

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001017	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2013
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NAME OF PROVIDER OR SUPPLIER MUNCIE EYE SPECIALISTS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N TILLOTSON AVE MUNCIE, IN 47304
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S000000	The visit was for a licensure survey. Facility Number: 005398 Survey Date: 9-03-13 to 9-04-13 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 09/09/13	S000000	Correct	
S000122	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3) The governing body shall do the following: (3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body. Based on document review and interview, the governing board failed to review and approve the medical staff bylaws within the past three years. Findings:	S000122	The Medical Staff is responsible for approving the bylaws and rules, and the bylaws and rules are reviewed and approved at least triennially by the governing body. The ASC Patient Care Manager will present to the medical staff the bylaws and rules	10/18/2013

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>1. On 9-03-13 at 0930 hours, staff A1 was requested to provide documentation indicating governing board approval of the medical staff bylaws, rules and regulations and none was provided prior to exit.</p> <p>2. The Bylaws of the Medical Staff of the Eye Specialists Surgery Center (approved 12-09) lacked signed and dated evidence of approval by the governing at least every three years.</p> <p>3. The governing board meeting minutes for 2010, 2011, 2012 and 2013 failed to document that the governing board had reviewed and approved the medical staff bylaws.</p> <p>4. During an interview on 9-04-13 at 1345 hours, staff A1 confirmed that the center lacked documentation of governing board approval of its medical staff bylaws within the past 3 years.</p> <p>5. During an interview on 9-04-13 at 1445 hours, medical staff A3 confirmed that the center lacked documentation of governing board approval of its medical staff bylaws within the past 3 years.</p>		for approval and then to the governing board for approval by October 18, 2013. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compicance.		

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S000166	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.</p> <p>Based upon document review and interview, the center failed to ensure that its policies/procedures were updated and reviewed at least triennially.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The document Reportable Events observed in the center policy binder between Policy 1.05 Quality Assessment and Risk Management Plan (revised 9-12) and Policy 1.07 Risk Management Program (revised 2-11) failed to indicate the surgery center name and a date of approval by a responsible person. 2. During an interview on 9-03-13 at 1630 hours, staff A1 confirmed that the document lacked evidence of center adoption or approval within the last three years. 	S000166	Document (Reportable Events) left in policy & procedure book for guidance was removed. Policy 14.02, which was updated 1-2013 to incorporate these reportable events & procedures, is reflected in facility's policy & procedure book. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	10/28/2013			

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S000226	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(3)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(3) Ensure that the center maintains a list of all contracted services, including the scope and nature of the services provided.</p> <p>Based on document review, the center failed to maintain a list of all contracted services, including the scope and nature of services provided, for 2 of 31 services.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. The document QA/PI Monitors failed to indicate 2 eye lens providers identified through a document review. 2. On 9-04-13 at 1415 hours, staff A1 confirmed that contracted services listed on the QA/PI Monitors lacked the indicated lens providers. 	S000226	The QA/PI Monitors was updated to include the two lens providers on September 11, 2013. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	09/11/2013			

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S000334	<p>410 IAC 15-2.4-2.2(a)(2) QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(2)</p> <p>(2) A process for reporting to the department each reportable event listed in subdivision (1) that is determined by the center's quality assessment and improvement program to have occurred within the center.</p> <p>(b) Subject to subsection (e), the process for determining the occurrence of the reportable events listed in subsection (a)(1) by the center's quality assessment and improvement program shall be designed by the center to accurately determine the occurrence of any of the reportable events listed in subsection (a)(1) within the center in a timely manner.</p> <p>(c) Subject to subsection (e), the process for reporting the occurrence of a reportable event listed in subsection (a)(1) shall comply with the following:</p> <p>(1) The report shall:</p> <p>(A) be made to the department;</p> <p>(B) be submitted not later than fifteen (15) working days after the reportable event is determined to have occurred by the center's quality assessment and improvement program;</p> <p>(C) be submitted not later than four (4) months after the potential reportable event is brought to the program's attention; and (D) identify the reportable event, the quarter of occurrence, and the center, but shall not include any identifying information for any:</p> <p>(i) patient;</p> <p>(ii) individual licensed under IC 25; or</p> <p>(iii) center employee involved;</p> <p>or any other information.</p> <p>(2) A potential reportable event may be identified by a center that:</p>			

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	<p>(A) receives a patient as a transfer; or</p> <p>(b) admits a patient subsequent to discharge;</p> <p>from another health care facility subject to a reportable event requirement. In the event that a center identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying center shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility's quality assessment and improvement program.</p> <p>(3) The report, and any documents permitted under this section to accompany the report, shall be submitted in an electronic format, including a format for electronically affixed signatures.</p> <p>(4) A quality assessment and improvement program may refrain from making a determination about the occurrence of a reportable event that involves a possible criminal act until criminal charges are filed in the applicable court of law.</p> <p>(d) The center's report of a reportable event listed in subsection (a)(1) shall be used by the department for purposes of publicly reporting the type and number of reportable events occurring within each center. The department's public report will be issued annually.</p> <p>(e) Any serious reportable listed in subsection (a)(1) that:</p> <p>(1) is determined to have occurred within the center between:</p> <p>(A) January 1, 2009; and</p> <p>(B) the effective date of this rule; and</p> <p>(2) has not been previously reported; must be reported within five (5) days of the effective date of this rule. (Indiana State Department of Health; 410 IAC 15-2.4-2.2)</p>			

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	<p>Based on document review and interview, the center lacked a process for reporting each reportable event that was determined by the quality assurance/performance improvement (QAPI) program to have occurred at the center.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 9-03-13 at 0930 hours, staff A1 was requested to provide documentation of the process for reporting events to the Indiana State Department of Health (ISDH) and none was provided prior to exit. 2. The policy/procedure Reportable Events (no approval date) lacked a provision indicating the process identified by state law 410 IAC 15-2.4-2.2(a)(2) for reporting events to the ISDH. 3. During an interview on 9-03-13 at 1630 hours, staff A1 confirmed that the center lacked a policy/procedure for reporting events to the ISDH. 	S000334	Document (Reportable Events) left in policy & procedure book for guidance was removed. Policy 14.02, updated 1-2013, was in policy & procedure book at time of audit. Said policy reflects process for reporting events to the Indiana State Department of Health. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	10/28/2013	

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S000434	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on review of the infection control plan, observation, and interview, the infection control committee failed to ensure a barrier occurred between the decontamination area and the semi-restricted/clean area of the surgery center.</p> <p>Findings:</p> <p>1. at 10:30 AM on 9/4/13, review of the policy and procedure manual (which included the 11 page "Infection Control Program" with a revised date of 2-12), indicated:</p> <p>a. on page two under "The Objectives of the Infection Control Program are:" "...5...Monitoring of sterilization processes..."</p> <p>2. at 11:55 AM on 9/4/13, while on tour of the surgery area with staff member</p>	S000434	Policy 10.00 Infection Control Program will be reviewed with staff with emphasis on barriers between soiled and cleaned areas of the facility by October 18, 2013. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.	10/18/2013			

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	<p>#50, the surgery center supervisor, it was observed that the decontamination room door was propped fully open to the semi restricted/clean area of the center (hallway to operating room suites) while a staff member was cleaning soiled instruments</p> <p>3. interview with staff member #50 at 12:00 PM on 9/4/13 indicated:</p> <p>a. the door to the decontamination room should remain closed except for times when staff are entering or exiting the room</p> <p>b. with the door propped open, there was no barrier between soiled and clean areas of the facility</p>			

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S000442	<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, employee health file review, and staff interview, the infection control committee failed to ensure the immunization history for 2 staff members (N4 and N5).</p> <p>Findings:</p> <p>1. at 9:00 AM on 9/4/13, review of the policy and procedure "Employee Physical Examination", policy number 3.11, with a date of 5-2010 indicated:</p> <p>a. under "Practice and Procedure", in section g., it reads: "Immunization history obtained for Rubeola, Rubella and Varicella..."</p> <p>2. at 12:20 PM on 9/3/13, review of</p>	S000442	Staff member N4 & N5 will have the appropriate titer drawn to reflect immunity status by October 18, 2013. Employees will no longer be able to self report history of Varicella. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	10/18/2013	

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	<p>personnel health files indicated:</p> <p>a. RN (registered nurse) N4 was hired 1/1/10 and had a self reported history of Varicella that was accepted from employment information provided from another facility</p> <p>b. Patient Services Rep N5 was hired April 2013 and lacked any documentation related to having had immunizations for Rubella, Rubeola, or Varicella (or physician's documentation of having had these diseases, or immune titers)</p> <p>3. interview with staff member #50, the surgery center supervisor, at 1:00 PM on 9/3/13 and 4:00 PM on 9/4/13, indicated:</p> <p>a. staff member N4 should have had a titer drawn upon hire, or when staff were re-checked for immunization status a year ago</p> <p>b. staff member N5 transferred from clinic staff to ASC (ambulatory surgery center) staff in April of this year</p> <p>c. it was thought that clinic staff had to have the same health history/immunization documentation as ASC staff</p> <p>d. this staff member "hasn't gotten around to getting N5's labs drawn", yet</p>				

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S000732	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially. Based upon document review and interview, the medical staff failed to follow its policy/procedure and ensure that its bylaws, rules and regulations were reviewed at least triennially.</p> <p>Findings:</p> <ol style="list-style-type: none"> On 11-13-12 at 0930 hours, staff A1 was requested to provide documentation indicating that the medical staff had reviewed its medical staff bylaws, rules and regulations within the past 3 years and none was provided prior to exit. The Bylaws of the Medical Staff of the Eye Specialists Surgery Center (approved 12-09) failed to indicate signed and dated evidence of review by the medical staff at least every three years. The 8-17-10 and 8-06-13 Committee Meeting Minutes as a Whole section heading Medical Staff lacked documentation of the medical staff bylaws approval by the medical staff as 	S000732	The Medical Staff is responsible for approving the bylaws & rules, and that the bylaws & rules are reviewed and approved at least triennially by the governing board. The ASC Patient Care Manager will present to the medical staff the bylaws & rules for approval and then to the governing board for approval by October 18, 2013. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	10/18/2013	

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S000920	<p>otherwise indicated by a footnote [8-10] and [Reviewed by RKS 8-13] on each page of the bylaws provided for review.</p> <p>4. During an interview on 9-04-13 at 1345 hours, staff A1 confirmed that the center lacked documentation of medical staff approval of its bylaws within the past 3 years.</p> <p>5. During an interview on 9-04-13 at 1445 hours, medical staff A3 confirmed that the center lacked documentation of medical staff approval of its bylaws within the past 3 years.</p> <p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following: Based on policy and procedure review, patient medical record review, and staff interview, the nursing supervisor failed to ensure that staff implemented policies related to follow up phone calls for 6 of 12 patients (#4, #5, #6, #8, #14, and #15), and related to discharging patients after less than 15 minutes in recovery for 5 of 12 patients (#4, #5, #6, #7, and #14).</p>	S000920	<p>Policy 5.37 Post Operative Telephone Call will be reviewed with staff that is making the calls and emphasis placed on two attempts to be made to patient by October 18, 2013. Policy 5.32 updated to reflect post operative patient processing procedure, policy pending approval by governing board. The ASC patient care manager will be responsible for completion, implementation & monitoring for compliance.</p>	10/18/2013			

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	<p>Findings:</p> <p>1. at 9:00 AM on 9/4/13, review of the policy and procedure "Post-Operative Telephone Call", policy number 5.37, dated 1-10, indicated:</p> <p>a. under "Practice & Procedures", it reads: "1. Telephone contact will be initiated with the patient within twenty-four to forty-eight hours of surgery...5. In the event the patient is not contacted on the initial attempt, one additional attempt will be made. If that is unsuccessful, appropriate documentation will be made in the medical record and it will be filed."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. #4 had surgery on 8/22/12 and had one unsuccessful follow up phone call made on 8/24/12 with no further attempts made to contact the patient</p> <p>b. pt. #5 had surgery on 8/14/13 and had one unsuccessful follow up phone call made on 8/16/13 with no further attempts made to contact the patient</p> <p>c. pt. #6 had surgery on 8/19/13 and had one unsuccessful follow up phone call made on 8/21/13 with no further attempts made to contact the patient</p> <p>d. pt. #8 had surgery on 8/7/13 and had one unsuccessful follow up phone call made on 8/9/13 with no further attempts made to contact the patient</p>						

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NAME OF PROVIDER OR SUPPLIER MUNCIE EYE SPECIALISTS SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N TILLOTSON AVE MUNCIE, IN 47304
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	<p>e. pt. #14 had surgery on 8/12/13 and had one unsuccessful follow up phone call made on 8/14/13 with no further attempts made to contact the patient</p> <p>f. pt. #15 had surgery on 8/7/13 and had one unsuccessful follow up phone call made on 8/9/13 with no further attempts made to contact the patient</p> <p>3. interview with staff member #50, the surgery center supervisor, at 1:55 PM on 9/4/13 indicated:</p> <p>a. the facility policy requires two attempts at reaching patients for post op follow up</p> <p>b. the patients listed in 2. above lacked a second attempt at contacting patients with a follow up phone call</p> <p>4. at 9:30 AM on 9/4/13, review of the policy and procedure "Post-Operative Patient Processing", policy number 5.32, with a revised date of 2-11, indicated:</p> <p>a. on page two under "Local Anesthetic", it reads: "1. Patient to remain in recovery room until stable, a minimum of 15 minutes..."</p> <p>b. on page two under "IV (intravenous) Sedated Patient", it reads: "1. the patient should remain in the recovery room approximately 15 minutes to one (1) hour depending upon type of surgery..."</p>			

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	<p>5. review of patient medical records indicated:</p> <p>a. pt. #4 had MAC (monitored anesthesia care) with Propofol and was discharged from the PACU (post anesthesia care unit) in 10 minutes (arrived 8:25 AM and discharged 8:35 AM)</p> <p>b. pt. #5 had MAC with IV Midazolam and was discharged from the PACU in 13 minutes (arrived at 10:12 AM and discharged at 10:25 AM)</p> <p>c. pt. #6 had MAC anesthesia with Propofol, Fentanyl, and Midazolam and was discharged from the PACU in 14 minutes (arrived at 10:26 AM and discharged at 10:40 AM)</p> <p>d. pt. #7 was discharged from the PACU in 13 minutes (arrived at 10:37 AM and discharged at 10:50 AM)</p> <p>e. pt. #14 had Mac anesthesia with Fentanyl and Midazolam and was discharged from the PACU in 13 minutes (arrived at 9:07 AM and discharged at 9:20 AM)</p> <p>6. interview with staff member #50, the surgery center supervisor, at 1:55 PM on 9/4/13, indicated:</p> <p>a. it was known that general anesthesia patients needed to remain in PACU for at least 30 minutes, but it was not clear that there was a 15 minute minimum in the facility policy for other types of</p>						

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S001146	<p>anesthesia</p> <p>b. if a minimum of 15 minutes is required for local anesthesia patients, then a minimum of 15 minutes for MAC patients would be appropriate</p> <p>c. the patients listed in 5. above were discharged from the PACU in less than 15 minutes</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 policy and procedure review, observation, and staff interview, the facility failed to ensure that no condition was created that might be a hazard to employees or patients in regard to a dirty microwave oven, two dirty refrigerators, and an accumulation of dust in a blanket warmer.</p> <p>Findings: 1. at 9:45 AM on 9/4/13, review of the policy and procedure "Blanket Warmer",</p>	S001146	The crash cart checklist, where the blanket warmer temperature is recorded, was updated to reflect when the warmer was cleaned. The warmer was cleaned 9-4-13. The snack refrigerator was defrosted and properly cleaned 9-4-13 and will be monitored every other week to ensure cleanliness. The microwave oven was properly cleaned and will be put on a cleaning schedule. Policy 10.01 was updated to reflect cleanliness of Patient refrigerators, policy	09/11/2013			

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	<p>policy number 5.51, with a date of "New 2012", indicated:</p> <p>a. under "Practices & Procedures", it reads in section 2.: "...b. Annual cleaning of the heater compartment is to be completed by nursing staff. i. Remove the false bottom. ii. Vacuum the area or wipe with a damp cloth."</p> <p>2. at 11:47 AM on 9/4/13, while on tour of the pre operative area of the facility in the company of staff member #50, the surgery center supervisor, it was observed that there was considerable dust under the false bottom shelf of the top cabinet of the Amsco blanket warmer</p> <p>3. interview with staff member #50 indicated it was unknown the last time the warmer was damp wiped, or cleaned</p> <p>4. at 10:00 AM on 9/4/13, review of the policy and procedure "Environmental Control", policy number 10.01, with a revised date of 1-13, indicated:</p> <p>a. under "Practices & Procedures", it reads in items 4. and 5.: "4. Patient refrigerators are monitored with a thermometer and temperatures are recorded the days of surgery in a log book...5. Employee refrigerator are monitored for cleanliness and food freshness on an ongoing basis.</p>		pending approval by governing board. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.				

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	<p>Microwave ovens are monitored for cleanliness."</p> <p>5. at 11:30 AM on 9/4/13, while on tour of the post operative patient food/pantry area in the company of staff members #50, the surgery center supervisor, and #51, the post op nurse, it was observed that:</p> <ul style="list-style-type: none"> a. the snack refrigerator had a great accumulation of ice build up in the freezer compartment b. the snack refrigerator had dirty, sticky, shelves on the door c. the snack refrigerator had crumbs on the gasket/seal of the door d. the microwave oven was dirty with an accumulation of crumbs, etc. under the rotating glass shelf <p>6. interview with staff members #50 and #51 at 11:35 AM on 9/4/13 indicated:</p> <ul style="list-style-type: none"> a. the refrigerator is on a monthly cleaning schedule b. the door of the refrigerator does not close completely, without extra effort, leading to freezer compartment build up c. the refrigerator may need to be on an every other week cleaning schedule to ensure cleanliness d. the microwave oven is not used for patients any longer and may need to be removed from the area 			
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	<p>e. the microwave oven is not on a cleaning schedule</p> <p>7. at 11:50 AM on 9/4/13, while on tour of the surgery area of the facility in the company of staff member #50, the surgery center supervisor, it was observed that the hallway refrigerator was dirty with debris on the lower shelf of the freezer compartment and some under the vegetable drawers of the refrigerator</p> <p>8. at 4:00 PM on 9/4/13, interview with staff member #51, the surgery center supervisor, indicated:</p> <p>a. the current policy (number 10.01) does not address cleanliness of the pantry/patient refrigerator, or the hallway refrigerator, only the employee refrigerator</p>						