

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005386	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/03/2013
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NAME OF PROVIDER OR SUPPLIER SURGICAL CENTER OF NEW ALBANY	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 GREEN VALLEY RD NEW ALBANY, IN 47150
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State licensure survey.</p> <p>Facility Number: 005386</p> <p>Survey Date: 10/03/2013</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/18/13</p>	S 000	<p><i>POC's made on different, hand written forms - attached.</i></p>	
S 310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT</p> <p>410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor.</p> <p>This RULE is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure transcription services as part of its comprehensive quality assessment and improvement (QA&I) program.</p> <p>Findings included:</p>	S 310		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S 310	Continued From page 1 1. Surgical Center of New Albany Performance Improvement Plan (last approved January 2013) indicated all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. The Quality Assurance Committee shall coordinate all activities designed to promote and attain the objectives of the Quality Assurance Plan. The Quality Committee serves as the focal point for integration of the quality activities conducted in the Center. It shall receive sufficient information from all sectors related to patient care and its evaluation to permit intelligent deliberation and to achieve the objectives of the Quality Assurance Plan. 2. Quality data provided by staff #1 for review indicated lack of documentation of transcription services. 3. At 2:10 PM on 10/03/2013, staff member #1 confirmed the transcription service was not being evaluated and/or monitored.	S 310		
S 400	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. This RULE is not met as evidenced by: Based on observation, interview and document	S 400		

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S 400	<p>Continued From page 2</p> <p>review, the facility failed to provide an environment that minimizes infection exposure and risk to patients for 1 of 3 operating rooms (OR) observed.</p> <p>Findings include:</p> <p>1. During tour of the surgical area beginning at 3:15 p.m. on 10/3/13, the following infection control issues were observed in OR #1: (A) The OR table had something wrapped in black plastic resting upon the OR table. The black plastic had visible holes in it and the plastic was taped along one side to close the plastic. The surface with holes would allow for fluids to seep into the plastic contaminating the contents and the taped area could not be disinfected between patients. (B) The anesthesia cart had a very soiled paper towel on the work surface. The towel was taped down in several areas with clear tape and had dried substances on it.</p> <p>2. Staff member #1 indicated the following in interview during the tour: (A) The object wrapped in plastic on the OR table was a foam type or eggcrate surface for patient comfort. (B) The towels on the anesthesia cart get changed every other day or so.</p> <p>3. Facility policy titled "INFECTION CONTROL IN ANESTHESIA" last reviewed/revised 5/23/12 states on page 2 and 3: "3. Surfaces of the anesthesia carts, drawer handles, touch screens.....will be cleaned and disinfected between uses on patients."</p> <p>4. Facility policy titled "ENVIRONMENTAL CLEANING BETWEEN SURGICAL CASES AND</p>	S 400		

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S 400	Continued From page 3 PROCEDURES" last reviewed/ revised 5/23/12 states "1. All horizontal surfaces in the operating/procedure (e.g., furniture, surgical lights, booms, equipment) will be damp dusted using an EPA registered disinfectant-dampened clean lint free cloth, before the first scheduled procedure of the day. Cleaning of the operating/procedure room between procedures will be done to re-establish a visibly clean and aseptic environment for patients and facility staff.....b. All nonporous surfaces such as mattress covers,.....will be cleaned and disinfected with EPA registered disinfectant. c. All receptacles (e.g., bins,.....) work surfaces and tables will be cleaned and disinfected with an EPA registered disinfectant.....e. Anesthesia personnel will be responsible for cleaning their equipment between cases."	S 400		
S 430	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ii) The infection control committee responsibilities must include, but are not limited to: (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: (ii) Universal precautions, including infectious waste management.	S 430		

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S 430	<p>Continued From page 4</p> <p>This RULE is not met as evidenced by: Based on document review and observation, the facility failed to ensure the outdoor Biohazard storage shed was labeled to indicate medical waste was being stored within the storage unit.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Infection Control and Prevention Manual Disposable Regulated / Non-Regulated Waste policy #IC.1.165 (last reviewed January 2012) indicated storage containers that contained medical waste must be labeled to specify the storage unit was for Biohazard Waste. 2. At 12:22 on 10/3/2013, an outside white locked storage cabinet that contained medical waste was not labeled that there was biohazard material within the cabinet. The cabinet had a diamond shape holder where a sign was observed missing. 	S 430		
S1010	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES</p> <p>410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the 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>	S1010		

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S1010	<p>Continued From page 5</p> <p>This RULE is not met as evidenced by: Based on observation and document review, the facility failed to discard single use vials of medication for 1 of 3 anesthesia carts observed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During tour of the surgical area beginning at 3:15 p.m. on 10/3/13, the following was observed in the anesthesia/med cart in operating room #2: (A) A 1 mg vial of Naloxone, opened with contents almost gone. The vial was marked as a single dose vial per manufacturer. Procedures were completed for the day at the time of the tour. 2. Facility policy titled "INJECTABLE MEDICATION/SALINE" last revised/revised 5/12 states on page 4 of 4: "5. Discard single-dose vials after use. Never use them again for another patient." 	S1010		

Surgical Center of New Albany
 2201 Green Valley Rd
 New Albany, IN 47150
 812 949 1223 Fax 812 945 4765

RECEIVED
 OCT 30 2013

October 23, 2013

Indiana State Department of Health
 2 North Meridian St
 Indianapolis, In 46204

Attention: Ann Hamel, RN, MSN

The following are the corrective action for the deficiency:

ID Prefix Tag	Summary statement of deficiencies	ID Prefix Tag	Plan of Correction	Complete Date
S310	410.15-2.4-2(a)(1) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor- Not met as evidenced by: Based on document review and staff interview, the facility failed to ensure transcription services as a part of its comprehensive quality assessment and improvement (QA&I) program.	S310	1. Annual review of transcription will be completed and presented to the AQPI committee in January of each year.	Responsible: Administrator Completion Date October 25,2013
S400	410 15-2.5-1(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers and visitors. This rule is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an environment that minimized infection exposure and risk to patients for 1 of 3 operating rooms. Findings: (A)The OR table had something wrapped in black plastic had visible holes in it	S400	A non absorbable cover without holes or tears and that can be disinfected will be used on foam mattress. There will be nothing on the anesthesia carts for easy cleaning.	Responsible: Administrator Completion Date October 30, 2013

	<p>and the plastic was taped along one side to close the plastic. The surface with holes would allow for fluids to seep into the plastic contaminating the contents and the taped area could not be disinfected between patients.</p> <p>(B) The anesthesia cart had a very soiled paper towel on the work surface. The towel was taped down in several areas with clear tape and had dried substances on it.</p>			
S430	<p>410 15-2.5-1(f)(2)(E)(ii). 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>(ii) Universal precautions, including infectious waste management.</p> <p>This rule is not met as evidenced by: Based on document review and observation, the facility failed to ensure the outdoor Biohazard storage shed was labeled to indicate medical waste was being stored within the storage unit.</p>	S430	<p>The outdoor Biohazard storage shed will have a visible Biohazard label</p>	<p>Responsible: Administrator Completion Date: November 15, 2013</p>
S1010	<p>410 15-2.5-6(3)(A) Pharmaceutical services must have the 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>This rule is not met as evidenced by: Based on observation and document review, the facility failed to discard single use vials of</p>	S1010	<p>All single dose vials will be discarded after opened.</p>	<p>Responsible: Administrator Completion Date: October 3, 2013</p>

	medication for 1 of 3 anesthesia carts observed.			
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Regards,



Tamara Jones, RN, BSN
Administrator