STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001169	A. BUILDING 00 B. WING	07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA SPECIALTY SURGERY CENTER	1380 W ARCH HAVEN AVE BLOOMINGTON, IN 47403

(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) COMPLETION DATE
S0000	This visit was for a State licensure survey. Facility Number: 011996 Survey Date: 7/18-19/12 Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor Albert Daeger Medical Surveyor QA: claughlin 07/26/12	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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S0153	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on personnel file review, policy and procedure review, contracted services documentation, and interview, the facility failed to ensure 2 of 2 contracted housekeeping staff (#A12 and A13) received orientation to the facility or required infection control training. Findings included: 1. Review of the facility's training files failed to indicate any orientation or training documentation for the contracted cleaning staff (#A12 and A13). 2. The facility policy "Infection Control Program- Housekeeping", last approved 11/29/11, included a training sheet listing specific procedures, Handwashing, Gowning in Scrubs, Hair Covering, OSHA- Blood Spills, Infectious Waste, Needles, Trash Disposal, and Chemical Handling with spaces for a signature and	S0153	The ASC administrator met with the contracted housekeeping staff 8/7/12 to review the facility housekeeping policy entitled "ASC Environmental Cleaning Policy and Procedure", and to review and instruct on the facility policy "Infection Control Program-Housekeeping". The housekeeping staff signed a second document indicating that the following procedures had been reviewed: 1. Hand washing/hand hygiene; 2. Wearing scrubs & hair covering; 3. Blood spills; 4. Trash disposal; 5. Chemical handling. In addition, the contracted housekeeping service had provided its employees with Bloodborne Pathogen training via BBP safety video and had each employee sign that they had reviewed and understood the BBP sinformation.The deficiency will be prevented in the future by the Admin or designee providing written documentation of education and training at the	08/07/2012

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	date to indicate the training had been done. 3. The facility policy "ASC Environmental Cleaning", originated 04/09/12, indicated, "...Environmental cleaning is a team effort. Personnel responsible for cleaning the environment and equipment will receive education and training on proper environmental cleaning and disinfection methods, agent use and selection, and safety precautions according to OSHA guidelines. The ASC shall maintain oversight and assure the quality of services provided when contracting for cleaning services provided by an outside agency." 4. The contracted cleaning service's handbook indicated on page 16, "...B. Training Records (See Appendix H) 1. Training records will include: a. The date(s) of the training session b. The contents or a summary of the training session c. The name(s) and qualifications of person(s) conducting the training d. The name and job titles of all persons attending the training session 2. Training records will be maintained for three years from the date the training occurred. C. Availability of Records 1. All records required to be maintained by this standard will be made available upon request to the Department of Commerce		onset of any newly acquired contracted housekeeping service orientation to the facility.Monitoring of this practice is the responsiblity of the Administrator.	

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	upon request for examination and copying." Page 28 of the literature was Appendix H which was titled "Information and Training Record for Employees with Potential Exposure to Bloodborne Pathogens". The form listed all of the required training with areas for the date of training, trainer name and qualifications, names and job titles of employees attending the training, and a line for the signature of the Training Coordinator. 5. At 4:00 PM on 07/18/12, the owner of the contracted cleaning company, #A11, and the shift supervisor, #A12, were interviewed regarding the services provided. They indicated they had just started with the facility May 28, 2012. They indicated another staff member, #A13, was trained on the job by staff member #A12 who also worked alongside him/her and observed this staff member for approximately 2 weeks. They indicated there was no classroom training and approximately 90% of the training was on the job. They indicated the staff files only contained applications, background checks, any certifications, any write-ups, and biannual evaluations, but no documented training records. 6. At 10:30 AM on 07/19/12, staff			

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	member #A1 indicated he/she walked through the facility with all 3 of the contracted cleaning staff at the start of the service and described in detail the requirements and expectations, but could not provide documentation of this. He/she also confirmed the lack of any training documentation, either through the facility or the contracted company.			

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S0422	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C) The infection control committee responsibilities must include, but are not limited to: (C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.			
	Based on review of product information, employee files review, and interview, the facility failed to ensure TB testing was performed per manufacturer's recommendations and CDC guidelines for 11 of 11 staff member files reviewed (#N1- N11). Findings included: 1. The manufacturer's product information for Tubersol, the solution used for TB testing, indicated the tests should be placed and read within 48 to 72 hours for accuracy. 2. Review of employee files indicated staff members #N1- N7 and #N9- N11 had TB tests placed on 01/17/12 and read on 01/19/12, but lacked documentation of times for either the placement or the reading, making it unable to determine the reading between 48 and 72 hours after placement.	S0422	The facility's "TB Skin Testing Form" was revised/reformatted to include the indication to record "time" as well as date for both the administration of and reading of the TB test.The RN providing the TB testing was instructed to provide times upon administration of and reading of the TB test.The Administrator is responsible to review the documentation and verify that the times are indeed recorded upon administration of and reading of the TB resuls.	08/06/2012

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	3. Review of the employee file for staff member #N8 indicated a TB test placed at 1540 on 01/28/12 and read on 01/31/12, but lacked documentation of a time for the reading, making it unable to determine the reading between 48 and 72 hours after placement. 4. At 10:00 AM on 07/19/12, staff member #A1 confirmed the lack of times for the TB testing and also confirmed the Infection Control Program followed CDC guidelines, which specified TB tests were to be read between 48 and 72 hours after placement.			

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S0428	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i) 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: (i) Sanitation. Based on observation, document review, and interview, the facility failed to ensure the surgical suites, procedure room, and patient areas were maintained in a clean, sanitary manner, according to policy. Findings included: 1. While in OR #2 (operating room) after the case observation at 1:25 PM on 07/18/12, the back surfaces of some of the equipment were observed with a layer of dust. 2. During the tour of the pre-op area at 1:35 PM on 07/18/12, accompanied by staff member #A8, the wall ledges, suction canisters, and bottoms of the patient carts were observed with a layer of dust. 3. During the tour of the recovery area at	S0428	The Administrator met with the contracted housekeeping service and reviewed the policy titled "ASC Environmental Cleaning Policy and Procedure" which outlines both the ASC staff and contracted staff responsiblities for cleaning items in each clinical area; items specifically identified in the survey.A weekly round by the Administrator or designee is scheduled to verify that results of the instruction for cleaning and responsible parties has been maintained.	08/07/2012

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	2:00 PM on 07/18/12, accompanied by staff member #A1, the wall ledges, suction canisters, support arms of monitors, and bottoms of patient carts were observed with a layer of dust. 4. At 2:15 PM on 07/18/12, in the procedure room that was being used as the office for the surveyors, a layer of dust was observed on the back of an Express patient monitor, a C-arm Elite work station, and a Venne 40 ultrasound. An Oak Works patient table with a very dirty bottom was also in the room. At 2:30 PM, a staff member came into the room to retrieve the ultrasound machine for a case in the operating room. 5. The facility policy "Anesthesia Equipment Cleaning", last approved 11/29/11, indicated, "...B. All equipment is washed with disinfectant at the close of business. C. Backs of machines, carts, and wheel carriages are cleaned PRN (as needed). Wheels are washed and cleaned of debris PRN." 6. The facility policy "ASC Environmental Cleaning", originated 04/09/12, indicated on page 2, "...2. At the beginning of each day or prior to the first procedure, the following will be damp-dusted using a clean lint free cloth dampened with a facility-approved,			

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	Environmental Protection Agency (EPA)-registered disinfectant: horizontal surfaces, OR/procedure room lights, OR/procedure room furniture including the back table, prep table, ring stands, Mayo stands, and operating table. ...5. Terminal cleaning of each operating and procedure room will be completed daily when the scheduled procedures are completed for the day. ...l. Clean and disinfect all horizontal surfaces. m. Clean suction canisters." The policy continued on page 4, "...vii. Clean all furnishings and horizontal surfaces in the room including chairs, window sill, call lights, television, telephone, computer keypads, tables or desks. ...viii. Wipe equipment on walls such as top of suction bottle, intercom and blood pressure manometer as well as IV pole." 7. At 4:00 PM on 07/18/12, the owner of the contracted cleaning company, #A11, and the shift supervisor, #A12, were interviewed regarding the services provided. They indicated they had just started with the facility May 28, 2012. They indicated another staff member, #A13, was trained on the job by staff member #A12 to clean the facility. They described their cleaning procedures and indicated the bottoms of the patient carts,			

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	the equipment surfaces, the suction canisters, and ledges were their responsibility. 8. At 10:30 AM on 07/19/12, staff member #A1 indicated he/she walked through the facility with all 3 of the contracted cleaning staff at the start of the service and described in detail the requirements and expectations, but could not provide documentation of this. He/she confirmed the sanitation deficiencies noted.			

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S0526	410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h) (h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed. Based on personnel file review, facility annual inservicing requirements, and interview, the facility failed to ensure annual competency regarding out of laboratory testing was completed for 7 of 7 staff members (registered nurses) who performed this testing (#N1- N7). Findings included: 1. Review of the personnel files for the registered nurses, staff members #N1- N7, failed to evidence any documentation of annual inservicing or competency for out of lab testing. 2. Review of the facility's annual mandatory inservicing requirements failed to indicate out of lab testing competency. 3. At 12:15 PM on 07/18/12, staff member #A1 indicated the registered nurses perform blood sugar testing and urine pregnancy testing on their patients, but did not receive annual competency testing for either of the procedures.	S0526	A competency documentation form was initiated for both blood glucose monitoring and urine HCG monitoring and each RN was observed for competency in each of these waived tests. Additionally, these competencies were added to the annual mandatory education requirement form. Verification of compliance will be validated by the Administrator by annual review of the mandatory education records.	07/26/2012

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S0772	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (M) A requirement that a medical history and physical examination be performed as follows: (i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed. (ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff. (iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy. Based on policy and procedure review, medical record review, and interview, the facility failed to ensure all patients undergoing surgical procedures had a history and physical performed by a physician within 30 days of the procedure for 10 of 30 patient records reviewed	S0772	Upon review of the records presented to the surveyor, a pattern of LIPs was identified as those not dating their H&Ps once completed in the office and submitted to the ASC for scheduling. The Administrator discussed the requirements for original signature and date on the	08/03/2012

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	(#P4, P5, P8, P12, P14, P18, P21, P22, P23, and P29). Findings included: 1. The facility policy "Medical Records Policies/Procedures", last revised 03/23/12, indicated on page 2, "...All patients require a history and physical which is documented and the documentation is placed in the patient record prior to surgery. The history and physical must be performed within thirty days prior to surgery, and also reviewed and updated upon admission to the Center, documenting any changes in the patient's condition since completion of the history and physical." 2. The medical record for patient #N4 indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 05/09/12, the day of surgery. 3. The medical record for patient #N5 indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 05/01/12, the day of surgery. 4. The medical record for patient #N8		H&P with the LIPs. Currently, as ASC staff receive the H&Ps for the scheduled surgery date, the staff member has been instructed to review the date and signature line and provide any incomplete H&Ps to the Administrator. The Administrator subsequently reviews the record for completion, and notifies the office and LIP if not completed, requesting a completed H&P for the ASC. Addendum: Upon review of the H&Ps with a missing date, and following further chart review, it was identified that 2 physicians only were involved, from the same practice. This practice was discussed with both LIPs, along with the correction required, along with discussion of the ofice staff for those LIPs. The process for correction monitoring involves the scheduling staff reviewing those LIPs H&Ps and they are received at the Center, and those with missing dates are brought to the attnetion of the Administrator for further follow-up as above.	

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	indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 01/25/12, the day of surgery. 5. The medical record for patient #N12 indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 02/08/12, the day of surgery. 6. The medical record for patient #N14 indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 04/17/12, the day of surgery. 7. The medical record for patient #N18 indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 05/29/12, the day of surgery. 8. The medical record for patient #N21 indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 06/05/12, the day of surgery.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA SPECIALTY SURGERY CENTER	1380 W ARCH HAVEN AVE BLOOMINGTON, IN 47403

(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) COMPLETION DATE
	9. The medical record for patient #N22 indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 02/21/12, the day of surgery. 10. The medical record for patient #N23 indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 05/16/12, the day of surgery. 11. The medical record for patient #N29 indicated an office history and physical, but without a physician signature or date of when performed, which was signed and dated as reviewed by the physician on 06/27/12, the day of surgery. 12. At 12:30 PM on 07/19/12, staff member #A1 confirmed the medical record findings and indicated the copies of the history and physicals were sent from the office and should have been signed and dated to ensure compliance with the 30 day regulation.			