

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001081		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012	
NAME OF PROVIDER OR SUPPLIER  CENTRAL INDIANA ORTHOPEDIC SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3600 W BETHEL AVENUE MUNCIE, IN 47304			
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Q0000	The visit was for a re-certification survey.  Facility Number: 010493  Survey Date: 10-09-12 to 10-11-12  Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor  Linda Plummer, RN Public Health Nurse Surveyor  QA: claughlin 11/05/12	O0000					

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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Q0201	<p>416.49(a) LABORATORY SERVICES</p> <p>If the ASC performs laboratory services, it must meet the requirements of Part 493 of this chapter. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of this chapter. The referral laboratory must be certified in the appropriate specialties and subspecialties of services to perform the referral test in accordance with the requirements of Part 493 of this chapter. Based on observation, document review, and staff interview, the facility failed to ensure that point of care testing supplies had not expired.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>at 3:05 PM on 10/9/12, while on tour of the Pre/Post op nursing station area, in the company of staff member #57, (a Pre/Post op nurse who acts as the pharmacy contact person), it was observed that 6 pregnancy tests had expired 8/2012</li> <li>at 3:06 PM on 10/9/12, interview with staff member #57 indicated the pregnancy tests are to be checked monthly for expiration dates</li> <li>at 12:05 PM on 10/11/12, review of the quarterly cleaning schedule ("Cabinet Cleaning Checklist") for the "Prep and Recovery" areas indicated the last time</li> </ol>	Q0201	<ol style="list-style-type: none"> <li>Removed expired pregnancy tests from stock on 10/9/2012.</li> <li>Implemented a check sheet to check the expiration dates of medication preparation supply cabinet monthly. The staff was inserviced on 11/12/2012. Our protocol for checking expiration date monthly was attached to the inside of the medication preparation supply cabinet.</li> <li>Prep/Recovery Nurses are responsible for checking this on a monthly basis. The Surgery Director will be responsible for monitoring that the monthly checklist is complete.</li> <li>10/15/2012.</li> </ol>	10/15/2012			

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	<p>cabinets were cleaned in the Pre/Post op nursing station area was 9/18/12</p> <p>4. at 2:30 PM on 10/11/12, review of a document titled "Checking Expiration Dates" indicated:</p> <ul style="list-style-type: none"> <li>a. "Expiration dates should be checked monthly"</li> <li>b. "Products that are expiring that month will be pulled off the shelf and disposed of"</li> <li>c. "Please make sure you tell...if you are removing an item that is expired so that she can make sure we have more available"</li> <li>d. "If a product is due to expire the following month please circle the expiration date in red and let...know."</li> </ul> <p>5. interview with staff members #50 and #52, the surgery director and the OR (operating room) manager, at 2:30 PM on 10/11/12, indicated:</p> <ul style="list-style-type: none"> <li>a. there is no facility policy related to monthly checking for out dated medications and supplies</li> <li>b. the facility process/protocol is listed in the document provided (see 4. above) that is posted in the nursing station for staff to follow</li> <li>c. the pregnancy tests should have been found, and discarded, with the August, or at the latest, the September monthly check for out dates</li> </ul>			

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Q0242	<p>416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.</p> <p>Based on policy and procedure review, personnel file review, and staff interview, the infection control practitioner failed to implement the policy related to employee health for 1 of 3 PRN (as needed) RNs (registered nurses) hired within the last 12 months (staff RN P3).</p> <p>Findings:</p> <p>1. at 4:15 PM on 10/10/12, review of the policy and procedure: "Employee Health", document number: AG-PERS-4 with a date of February 23, 2012, indicated:</p> <p style="padding-left: 20px;">a. under "Policy", it reads in section 2., "The Surgery Director shall ensure all employees have proof of immunity to hepatitis B (or evidence the series was offered and refused),..."</p> <p>2. review of personnel files at 1:05 PM on 10/9/12 indicated:</p> <p style="padding-left: 20px;">a. staff RN P3 was hired 4/2/12 and had a "Hep B Surface" titer drawn on the same date</p> <p style="padding-left: 20px;">b. the Hepatitis result for staff member</p>	00242	<p>1. A repeat Hepatitis B series was started on October 26, 2012 for this employee. 2. In addition to our annual employee file review, we have revised our procedure. Employee immunization records will be monitored for correctness of results and signed by two RNs before it is placed in the employee's record. 3. The Director of Surgery is responsible. 4. Change was implemented on 10/11/2012.</p>	10/11/2012			

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	<p>P3 was "0.27" with the notation by the lab that values of "0.00 - 0.99" were "Inconsistent with Immunity"</p> <p>3. interview with staff members #50, the Director of Surgery, and #51, the OR (operating room) Surgery Manager and Safety Manager, indicated:</p> <p>a. the 4/2/12 Hepatitis results indicate staff member P3 is not immune for Hepatitis B</p> <p>b. this was "missed" by facility staff</p> <p>c. staff member P3 should have been notified of this lab result and offered a booster for Hepatitis B, per facility protocol</p>				

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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 010493</p> <p>Survey Date: 10-09-12 to 10-11-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Linda Plummer, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 11/05/12</p>	S0000			

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S0442	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on policy and procedure review, personnel file review, and staff interview, the infection control practitioner failed to implement the policy related to employee health for 1 of 3 PRN (as needed) RNs (registered nurses) hired within the last 12 months (staff RN P3).</p> <p>Findings: 1. at 4:15 PM on 10/10/12, review of the policy and procedure: "Employee Health", document number: AG-PERS-4 with a date of February 23, 2012, indicated: a. under "Policy", it reads in section 2., "The Surgery Director shall ensure all employees have proof of immunity to hepatitis B (or evidence the series was offered and refused),..."</p>	S0442	<p>1. A repeat Hepatitis B series was started on October 26, 2012 for this employee. 2. In addition to our annual employee file review, we have revised our procedure. Employee immunization records will be monitored for correctness of results and signed by two RNs before it is placed in the employee's record. 3. The Director of Surgery is responsible. 4. Change was implemented on 10/11/2012.</p>	10/11/2012			

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	<p>2. review of personnel files at 1:05 PM on 10/9/12 indicated:</p> <p>a. staff RN P3 was hired 4/2/12 and had a "Hep B Surface" titer drawn on the same date</p> <p>b. the Hepatitis result for staff member P3 was "0.27" with the notation by the lab that values of "0.00 - 0.99" were "Inconsistent with Immunity"</p> <p>3. interview with staff members #50, the Director of Surgery, and #51, the OR (operating room) Surgery Manager and Safety Manager, indicated:</p> <p>a. the 4/2/12 Hepatitis results indicate staff member P3 is not immune for Hepatitis B</p> <p>b. this was "missed" by facility staff</p> <p>c. staff member P3 should have been notified of this lab result and offered a booster for Hepatitis B, per facility protocol</p>				

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S0504	<p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2(a)</p> <p>(a) The center shall provide, or make available, those pathology and medical laboratory services and consultation necessary to meet the needs of patients as determined by the medical staff.</p> <p>Based on observation, document review, and staff interview, the facility failed to ensure that point of care testing supplies had not expired.</p> <p>Findings:</p> <p>1. at 3:05 PM on 10/9/12, while on tour of the Pre/Post op nursing station area, in the company of staff member #57, (a Pre/Post op nurse who acts as the pharmacy contact person), it was observed that 6 pregnancy tests had expired 8/2012</p> <p>2. at 3:06 PM on 10/9/12, interview with staff member #57 indicated the pregnancy tests are to be checked monthly for expiration dates</p> <p>3. at 12:05 PM on 10/11/12, review of the quarterly cleaning schedule ("Cabinet Cleaning Checklist") for the "Prep and Recovery" areas indicated the last time cabinets were cleaned in the Pre/Post op nursing station area was 9/18/12</p>	S0504	<p>1. Removed expired pregnancy tests from stock on 10/9/2012.2. Implemented a check sheet to check the expiration dates of medication preparation supply cabinet monthly. The staff was inserviced on 11/12/2012.Our protocol for checking expiration date monthly was attached to the inside of the medication preparation supply cabinet.3. Prep/Recovery Nurses are responsible for checking this on a monthly basis.The Surgery Director will be responsible for monitoring that the monthly checklist is complete.4. 10/15/2012.</p>	10/15/2012			

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	<p>4. at 2:30 PM on 10/11/12, review of a document titled "Checking Expiration Dates" indicated:</p> <ul style="list-style-type: none"> <li>a. "Expiration dates should be checked monthly"</li> <li>b. "Products that are expiring that month will be pulled off the shelf and disposed of"</li> <li>c. "Please make sure you tell...if you are removing an item that is expired so that she can make sure we have more available"</li> <li>d. "If a product is due to expire the following month please circle the expiration date in red and let...know."</li> </ul> <p>5. interview with staff members #50 and #52, the surgery director and the OR (operating room) manager, at 2:30 PM on 10/11/12, indicated:</p> <ul style="list-style-type: none"> <li>a. there is no facility policy related to monthly checking for out dated medications and supplies</li> <li>b. the facility process/protocol is listed in the document provided (see 4. above) that is posted in the nursing station for staff to follow</li> <li>c. the pregnancy tests should have been found, and discarded, with the August, or at the latest, the September monthly check for out dates</li> </ul>			

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S1164	<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 observation, manufacturer's manual review, document review, and interview, the facility failed to ensure the blanket warmer was maintained per manufacturer's recommendations.</p> <p>Findings: 1. at 11:40 AM on 10/10/12, review of the manufacturer's "Operation and Maintenance" manual for the Blickman Digital Warming Cabinet indicated: a. under "Operating Instructions", it reads: "...Maintenance and Component Replacement Procedures...2. Periodically,</p>	S1164	<p>1. The blanket warmer heater compartment was cleaned on 10/9/2012.2. A monthly checklist for cleaning the heater compartment of the blanket warmer was developed on 10/10/2012.3. The Facility Manager will ensure that the heater compartment of the blanket warmer is cleaned monthly.4. 10/10/2012.</p>	10/12/2012

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	<p>lint or threads may accumulate in the heater compartment. Removing the false bottom permits access to this area and vacuuming or cleaning can help keep the unit operating more efficiently."</p> <p>2. at 3:30 PM on 10/9/12, while in the Pre/Post op patient care area in the presence of staff member #57, a Pre/Post op nurse, the Blickman blanket warmer was observed to have a build up of dust under the false bottom shelf of the unit</p> <p>3. interview with staff member #57 at 3:33 PM on 10/9/12, indicated:</p> <p>a. staff was unaware that the bottom shelf was removable</p> <p>b. nursing staff does not routinely clean under the false bottom shelf</p> <p>4. at 12:05 PM on 10/11/12, review of the quarterly cleaning schedule ("Cabinet Cleaning Checklist") for the "Prep and Recovery" areas indicated the blanket warmer is not listed on this checklist.</p> <p>5. interview with staff members #50 and #52, the surgery director and the OR (operating room) manager, at 2:30 PM on 10/11/12, indicated:</p> <p>a. staff reports cleaning the top of the blanket warmer and the shelves, but not under the false bottom shelf, as recommended in the blanket warmer</p>				

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	manual			