

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001169	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
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NAME OF PROVIDER OR SUPPLIER INDIANA SPECIALTY SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 W ARCH HAVEN AVE BLOOMINGTON, IN 47403
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S000000	<p>This visit was for the investigation of one (1) State complaint.</p> <p>Date of survey: 6-6-13</p> <p>Facility number: 011996</p> <p>Complaint number: IN00129120 Substantiated; Deficiencies related to allegations cited.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 07/15/13</p>	S000000		

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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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 observation, document review and interview, the facility failed to allow sufficient time between procedures for effective disinfection of the room, failed to store boxes of supplies on shelving units and not on the floor, failed to keep shower stalls available for use, failed to store clean mop heads in a clean room, and failed to dispose of disposable linens after a procedure.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of patient #13 medical record indicated the following: <ul style="list-style-type: none"> (A) He/she had a pain management procedure performed in the procedure room on 5/21/13. (B) He/she exited the procedure room at 1717. Review of patient #10 medical record indicated the following: <ul style="list-style-type: none"> (A) He/she had a pain management procedure performed in the procedure room on 5/21/13. (B) He/she entered the procedure room at 	S000400	<p>Effective 6-21-13, the staff participating in pain management procedures have been setting a timer to help manage recognition of the contact time for the disinfectant solution. The Administrator/designee is responsible for evaluating compliance by monitoring procedure time documentation in the patient's record on a weekly basis, and spot-checking practice. Shelving has been provided in the receiving area for supplies delivered. The Administrator/designee is responsible for assuring compliance with this practice and will monitor on a daily basis. The shower stall are emptied and clean mop heads have been relocated to cabinets in each operating room. The Administrator/designee will evaluate on a monthly basis for compliance. Staff have been re-educated that any sterile towel that remained on the field during a surgical procedure must be disposed of after the completion of the case. The Administrator/designee will observe for compliance on a</p>	07/26/2013			

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	<p>1719 (2 minute after patient #13 exited) and exited the room at 1735.</p> <p>3. Review of patient #11 medical record indicated the following: (A) He/she had a pain management procedure performed in the procedure room on 5/21/13. (B) He/she entered the procedure room at 1738. (3 minutes after patient #10 exited the room)</p> <p>4. Review of label instructions for Caviwipes indicated that the surface must remain visibly wet for a period of 3 minutes for use as a disinfectant.</p> <p>5. During tour of the facility beginning at 10:35 a.m. on 6/6/13 the following observations were made: (A) Both facility showers were full of boxes and items. The showers were not functional due to the amount of items stored in them. (B) Numerous boxes of supplies were stored directly on the floor in the staff lounge. (C) Clean mop heads were observed stored in the soiled utility room.</p> <p>6. Numerous staff indicated that boxes are in the lounge including, but not limited to: (A) Staff member #N8 indicated in</p>		weekly basis. Staff were instructed on each of these items during staff meeting 7-19-13.		

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	<p>interview beginning at 11:10 a.m. on 6/6/13 that supplies are kept in the staff lounge and are put away in "a day or 2." (B) Staff member #N7 indicated in interview beginning at 11:20 a.m. on 6/6/13 that the boxes observed during tour were boxes borrowed from another facility and included, but was not limited to, IV fluids, a vapor generator, and knee coolers for ice.</p> <p>7. Staff members #N1-N7 indicated in interviews beginning at 11:10 a.m. on 6/6/13 that the showers are used for storage.</p> <p>8. Staff member #N1 indicated the following in interview beginning at 12:49 p.m. on 6/6/13: (A) If towels from a case are not soiled, he/she will use them to wrap instruments for sterilization to cut down on cost. The towels are kept back after the case to use for this. The towels are supposed to be disposed of after the case.</p>				

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S000428	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</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>(i) Sanitation.</p> <p>Based on document review and observation, the facility failed to ensure the operating room (OR) was cleaned according to facility policy for 1 OR cleaning observed.</p> <p>Findings include:</p> <p>1. Facility policy titled "ASC ENVIRONMENTAL CLEANING POLICY & PROCEDURE" last reviewed/revised 1/28/13 states on page 2: "4. Cleaning of OR/procedure room between procedures must be done with a facility-approved, EPA-registered disinfectantd. Collect and remove trash. Soiled sponges, suction canisters, tubing, and other waste should be handled as infectious waste. Clean outside of suction canisters; lift the bag and carry it out of the operating room to the pick-up point for this trash. e. Remove gloves</p>	S000428	<p>On 6-28-13, each OR circulator reviewed the ASC Environmental Cleaning Policy, including the sequence of cleaning steps, along with the surgical technologists. On 7-19-13, the steps for cleaning the OR were reviewed at staff meeting. Additionally, the sequence of steps was placed on a laminated poster and placed in each OR and treatment room for immediate reference. The Administrator/designee is responsible for assuring compliance and will monitor on a weekly basis.</p>	07/19/2013			

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	<p>and clean hands f. Use a cloth dampened in disinfectant solution to clean and disinfect horizontal surfaces that have come in contact with a patient or body fluids.....h. Damp mop floor only if visibly soiled; allow to air dry...."</p> <p>2. During tour of the facility beginning at 10:35 a.m. on 6/6/13, staff member #N4 was observed cleaning OR #2 after a procedure. There was a pink tinged liquid visible on the floor. He/she was observed picking up a foot pedal to a piece of equipment from the floor that was dripping with liquid and wiping it quickly with a cleaning wipe. There was nothing used to absorb the liquid from the piece prior to using a disinfectant wipe. After wiping, the pedal was put away within the room. He/she was cleaning the surfaces within the room and the trash had not been removed nor had the canisters full of blood tinged solution been removed per facility policy.</p>			

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S000436	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(v)</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>(v) Reuse of disposables.</p> <p>Based on document review and interviews, the facility failed to follow manufacturers recommendations and facility policy related to single use medical devices.</p> <p>Findings include:</p> <p>1. Facility policy titled "REPROCESSING SINGLE-USE MEDICAL DEVICES" last reviewed/revised 1/28/13 states on page 1: ".....3. Single-use medical devices shall not be reprocessed within the facility."</p> <p>2. Review of sterilization logs for sterilizers #1 and #2 for May 2013 indicated the following: (A) On 5/7/13 at 12:43 p.m. the facility sterilized the biceps drill and tendon guide on a regular cycle in sterilizer #1.</p>	S000436	By June 14, 2013, all staff responsible for sterilization were instructed that single-use items that were identified by the manufacturer as not able to be resterilized were not to be resterilized within the Center. This information was repeated during staff meeting 7-19-13. This practice will be monitored by the Administrator/designee by observation of sterilization records on a weekly basis until the practice has been demonstrated as terminated for 2 months, then spot-checks after that time.	06/14/2013			

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	<p>Per manufacturer interview, this is a sterile, single patient use item.</p> <p>(B) On 5/21/13 at 2:54 p.m. the facility sterilized the biceps drill and tendon guide on a regular cycle in sterilizer #1.</p> <p>3. Staff member #N7 indicated in interview beginning at 11:20 a.m. on 6/6/13 that the facility reprocesses the guide pin for biceps tendon procedure.</p> <p>4. Staff member #A1 indicated via email at 12:59 p.m. on 6/11/13 that the Wire, Pin and Drill Pac is referred to as biceps drill and tendon guide on the sterilization logs.</p> <p>5. Employee #A at MTB1 customer service indicated in phone interview at 12:00 p.m. on 6/11/13 that the wire, pin and drill pac REF #7209204 is a sterile item for single patient use.</p>				

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S000444	<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 document review, observation, and interview, the facility failed to ensure surgical scrubs were stored according to acceptable standards of practice, failed to ensure staff changed into clean clothing after taking out trash and prior to entering the OR corridors, and failed to address the use of cover gowns or changing of scrubs after going outside with trash in their policy.</p> <p>Findings include:</p> <p>1. AORN recommended practices for surgical attire states on page 2: "Recommendation II Clean surgical attire, including shoes, head covering.... should be worn in the semirestricted and restricted areas of the surgical or invasive procedure setting.... and page 12 states:</p>	S000444	The scrubs in both the male and female locker rooms are not stored in lockers, but placed on designated wire shelves with nylon covers. Street clothes are not stored within the wire shelves and are not touching the scrubs. Staff and credentialed practitioners were directed not to leave the Center wearing scrubs. Policy entitled "Operating Room Attire" was revised to direct staff leaving the building to empty trash to wear a cover gown over scrubs for that event. Staff was apprised of these guidelines by staff meeting 7-19-13. The Administrator/designee will monitor for compliance by observation weekly.	07/19/2013

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	<p>"v.b. Clean surgical attire should be stored in a clean, enclosed cart or cabinet. Storing clean surgical attire in a locker with personal items from outside of the hospital may contaminate the clean surgical attire. Enteric viruses have been detected in lockers where contaminated attire can act as reservoirs for viral transmission....."</p> <p>2. Facility policy titled "OPERATING ROOM RULES" last reviewed/revised 1/28/13 contains dress code criteria, however does not address dress code requirements for staff exiting the building and returning.</p> <p>3. The following observations were made during tour beginning at 10:35 a.m. on 6/6/13: (A) Staff member #N7 was observed taking a bag of trash out the employee exit. He/she was wearing scrubs and was observed going into the semi-restricted OR corridor after taking out the trash. (B) Clean scrubs were observed in bins on a shelf in the locker room. The bins also contained personal clothing in or upon the bins. Additionally, clean scrubs were observed in an open personnel locker that also contained personal supplies including books.</p> <p>4. Staff member #N7 indicated the</p>				

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	<p>following in interview beginning at 11:20 a.m. on 6/6/13:</p> <p>(A) When asked about being in the OR hall after taking trash out, he/she replied that if he/she went into the OR, he/she would change their scrubs after being outside.</p> <p>(B) He/she indicated that their scrubs are stored in their locker.</p>			

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S000450	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(g)</p> <p>(g) Sterilization of equipment and supplies must be provided, within the scope of the service offered, in accordance with acceptable standards of practice or manufacturer's recommendations and applicable state laws and rules, 410 IAC 1-4. Sterilization services must be directed by a qualified person or persons and must provide for the following:</p> <p>Based on document review and staff interview, the facility failed to provide sterilization services according to facility policy for two (2) pieces of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "STERILIZATION GUIDELINES: SHORT STERILIZATION CYCLE" last reviewed/revised 1/28/13 states on page 1: ".....7. Only in the event of an urgent or unpredicted need for a specific device, such as when an instrument is dropped, should this cycle be run with an unwrapped or uncontained load." 2. Review of sterilization logs for sterilizers #1 and #2 for May 2013 indicated the following: (A) The facility flashed in sterilizer #2 the CRT tomes on numerous dates 	S000450	All staff directly participating in sterilization were instructed to sterilize instruments according to policy, and that the CTR tomes and Berend's nips would require a minimum run time of 10 minutes, not short cycle immediate use. During staff meeting 7-19-13, all staff were updated on the purpose of the short cycle, immediate use sterilization policy and its application. The Administrator/designee will monitor for compliance on a weekly basis.	07/19/2013

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	<p>including, but not limited to, 5/3/13 at 12:02 p.m. and 12:43 p.m. and on 5/14/13 at 8:15 a.m. and 9:23 a.m.</p> <p>(B) The facility flashed in sterilizer #2 the Berend nips on 5/31/13 at 7:44 a.m. and at 9:23 a.m. on same date.</p> <p>3. Staff member #A1 indicated the following in interview beginning at 3:15 p.m. on 6/6/13:</p> <p>(A) The facility has only 1 Berend Nips and the CTR tomes are reprocessed (by flash) due to back to back procedures and the manufacturer no longer makes them and the surgeon likes it.</p>			