

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001087	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2012
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NAME OF PROVIDER OR SUPPLIER INDIANA SURGERY CENTER-EAST	STREET ADDRESS, CITY, STATE, ZIP CODE 5445 E 16TH ST INDIANAPOLIS, IN 46218
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S0000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 010817</p> <p>Survey Date: 8-20/22-12</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 08/24/12</p> <p>10/24/12 revised due to IDR</p>	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0432	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on document review and interview, the facility failed to follow established policy & procedure for terminal cleaning of the operating rooms.</p> <p>Findings include:</p> <p>1. Review of policy/procedure Cleaning Operating Room: End of Procedure and Terminal indicated the following; "2. Cleaning, End of the day. a. At the conclusion of the day's schedule, terminally clean OR rooms, scrub/utility areas, corridors, OR tables, furniture and equipment. c. Saturate all surfaces with approved disinfectant while wearing gloves." This policy/procedure was last reviewed/revised on 10-13-11.</p> <p>2. On 08-22-12 at 1130 hours, staff #46</p>	S0432	<p>410 IAC 15-2.5-1(f)(2)(E)(iii) Infection Control Program</p> <p>1. Policy Cleaning Operating Room: End of Procedure and Terminal will be updated to reflect current practice around the cleaning of the OR walls/ceilings on a monthly basis unless visibly saturated. (See attachment A) 2. Policy will be reviewed yearly for discrepancies in practice. 3. Infection Control Officers in conjunction with the Executive Director. 4. Policy will be sent for approval on October 18, 2012.</p>	10/18/2012

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	confirmed that the walls in the Operating Rooms are cleaned monthly with wexcide and caviwipes.			

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S0888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review, the facility failed to ensure that operative reports describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery for 7 of 30 medical records (MR) reviewed (Patient #2, 4, 6, 9, 12, 21 and 27).</p> <p>Findings include:</p> <p>1. Review of the following MRs indicated the following: Patient #2 had surgery on 05-09-12 and the Operative Report was dictated on</p>	S0888	410 IAC 15-2.5-4(d)(2)(F) Medical Staff; Anesthesia and Surgical 1. All surgeons will now receive electronic notification when operative reports are not dictated immediately following surgery until the deficiency is completed. Monitoring on a weekly basis to see that dictations are now being done to facility policy. The very first step toward improving a process is to understand the process. Re-education of our Physicians who have displayed inadequate knowledge of how the process does work, coupled with inadequate knowledge of how the process should work will be address by one or all the following	09/04/2012	

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	<p>08-20-12. Patient #4 had surgery on 05-29-12 and the Operative Report was dictated on 05-30-12. Patient #6 had surgery on 01-13-12 and the Operative Report was dictated on 02-22-12. Patient #9 had surgery on 04-05-12 and the Operative Report was dictated on 04-06-12. Patient #12 had surgery on 06-05-12 and the Operative Report was dictated on 07-13-12. Patient #21 had surgery on 06-26-12 and the Operative Report was dictated on 06-27-12. Patient #27 had surgery on 05-15-12 and the Operative Report was dictated on 05-17-12.</p>		<p>steps: 1. Tips and Tricks handout 2. EPIC class 3. One-on-one training with a HIT leader The HIM department electronically monitors daily all outpatient records and notes any deficiencies. The physician is notified of the deficiencies in their inbox each time they sign into the computer system. Each Monday a letter will be mailed to the physicians who have not completed their deficiencies. The HIM Deficiency Supervisor is responsible for overseeing all deficiency notices. If the physician continues to fail to complete his/her deficiencies after two notices the HIM Deficiency Supervisor will contact the office to offer the physician assistance with one of the mentioned above steps. If the physician reaches a third notice, the HIM Deficiency Supervisor will notify the Director of Coding and Medical Records. The Director of Coding and Medical Records will notify the Executive Director of the Community Surgery Center. The Executive Director of the Community Surgery Center along with Medical Director will contact the physician concerning his/her deficiencies. It will also be determined at that time if admitting privileges will be suspended until all incomplete records are completed. On August 22, 2012 the Community Surgery Center went to an electronic medical record.</p>		

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			Policies are still being developed and are to be completed no later than May 1, 2013. 2.. Our recent conversion to Electronic Medical Record provided timely notification for missing reports. 3. Business Office Team Leader 4. September 4, 2012		

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S0920	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following: Based on document review, the facility failed to follow written patient care policies and procedures for blood transfusions for 1 of 3 patient blood transfusion medical records (MR) reviewed (Patient #8).</p> <p>Findings include;</p> <p>1. Review of policy/procedure Blood and Blood Products Administration indicated the following: "Procedure C. An informed consent for blood product transfusion must be signed before nursing draws a type and screen or a type and crossmatch. D. Blood is to be started as soon as received from Blood Bank. Under No circumstances is blood to be stored in refrigerator in the nursing area." This policy/procedure was last reviewed/revised on 10-13-11.</p> <p>2. Review of patient #18's MR indicated that unit # W040711113423, an A positive packed red blood cells, was</p>	S0920	<p>410 IAC 15-2.5-5(b) Patient Care Services</p> <p>1. All patients receiving blood or blood products will sign a consent prior to nursing draw for a type and screen a type and cross match. Policy and procedure will be updated to address the storage of blood products prior to its administration. (See attachment B) 2. All medical record of those patients receiving blood products will be audited for consent and proper storage of blood and/or blood products. 3. Patient Room Team Leader in conjunction with Executive Director 4. September 10, 2012</p>	09/10/2012	

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	<p>signed out of the Blood Bank on 12-13-11 at 0013 hours. The patient's MR indicated the unit of packed red blood cells was started at 0306 hours. The Transfusion Record had in bold print the following; "Do not store blood on nursing unit. Transfuse to patient or return to Blood Bank within 30 minutes."</p> <p>Review of patient #8's MR lacked documentation of a consent for blood product transfusion. The patient's MR had a Consent to Blood or Blood Component Transfusion from facility #2 dated 12-13-11. It could not be determined that the patient had consented for blood product transfusion from the facility.</p>			

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S1146	<p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on observation, the facility maintained 2 conditions which may result in a hazard to patients, public, or employees.</p> <p>Findings:</p> <p>1. On 8-22-12 at 3:10 pm, in the presence of employee #A4, it was observed in the Washer Room, there was an alcohol-based hand sanitizer (ABHS) affixed to a wall. Below it and approximately 2" to the left, there was an electrical switch. There was also observed to be streaks (stains) on the wall below the ABHS, which may have been from the ABHS.</p> <p>2. In the above case, the close location relative to an ignition source and the staining on the wall, posed a fire hazard if</p>	S1146	<p>410 IAC 15-2.5-7(b)(2) Physical Plant, Equipment Maintenance</p> <p>1. Alcohol based hand sanitizer affixed to the wall in the washer room was removed on 8/23/12. 2. All future hand sanitizers affixed to the wall will be authorized by property management liaison and Executive Director. 3. Property Management Liaison and Executive Director. 4. August 23, 2012</p> <p>1. Deionizer room pit will be covered to prevent any potential safety hazards. 2. Deionizer room will be checked monthly by Property Management liaison to verify covering is intact. 3. Property Maintenance liaison in conjunction with Executive</p>	08/23/2012			

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	<p>the flammable alcohol was sprayed or dropped into the electrical ignition source.</p> <p>3. On 8-22-12 at 3:15 pm, in the presence of employee #A4, it was observed in the Deionizer Room there was an uncovered pit on the floor. The pit was approximately 2' x 3' and 10' deep. It was also observed there was some piping and tubing running vertically from the bottom to the top of the pit. However, the open, non-grated pit area not affected by the piping and tubing was still large enough to allow for a person who tripped, fell or be accidentally pushed into the pit, to sustain injury.</p>		<p>Director. 4. September 11, 2012</p>		

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S1162	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: Based on document review and interview, it could not be determined the facility followed the manufacturer's recommendation for the preventive maintenance (PM) of 1 sterilizer and followed facility policy for the schedule and testing of the nurse emergency call (code) system.</p> <p>Findings:</p> <p>1. Review of documentation of PM of a sterilizer indicated there had been some checks conducted.</p> <p>2. In interview, on 8-22-12 at 3:00 pm, employee #A1 indicated there was no documentation of manufacturer's recommendation for the PM of a</p>	S1162	<p>410 IAC 15-2.5-7 Physical Plant, Equipment Maintenance</p> <p>1. Prevention Maintenance (PM) for the sterilizer and the nurse call will be conducted according to manufacturer's recommendation and in compliance with Center's policy.</p> <p>2. All equipment requiring a PM will be placed on a schedule per manufacturer's recommendation and be included in one PM document that is reviewed annually.</p> <p>3. Clinical Engineering and Support Services Team Leader</p> <p>4. September 22, 2012</p>	09/22/2012

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	<p>sterilizer. Thus, it could not be determined if the facility followed manufacturer's recommendations for the PM of the sterilizer.</p> <p>3. Review of documentation of testing of the facility's nurse emergency call (code) system indicated there had been some testing conducted.</p> <p>4. In interview, on 8-22-12 at 3:00 pm, employee #A1 indicated there was no documentation of a policy regarding this testing. Thus, it could not be determined if the facility followed their policy for testing of the equipment.</p>			