STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
Q0000	This visit was for a recertification survey. Facility #: 002663 Survey Dates: 1-9/11-12 Surveyors: Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor Sandra Nolfi, RN Public Health Nurse Surveyor QA: claughlin 01/20/12	O0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
Q0041	416.41(a) CONTRACT SERVICES When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner. Based on policy review, observation, and interview, the facility failed to ensure the operating rooms were cleaned according to acceptable standards of practice by the contracted cleaning service. Findings included: 1. The facility's policy, titled "Dress Requirements", last reviewed 08/07/10, stated under Procedures, "...1. Street clothes are not permitted in designated restricted areas (scrub suits, hats, masks, and shoe covers are provided for staff and visitors entering these areas.)" 2. The facility's policy, titled "Housekeeping Policy", last reviewed 08/07/10, stated on page 2, "...E. Cleaning apparel for personnel. While cleaning the recovery room, operating room, clean processing rooms, soiled rooms and the surgical hallways, cleaning personnel will put on the following apparel prior to entering the areas: 1. Surgical scrub suit 2. Surgical hat 3. Surgical shoe covers 4. Surgical mask (only required in OR)."	O0041	To ensure operating rooms are cleaned by the contracted housekeeping service according to acceptable standards of practice, an in-service was conducted by the Surgery Center Director and encompassed a review of the ASC policy regarding dress requirements for cleaning personnel, directions for preparation and dilution of floor cleaning chemicals, as specified by the manufacturer's label, and instructions for use of an alternative cleaner specifically designed to disinfect hard surfaces and equipment thereby replacing the previous cleaning agent which was being inappropriately employed. A calibrated bucket and measuring cup had been purchased prior to adhere to manufacturer's directions for exact chemical dilution ratios. All housekeeping staff were in attendance. The Surgery Center Director will conduct an unannounced observance/evaluation of housekeeping personnel during the first quarter of 2012 and a minimum of annually thereafter to ensure standards continue to me met.	01/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	3. Upon entering the operating room at 3:30 PM on 01/10/12, accompanied by staff member #N1, the cleaning service staff members #N15 and N16 were observed dressed in surgical garb preparing to begin the cleaning procedure. Neither staff member was wearing a mask and asked staff member #N1 whether they should put one on. Staff member #N15 was wearing a white long sleeved turtle neck that extended above the neck of the scrub top and below the short sleeves of the top. A blue bucket, containing approximately 2 gallons of clear solution, was indicated for the rags to disinfect all surfaces in the room. Staff member #N15 indicated 3 caps of Hepacide Quaternary solution were mixed in 1 gallon of water. The cap indicated was the screw on cap with the spray device attached to the ready-to-spray bottle of disinfectant. The manufacturer's directions on the bottle were to spray the disinfectant on surfaces and allow a 10 minute kill time. A mop bucket, containing approximately 4 gallons of a clear solution, was also ready to be used in the room. Staff member #N15 indicated that solution was mixed in the housekeeping closet. 4. At 3:50 PM on 01/10/12, the housekeeping closet was visited. Staff member #N15 indicated a container of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Vesphene disinfectant was the chemical used in the water to mop the floors. He/she indicated 1/4 cup of disinfectant was mixed with 1 1/2- 2 gallons of water and stated that's the amount that was in the bucket observed in the OR. No measuring devices in the closet or markings on either of the buckets were observed. The manufacturer's instructions on the Vesphene were to mix 1 ounce of disinfectant per gallon of water. 5. Staff member #N15 indicated that after 15 years in the business, he/she could measure without markings.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
Q0081	416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES (a)(1) The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors. (a)(2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC. (c)(1) The ASC must set priorities for its performance improvement activities that - (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care.			
	Based on document review and interview, the facility Quality Assurance and Performance Improvement (QAPI) program failed to develop a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH). Findings include: 1. Review of facility documents on 1-10-12 lacked evidence that the facility	O0081	In compliance with standards of practice through which the QAPI program continuously utilizes indicators to measure, analyze and track aspects of performance that includes care and services furnished in the ASC, a tool has been developed to determine the occurrence of events within the center which are reportable to the ISDH (see attachment A). This tool will be completed monthly by the Surgery Center Director with findings presented to the quarterly meetings of the Center's Safety Committee, Quality	01/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Quality Assurance and Performance Improvement (QAPI) program developed a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH) or that these events were included in the facility QAPI program. 2. Interview with B#1 on 1-10-12 at 1455 hours confirmed the facility Quality Assurance and Performance Improvement (QAPI) program failed to develop a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH) or that these events were included in the facility QAPI program.		Assurance Committee and Board of Directors. Note, events listed in the tool are limited to those which have relevance to care and services provided by an Ophthalmic specific surgery center. Should any of the those reportable events listed occur, appropriate documentation via incident report and/or grievance filing would be initiated at the time of said event.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
Q0106	416.44(d) EMERGENCY PERSONNEL Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC. Based on personnel file review, policy and procedure review, and interview, the facility failed to follow its Position Description regarding ACLS certification for 6 of 6 staff nurses (#N9- 14) employed at the center. Findings included: 1. Review of the facility's Position Description for "Staff Nurse- Operating Room" and "Staff Nurse- Recovery Room", was "CPR and ACLS certification required" listed under "Qualifications". 2. Review of the personnel files for the 6 staff nurses (#N9-14) failed to indicate any documentation of ACLS certification. 3. At 2:00 PM on 01/10/12, staff member #N1 indicated the nurses were not required to have ACLS certification, but confirmed the requirement was written in the job descriptions.	O0106	In adherence to Center policy which states staff nurses employed by the ASC must be ACLS certified, all RNs will complete ACLS training by July 1 of 2012. As one RN will be absent for maternity leave in the upcoming months, the course will not be scheduled until her return to work thus allowing all nursing personnel to participate. The course will be conducted by RESQ Health and Safety Training and it is the responsibility of the Surgery Center Director to fulfill the scheduling arrangements.	01/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
Q0230	416.50(b)(2), 416.50(b)(3) EXERCISE OF RIGHTS BY OTHERS (2) If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf. (3) If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. Based on document review and interview, the facility failed to develop a policy/procedure to protect the rights of a patient adjudged incompetent by a court of law. Findings include: 1. Review of facility documents on 1-9-12 - 1-11-12 lacked evidence that the facility had developed a policy/procedure to protect the rights of patients adjudged incompetent by a court of law. 2. Interview with B#1 on 1-10-12 at 1450 hours confirmed the facility has not developed a policy/procedure to protect the rights of patients adjudged incompetent by a court of law.	Q0230	In compliance with standards of care for the protection of patient rights, a policy/procedure has been developed which assures the rights of surgery center patients adjudged incompetent by a court of law (see attachment B), effective immediately. All Center policies are reviewed and approved by the Board of Directors.	01/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
Q0241	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on observation, policy and procedure review, and interview, the facility failed to ensure cleaning policies were based on acceptable standards of practice and the operating room and post-op area were cleaned between patients to ensure a safe environment. Findings included: 1. At the end of the surgical case observation, at 10:15 AM on 01/11/12, staff members #N7 and N10 cleaned the room in preparation for the next case. An approved disinfectant was used to wipe the horizontal surfaces and the mattress of the operating table/bed. The siderails of the table/bed, the blood pressure cuff, and the oxygen saturation probe, that had all been used on the case, were not cleaned in any manner. 2. After the patient was discharged from the post-op area, at 10:25 AM on 01/11/12, the staff member sprayed the counter tops and the recliner with Dispatch, waited 45 seconds and wiped the surfaces. He/she also sprayed the	Q0241	In accordance with standards of practice for providing a sanitary environment for the provision of surgical services, the policies/procedures addressing the routine cleaning of operating room suites and pre-post op bays between patients have been revised to incorporate the disinfection of all items which have direct contact with every patient during their stay at the Center (see attachments C&D). All ASC personnel have been informed of the policy alterations and have participated in education regarding manufacturer's recommendations for the appropriate use of Center approved disinfectants, during the January staff meeting. All Center policy revisions are reviewed and approved by the Board of Directors.	01/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	wheelchair and wiped after 15 seconds. He/she did not clean the blood pressure cuff or the oxygen saturation probe. The manufacturer's directions for the Dispatch were to spray and allow 1 minute kill time before wiping or drying. 3. The facility policy titled "Routine Cleaning of Operating Room", last reviewed 08/07/10, stated, "...Between Cases- Operating Room, OR personnel will do the following: 1. Patient carts, back-tables, and mayo stands will be washed with a germicide and dried. ...6. Damp clean the back table, the mayo stand, OR table, and any other equipment which could have become soiled during the case, if deemed necessary." The policy did not address any equipment that came in contact with the patient, regardless of whether or not it appeared soiled. 4. The facility policy titled "Infection Control Procedures- PAR Area", last reviewed 08/07/10, stated, "...1. Patient chairs are washed with germicidal solution after each patient." The policy did not address any other equipment that came in contact with the patient. 5. At 11:00 AM on 01/11/12, staff member #N1 confirmed that all of the equipment coming in contact with a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	patient was not routinely disinfected between patients.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
Q0242	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. Based on facility document review and interview, the center failed to provide documentation of having selected any nationally recognized guidelines for their infection control program. Findings included: 1. Review of the facility's Infection Control Plan, policies and procedures, and infection control meeting minutes failed to provide documentation that any nationally recognized guidelines had been selected to follow for the center's infection control program. 2. At 11:30 AM on 01/11/12, staff member #N1 indicated the facility followed the CDC infection control guidelines, but confirmed there was no documentation to substantiate this.	O0242	In compliance with maintaining an ongoing infection control program adhering to nationally recognized guidelines, the Infection Control Committee will confirm that the Center has been and will continue to follow protocols established by the CDC as the standard of care for the Center's infection control plan. This standard will be presented to the Infection Control Committee by the Surgery Center Director during their next scheduled meeting slated for February.	02/07/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0156	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (E) Require that the chief executive officer develop and implement policies and programs for the following: (E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on review of personnel files, review of policy and procedure manuals, and interview, the facility failed to ensure all employees had current job descriptions for 11 of 11 files reviewed (#N4-14) and annual performance evaluations based on a current job description in 6 of 6 files reviewed (#N4-8 and B#2). Findings included: 1. Review of employee files for the facility's registered nurses, staff members #N9-14, failed to indicate any job descriptions. 2. Review of employee files for the facility's unlicensed patient care staff,	S0156	In accordance with standards for maintaining current job descriptions and responsibilities for all Center personnel including annual evaluations based upon the scope of work outlined in the individuals position summary, the following corrections have been instituted. 1. Job descriptions contained within the Center P&P have been revised with respect to position title and function. (See attachments E, F, G and H) 2. A copy of the appropriate job description has been inserted into each staff member's employee file. · RN (all nursing staff) · Scrub Technician (CST and ST staff) · Technician (unlicensed support staff) · Executive Director (Center Administrator)3. The 2012 employee evaluations, to be	01/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	members #N4-8, failed to indicate any job descriptions. 3. Review of the employee file for staff member #N4 indicated an annual performance evaluation for the position of "Tech" was done on 10/10/11. 4. Review of the employee file for staff member #N5 indicated an annual performance evaluation for the position of "CST" was done on 10/10/11. 5. Review of the employee file for staff member #N6 indicated an annual performance evaluation for the position of "Surg Tech" was done on 10/10/11. 6. Review of the employee file for staff member #N7 indicated an annual performance evaluation for the position of "Surgical Technologist" was done on 10/10/11. 7. Review of the employee file for staff member #N8 indicated an annual performance evaluation for the position of "Pre-post op assistant" was done on 10/10/11. 8. Each of the performance evaluations contained the statement, "By signing below the Employee named above acknowledges that they have been		conducted by the Surgery Center Director in October, will reflect the above alterations. 4. A staff file has been established for the Executive Director to include: resume, results of PPD testing and annual evaluation. Resume and evaluation have been submitted. PPD testing will be conducted in October, for cost containment, with all ASC staff duing the mandatory in-servicing event. The Surgery Center Director is responsible for assuring completion of evaluations on all ASC employees annually. All Center policy revisions are reviewed and approved by the Board of Directors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	provided with a copy of the job description describing the position named above. The employee also acknowledges having read and understood the Position Summary Description, the scope of work description and the qualifications list thereon. The employee hereby states their belief that they are capable and qualified to fill the described position." 9. Review of the policy and procedure manual indicated only 2 job descriptions for the unlicensed patient care staff, "Operating Room Technician" and "Operating Room Assistant". Both descriptions stated, "Position Summary-Works with the surgical team to perform scrub duties and other related procedures as necessary to assist the professional staff"; however, the words "scrub duties and other" were marked out for the "Operating Room Assistant". 10. At 2:00 PM on 01/10/12, staff member #N1 indicated the employees received a copy of their job descriptions upon hire, but confirmed there were no copies in the files to indicate what they actually received. He/she also indicated the job descriptions for the unlicensed staff did not match their annual performance evaluations. 11. Review of personnel documents on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	1-9-12 lacked evidence that B#2 had a personnel file or that a performance evaluation had been completed since the date of hire in 2000. 12. Review of facility documents on 1-10-12 indicated the following in the Employee Manual: We will conduct Performance Appraisal annually at the beginning of each fiscal year. The appraisal will be discussed with you by the Director, and you will be asked to sign the form as an acknowledgment of the appraisal interview. The appraisal will also be reviewed by the Board of Directors and then filed in your personnel folder for future reference. 13. Review of facility documents on 1-10-12 indicated the following: SUBJECT: EMPLOYMENT APPLICATION AND RECORD under B. PERSONNEL RECORD; each employee shall have a personnel record on file in the Center; B. 2. The personnel record shall include such information as deemed appropriate by the Director with the following minimum requirements: Annual performance review. 14. Review of facility documents on 1-10-12 indicated the following in the policy titled PERFORMANCE EVALUATION: All employees of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Center will receive performance evaluations and formal performance reviews on an annual basis. 15. Interview with B#2 on 1-9-12 at 1030 hours confirmed he/she does not have a personnel file and has not had a performance evaluation since hire in 2000.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0162	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G) Require that the chief executive officer develop and implement policies and programs for the following: (G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care. Based on personnel file review, policy and procedure review, and interview, the facility failed to follow its Position Description regarding ACLS certification for 6 of 6 staff nurses (#N9- 14) employed at the center. Findings included: 1. Review of the personnel files for the 6 staff nurses (#N9- 14) failed to indicate any documentation of ACLS certification. 2. Review of the facility's Position Description for "Staff Nurse- Operating Room" and "Staff Nurse- Recovery Room", was "CPR and ACLS certification required" listed under "Qualifications". 3. At 2:00 PM on 01/10/12, staff member	S0162	In adherence to Center policy which states staff nurses employed by the ASC must be ACLS certified, all RNs will complete ACLS training by July 1 of 2012. As one RN will be absent for maternity leave in the upcoming months, the course will not be scheduled until her return to work thus allowing all nursing personnel to participate. The course will be conducted by RESQ Health and Safety Training and it is the responsibility of the Surgery Center Director to fulfill the scheduling arrangements.	01/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	#N1 indicated the nurses were not required to have ACLS certification, but confirmed the requirement was written in the job descriptions.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0166	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (I) Require that the chief executive officer develop and implement policies and programs for the following: (I) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially. Based on document review and interview, the facility failed to ensure its facility policies and procedures were reviewed and updated at least triennially. Findings include: 1. Review of facility policies and procedures on 1-9-12 through 1-11-12 indicated facility policies and procedures were revised with additions/deletions with lines drawn through or crossing out of policies and procedures. The documentation lacked evidence of dating or signing when these revisions occurred. 2. Interview with B#1 on 1-10-12 at 1400 hours confirmed the facility policies and procedures have been revised by crossing through lines and crossing out areas without a signature/date to indicate when the revisions occurred.	S0166	To comply with the requirement that Center policies and procedures are reviewed/revised at a minimum of every three years, the P&P manually in its entirety will be audited per the Surgery Center Director by end of the 2012 calendar year. The schedule for this process is as follows: · First quarter: Governing Body, Medical Staff, Personnel and Medical Records · Second quarter: Nursing Services and Patient Care · Third quarter: Physician Orders, Anesthesia, Pharmacy and Laboratory Services, Infection Control and Sterile Technique · Fourth Quarter: Housekeeping, Laundry and Maintenance Services, Safety and Administration. Upon completion of each quarter's policies; all updates/modifications will be presented to the Board of Directors for approval at the next scheduled quarterly meeting by the Surgery Center Director. After 2012, review and	01/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
			endorsement of Center policies, by the Board, will be done annually. The Surgery Center Director will adhere to the aforementioned quarterly P&P manual review schedule on a triennial basis with specific policy modifications/changes occurring PRN.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0172	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L) Require that the chief executive officer develop and implement policies and programs for the following: (L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable. Based on document review and interview, the Executive Director failed to ensure a personnel file for 1 of 1 (B#2) staff members reviewed. Findings include: 1. Review of personnel documents on 1-9-12 lacked evidence that 1 of 1 staff members (B#2) had a personnel file. 2. Review of facility documents on 1-10-12 indicated the following: SUBJECT: EMPLOYMENT APPLICATION AND RECORD under B. PERSONNEL RECORD; each employee shall have a personnel record on file in the Center. 3. Interview with B#2 on 1-9-12 at 1030	S0172	In accordance with standards for maintaining personnel records, a staff file has been established for the Executive Director to include: resume, results of PPD testing and annual evaluation. Resume and evaluation have been submitted. PPD testing will be conducted in October, for cost containment, with all ASC staff during the mandatory in-servicing event. The Surgery Center Director is responsible for assuring completion of evaluations on all ASC employees annually. All Center policy revisions are reviewed and approved by the Board of Directors.	01/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	hours confirmed he/she does not have a personnel file; B#2 confirms he/she was hired in 2000.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0300	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a) (a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the facility failed to follow the facility Quality Assurance Plan to reappraise its structure and functions at least annually. Findings include: 1. Review of the facility Quality Assurance (QA) Plan on 1-10-12 indicated the following under PROGRAM REAPPRAISAL: The structure and functions of the Quality Assurance Program will be reappraised at least annually to assure that the program is achieving its objectives, is effective, is cost efficient and consistent with external requirements. 2. Review of the facility documents on 1-10-12 indicates the QA plan was last reappraised with the facility policies/procedures on 8-7-10. 3. Interview with B#1 on 1-10-12 at 0920	S0300	In compliance with the Center QA Program which dictates that the plan will be reappraised annually, as stated in the plan of correction for S166, all governing body polices (which encompasses the QA plan) will be reviewed and revised during the first quarter of 2012 by the Surgery Center Director. The reappraised QA plan will then be presented to the Quality Assurance Committee and Board of Directors for approval at their next scheduled quarterly meeting. Upon completion of the 2012 calendar year, the plan will be reappraised and approved during the second quarter QA Committee and Board of Directors meetings annually thereafter. ADDENDUM:THE QA PLAN IS CURRENTLY BEING REVIEWED BY THE SURGERY CENTER DIRECTOR WITH REVISIONS TO BE PRESENTED TO THE QA COMMITTEE AND BOARD	01/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	hours confirmed the facility QA plan indicates the plan will be reappraised at least annually; B#1 confirms the QA plan was last reappraised 8-7-10 and not annually as required by the facility QA plan.		OF DIRECTORS FOR APPROVAL AT THEIR NEXT SCHEDULED MEETING TO OCCUR IN APRIL OF THIS YEAR.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0320	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (2) All functions, including, but not limited to, the following: (A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies. Based on document review and interview, the facility failed to include transfers, medication errors, and the response to patient emergencies in the facility Quality Assurance and Performance Improvement (QAPI) program. Findings include: 1. Review of facility documents on 1-10-12 lacked evidence that transfers, medication errors, and the response to patient emergencies were included in the facility Quality Assurance and Performance Improvement (QAPI) program. 2. Interview with B#1 on 1-10-12 at 1455 hours confirmed transfers, medication errors, and the response to patient emergencies were not included in the	S0320	To satisfy requirements specific to the inclusion of: patient transfers, medication errors and response to patient emergencies in the Center's QA plan, these untoward events have been added to the objectives and scope of the QA Plan (see attachment I). Additionally, a tracking tool has been designed (see attachment J) to be completed quarterly by the Surgery Center Director and submitted to the QA Committee to establish an ongoing system for monitoring and evaluating theses adverse events. The QA plan revisions and first quarter tracking tool and will be presented to the QA Committee at their next scheduled quarterly meeting. All policy revisions are reviewed and approved by the Board of Directors.ADDENDUM:THE	01/30/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	facility Quality Assurance and Performance Improvement (QAPI) program.		TRACKING TOOL DESIGNED TO SATISFY THE ABOVE PLAN OF CORRECTION WILL BE COMPLETED ON A QUARTERLY BASIS AND WILL INITIALLY BE UTILIZED AT THE END OF THE FIRST QUARTER 2012. THE COMPLETED TOOL AND QA PLAN REVISIONS WILL BE PRESENTED TO THE QA COMMITTEE DURING THEIR FIRST SCHEDULED MEETING THIS YEAR SLATED FOR APRIL.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0332	410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1) Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following: (1) A process for determining the occurrence of the following reportable events within the center: (A) The following surgical events: (i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. (iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both (iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded: (AA) Objects intentionally implanted as part of a planned intervention. (BB) Objects present before surgery that were intentionally retained.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such as microneedles or broken screws. (v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. (B) The following product or device events: (i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product. (ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following: (AA) Catheters. (BB) Drains and other specialized tubes. (CC) Infusion pumps. (DD) Ventilators. (iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism. (C) The following patient protection events: (i) Infant discharged to the wrong person. (ii) Patient death or serious disability associated with patient elopement. (iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	the center. Excluded are deaths resulting from self inflicted injuries that were the reason for admission to the center. (D) The following care management events: (i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong: (AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration. Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability. (ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products. (iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following: (AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy. (iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center. (v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates. (vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar. (vii) Patient death or serious disability resulting from joint movement therapy performed in the center. (viii) Artificial insemination with the wrong donor sperm or wrong egg. (E) The following environmental events: (i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion. (ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient: (AA) contains the wrong gas; or (BB) is contaminated by toxic substances. (iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center. (iv) Patient death or serious disability associated with a fall while being cared for in the center. (v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center. (F) The following criminal events: (i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider. (ii) Abduction of a patient of any age. (iii) Sexual assault on a patient within or on the grounds of the center. (iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Based on document review and interview, the facility Quality Assurance and Performance Improvement (QAPI) program failed to develop a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH). Findings include: 1. Review of facility documents on 1-10-12 lacked evidence that the facility Quality Assurance and Performance Improvement (QAPI) program developed a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH). 2. Interview with B#1 on 1-10-12 at 1455 hours confirmed the facility Quality Assurance and Performance Improvement (QAPI) program failed to develop a process to determine the occurrence of reportable events within the center that are reportable to the Indiana State Department of Health (ISDH).	S0332	In compliance with standards of practice through which the QAPI program continuously utilizes indicators to measure, analyze and track aspects of performance that includes care and services furnished in the ASC, a tool has been developed to determine the occurrence of events within the center which are reportable to the ISDH (see attachment A). This tool will be completed monthly by the Surgery Center Director with findings presented to the quarterly meetings of the Center's Safety Committee, Quality Assurance Committee and Board of Directors. Note, events listed in the tool are limited to those which have relevance to care and services provided by an Ophthalmic specific surgery center. Should any of the those reportable events listed occur, appropriate documentation via incident report and/or grievance filing would be initiated at the time of said event.	01/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0334	410 IAC 15-2.4-2.2(a)(2) QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(2) (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. (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. (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: (1) The report shall: (A) be made to the department; (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; (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: (i) patient; (ii) individual licensed under IC 25; or (iii) center employee involved; or any other information. (2) A potential reportable event may be identified by a center that:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15C0001097		01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	(A) receives a patient as a transfer; or (b) admits a patient subsequent to discharge; 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. (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. (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. (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. (e) Any serious reportable listed in subsection (a)(1) that: (1) is determined to have occurred within the center between: (A) January 1, 2009; and (B) the effective date of this rule; and (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) Based on document review and interview,	S0334	In accordance with standards	01/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	the facility failed to include adverse events, reportable to the Indiana State Department of Health (ISDH), in the facility Quality Assurance and Performance Improvement (QAPI) program. Findings include: 1. Review of facility QAPI documents lacked evidence that adverse events, reportable to the ISDH, were included in the facility QAPI program. 2. Interview with B#1 on 1-10-12 at 1455 hours confirmed adverse events, reportable to the ISDH, are not included in the facility QAPI program.		practice concerning inclusion of adverse events reportable to the ISDH in the Center QA Program, a tool has been developed (See attachment A) to determine the occurrence of such events, to be completed monthly by the Surgery Center Director, with findings presented to the quarterly meetings of the Center's Safety Committee, Quality Assurance Committee and Board of Directors as part of the ongoing quality assessment process specified by the Center's Quality Assurance Plan. (See attachment I).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S0432	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii) 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: (iii) Cleaning, disinfection, and sterilization.			
	Based on observation, policy and procedure review, and interview, the facility failed to ensure cleaning policies were based on acceptable standards of practice and the operating room and post-op area were cleaned between patients to ensure a safe environment. Findings included: 1. At the end of the surgical case observation, at 10:15 AM on 01/11/12, staff members #N7 and N10 cleaned the room in preparation for the next case. An approved disinfectant was used to wipe the horizontal surfaces and the mattress of the operating table/bed. The siderails of the table/bed, the blood pressure cuff, and the oxygen saturation probe, that had all been used on the case, were not cleaned in any way.	S0432	In accordance with standards of practice for providing a sanitary environment for the provision of surgical services, the policies/procedures addressing the routine cleaning of operating room suites and pre-post op bays between patients have been revised to incorporate the disinfection of all items which have direct contact with every patient during their stay at the Center (see attachments C&D). All ASC personnel have been informed of the policy alterations and have participated in education regarding manufacturer's recommendations for the appropriate use of Center approved disinfectants, by the Surgery Center Director, during the January staff meeting. All Center policy revisions are reviewed and approved by the Board of Directors.	01/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	2. After the patient was discharged from the post-op area, at 10:25 AM on 01/11/12, the staff member sprayed the counter tops and the recliner with Dispatch, waited 45 seconds and wiped the surfaces. He/she also sprayed the wheelchair and wiped after 15 seconds. He/she did not clean the blood pressure cuff or the oxygen saturation probe. The manufacturer's directions for the Dispatch were to spray and allow 1 minute kill time before wiping or drying. 3. The facility policy titled "Routine Cleaning of Operating Room", last reviewed 08/07/10, stated, "...Between Cases- Operating Room, OR personnel will do the following: 1. Patient carts, back-tables, and mayo stands will be washed with a germicide and dried. ...6. Damp clean the back table, the mayo stand, OR table, and any other equipment which could have become soiled during the case, if deemed necessary." The policy did not address any equipment that came in contact with the patient, regardless of whether or not it appeared soiled. 4. The facility policy titled "Infection Control Procedures- PAR Area", last reviewed 08/07/10, stated, "...1. Patient chairs are washed with germicidal			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	solution after each patient." The policy did not address any other equipment that came in contact with the patient. 5. At 11:00 AM on 01/11/12, staff member #N1 confirmed that all of the equipment coming in contact with a patient was not routinely disinfected between patients.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
S1174	410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(A) (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: (5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: (A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice. Based on policy review, observation, and interview, the facility failed to ensure the operating rooms were cleaned according to acceptable standards of practice by the contracted cleaning service. Findings included: 1. The facility's policy, titled "Dress Requirements", last reviewed 08/07/10,	S1174	To ensure operating rooms are cleaned by the contracted housekeeping service according to acceptable standards of practice, an in-service was conducted by the Surgery Center Director and encompassed a review of the ASC policy regarding dress requirements for cleaning personnel, directions for preparation and dilution of floor cleaning chemicals, as specified by the manufacturer's label, and	01/26/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012
NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	stated under Procedures, "...1. Street clothes are not permitted in designated restricted areas (scrub suits, hats, masks, and shoe covers are provided for staff and visitors entering these areas.)" 2. The facility's policy, titled "Housekeeping Policy", last reviewed 08/07/10, stated on page 2, "...E. Cleaning apparel for personnel. While cleaning the recovery room, operating room, clean processing rooms, soiled rooms and the surgical hallways, cleaning personnel will put on the following apparel prior to entering the areas: 1. Surgical scrub suit 2. Surgical hat 3. Surgical shoe covers 4. Surgical mask (only required in OR)." 3. Upon entering the operating room at 3:30 PM on 01/10/12, accompanied by staff member #N1, the cleaning service staff members #N15 and N16 were observed dressed in surgical garb preparing to begin the cleaning procedure. Neither staff member was wearing a mask and asked staff member #N1 whether they should put one on. Staff member #N15 was wearing a white long sleeved turtle neck that extended above the neck of the scrub top and below the short sleeves of the top. A blue bucket, containing approximately 2 gallons of clear solution, was indicated		instructions for use of an alternative cleaner specifically designed to disinfect hard surfaces and equipment thereby replacing the previous cleaning agent which was being inappropriately employed. A calibrated bucket and measuring cup had been purchased prior to adhere to manufacturer's directions for exact chemical dilution ratios. All housekeeping staff were in attendance. The Surgery Center Director will conduct an unannounced observance/evaluation of housekeeping personnel during the first quarter of 2012 and a minimum of annually thereafter to ensure standards continue to me met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	for the rags to disinfect all surfaces in the room. Staff member #N15 indicated 3 caps of Hepacide Quaternary solution were mixed in 1 gallon of water. The cap indicated was the screw on cap with the spray device attached to the ready-to-spray bottle of disinfectant. The manufacturer's directions on the bottle were to spray the disinfectant on surfaces and allow a 10 minute kill time. A mop bucket, containing approximately 4 gallons of a clear solution, was also ready to be used in the room. Staff member #N15 indicated that solution was mixed in the housekeeping closet. 4. At 3:50 PM on 01/10/12, the housekeeping closet was visited. Staff member #N15 indicated a container of Vesphene disinfectant was the chemical used in the water to mop the floors. He/she indicated 1/4 cup of disinfectant was mixed with 1 1/2- 2 gallons of water and stated that's the amount that was in the bucket observed in the OR. No measuring devices in the closet or markings on either of the buckets were observed. The manufacturer's instructions on the Vesphene were to mix 1 ounce of disinfectant per gallon of water. 5. Staff member #N15 indicated that after 15 years in the business, he/she could measure without markings.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANKRATZ EYE INSTITUTE LLC	3135 MIDDLE RD COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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