff members. 4. If solution is stored in the warming cabinet, the cabinet should be labeled temp range settings. 5. Temperature of solutions is the responsibility of the surgeon and is a matter of individual professional judgement and practice. 6. Cabinet temperature malfunctions should be reported to clinical engineering for maintenance. ...8. Blanket warming cabinet temperatures should not exceed 150 degrees. 9. Blankets should be rotated on a			

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	<p>first-in, first-out basis. ...11. Solutions should be rotated on a first-in, first-out basis."</p> <p>13. The facility policy "Electrical Equipment", last reviewed 08/05/11, indicated, "2. Any equipment found to be defective is tagged, removed from service, and reported to the Clinical Nurse Manager."</p> <p>14. AORN (Association of periOperative Registered Nurses) recommendations indicated both fluid and blanket warmers should be monitored regularly with blanket cabinets not above 130 degrees F. and fluids warmed and stored according to manufacturer guidelines.</p> <p>15. At 11:45 AM on 07/10/14, staff member A1 confirmed the facility followed AORN recommendations, but indicated the fluids did not remain in the warmer for any length of time and staff was aware of the problems with the</p>			

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	PACU warmer and were not using those blankets.				