

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001111		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/10/2012	
NAME OF PROVIDER OR SUPPLIER WABASH VALLEY EYE SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CLEARVIEW DR VINCENNES, IN 47591			
(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	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 002897</p> <p>Survey Date: 05/09/12 through 05/10/12</p> <p>Surveyors: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: claughlin 06/18/12</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001111	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WABASH VALLEY EYE SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CLEARVIEW DR VINCENNES, IN 47591
--	---

(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
S0414	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on review of administrative documents, infection control meeting minutes, and interview, the facility failed to ensure the Infection Control Committee met quarterly and included the person responsible for the program.</p> <p>Findings included:</p> <p>1. The facility job description for the Infection Preventionist indicated, "...3.</p>	S0414	All members of the Infection Control Committee will meet quarterly together and conduct the quarterly meeting. The Infection Preventionist for Wabash Valley Eye Center will conduct this meeting. This will start with the next quarterly meeting scheduled for July 17th, 2012. Chelsea Rodimel, Infection Preventionist for Wabash Valley Eye Surger Center, will be responsible for making sure this meeting is conducted every	07/17/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001111		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/10/2012	
NAME OF PROVIDER OR SUPPLIER WABASH VALLEY EYE SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CLEARVIEW DR VINCENNES, IN 47591			
(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			
	<p>Prepares the agenda for the Infection Prevention Committee".</p> <p>2. The minutes of the Infection Control/Tissue Review Committee indicated a meeting was held at the facility on April 4, 2012 and listed the names of 4 of the 5 members of the committee as being present. The Infection Preventionist, staff member #P4, was one of the members listed as present. The minutes were signed by staff member #P9, the facility administrator who signed as secretary of the committee.</p> <p>3. At 2:15 PM on 05/09/12, staff member #P4, the Infection Preventionist, was interviewed. He/she indicated he/she was new to the position and was just hired at the end of January. He/she indicated he/she worked with the previous nurse for 2 weeks before he/she left. He/she indicated she met with staff member #P10, the director, every Wednesday to discuss any issues or concerns. When questioned about the Infection Control meeting and preparing the agenda, staff member #P4 indicated he/she had not prepared an agenda or attended any official meeting. When questioned about the next meeting, staff member #P4 indicated he/she did not know when a meeting was scheduled. When questioned by the other surveyor about an</p>		<p>quarter and that we have all members present for this meeting. This will be monitored by a sign in sheet that each member will sign.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001111	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/10/2012
NAME OF PROVIDER OR SUPPLIER WABASH VALLEY EYE SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CLEARVIEW DR VINCENNES, IN 47591		
(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	
	<p>Infection Control Committee meeting on April 4, 2012, staff member #P4 again indicated he/she had not been at a formal meeting with the other staff members of the committee.</p> <p>4. At 12:30 PM on 05/10/12, the director, staff member #P10, was interviewed. He/she indicated that staff meet informally to discuss any issues since the facility was so small, had only one physician, and did not have any infections. When questioned about the Infection Control Committee meeting on April 4, 2012, he/she confirmed it was not a formal meeting and the notes were only sent to staff member #P9 who typed them up.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001111		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/10/2012	
NAME OF PROVIDER OR SUPPLIER WABASH VALLEY EYE SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CLEARVIEW DR VINCENNES, IN 47591			
(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			
S0422	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(C)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(C) Reviewing employee exposure incidents and making appropriate recommendations to minimize risk.</p> <p>Based on policy and procedure review, form used for skin testing review, employee file review, and interview, the facility failed to ensure all staff received TB testing according to the policy and the form used for 8 of 8 files reviewed (#P1-P8).</p> <p>Findings included:</p> <p>1. The facility policy "Tuberculosis Screening for Employees", last reviewed 10/16/09, indicated, "...1. Tuberculin skin testing A. New employees 1. New employees who have been made a conditional offer of employment shall be screened for presence of infection with M. tuberculosis using the Mantoux TST. Skin testing will employ the two-step procedure. ...4. Individuals with documented history of negative TST performed within the last 12 months need to receive only one (1) intradermal injection of TST tuberculin. (Note: In this instance, the prior skin test serves as</p>	S0422	<p>The facility policy for tuberculosis screening regarding new employees will be reviewed and changed to include a two-step procedure for TB testing. The form used to document the TB testing will be reviewed and at least two changes will be made to the form by July 17, 2012: 1. The form will state the Mantoux skin test will be read 48-72 hours after the injection. 2. The form will be updated to include the date and time the injection was given and the date and time the injection was read. Employees will receive a second TB test to make everyone compliant with the two-step procedure for testing by July 31, 2012. Deedra Funk RN, Surgical Coordinator for Wabash Valley Eye Surgery Center will be responsible for making sure all employees receive the two-step TB test. This will be monitored by Deedra Funk RN, Surgical Coordinator for all new hires and yearly for all employees.</p>	07/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001111	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WABASH VALLEY EYE SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CLEARVIEW DR VINCENNES, IN 47591
--	---

(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
	<p>the 1st step of a two-step procedure)." The policy continued on page 3, "...D. The Mantoux test should be read 48 to 72 hours after the injection."</p> <p>2. The facility form "Mantoux Skin Test Consent/Administration Record" indicated, "...I understand I must have my test read in 48 hours (2 days) for age group 55 and under or 72 hours (3 days) for age group 55 and over".</p> <p>3. Review of the employee files indicated staff members #P1, P2, P3, P6, P7, and P8 had current 2011 TB tests documented, but all lacked any times for the placement or the reading to determine adherence to reading the test within 48-72 hours.</p> <p>4. The records indicated staff members #P1, P3, P6, P7, and P8 were under 55 years of age, but had their tests read in 3 days, not in 2 days as specified on the testing form.</p> <p>5. The files for staff members #P4 (hire date 01/31/12) and #P5 (hire date 03/13/12) lacked documentation of the two-step procedure being performed.</p> <p>6. At 9:15 AM on 05/10/12, staff member #P10 indicated he/she was not aware of the policy requiring the two-step</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001111		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/10/2012	
NAME OF PROVIDER OR SUPPLIER WABASH VALLEY EYE SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CLEARVIEW DR VINCENNES, IN 47591			
(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			
	<p>procedure and confirmed it had not been done. He/she indicated the training for the TB testing was provided by the area hospital and that was where they got the information regarding the different readings for different age groups for their form. However, after contacting the training staff at the hospital, staff member #P10 was unable to obtain any rationale or further information as to why it was done that way. He/she indicated the manufacturer's insert for the testing solution used, Aplisol, just indicated the test was to be read within 48 to 72 hours. He/she also indicated that the facility form actually had the age groups transposed, according to the hospital training staff.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001111		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/10/2012	
NAME OF PROVIDER OR SUPPLIER WABASH VALLEY EYE SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CLEARVIEW DR VINCENNES, IN 47591			
(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			
S1170	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and staff interview, the facility failed to ensure the Defrillator Monitor was discharged and performed on the daily shift routine inspection.</p> <p>Findings included:</p> <p>1. Hewlett Packard 43100A Defrillator/Monitor operating manual states, "Every Shift: Verify that the instrument is connected to AC power and that the Battery Charger LED is lit; Check for adequate thermal paper in the</p>	S1170	Documentation for the defibulator check (which is conducted according to the manufactor's recommendations) will be listed on the daily check sheet. This check was bundled with the crash cart check and we have separated these two checks and each one now has separate documentation. This check is performed every day the surgery center is open by Deedra Funk RN, Surgical Coordinator. The policy regarding Facility and Environment was reviewed and changed to reflect that the emergency equipment will be checked every day the surgery	07/13/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001111	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/10/2012
NAME OF PROVIDER OR SUPPLIER WABASH VALLEY EYE SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2020 CLEARVIEW DR VINCENNES, IN 47591		
(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	
	<p>recorder; Check for presence of ECG Leads, electrodes.' The operating manual indicates the AED should be discharged every week.</p> <p>2. The facility's policy, Equipment/Supplies Checklist Schedule notes that the equipment/supplies shall be monitored periodically to assure readiness for operating. The equipment/supplies shall be monitored according to a daily, weekly, monthly and quarterly schedule. The policy references the Defibrillator was to be monitored monthly.</p> <p>3. The facility was open 3-days a week: Monday/Wednesday/Friday. The daily and monthly logs were reviewed. Neither log references the Defrillator was checked according to the manufacturer's recommendations.</p>		center is open according the manufactor's recommendations.		