

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001165	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/08/2014
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NAME OF PROVIDER OR SUPPLIER  MOORESVILLE ENDOSCOPY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 HADLEY RD STE 101 MOORESVILLE, IN 46158
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S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 012150</p> <p>Survey Date: 07/07/2014 through 07/08/2014</p> <p>Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 07/11/14</p>	S000000		
S000442	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</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</p>			

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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	<p>programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on employee file review, policy review, and interview, the employee health program failed to ensure all staff had documentation of immunization status in 2 of 7 files reviewed (#P1 and P7).</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The file for staff member P1 indicated a Health History form with the box checked for "Reliable history of Chicken Pox", but no actual documentation of proof of the disease or immunity.</li> <li>The file for staff member P7 indicated a Health History form with the box checked for "Reliable history of Chicken Pox", but no actual documentation of proof of the disease or immunity.</li> <li>The facility policy, "Infection Control Plan", last reviewed 07/25/12, indicated, "11. Employee Health Program including, but not limited to: ...d. Documentation of history or immunity to</li> </ol>	S000442	<p>Employees unable to obtain documented verification from a healthcare professional that they have received vaccination for or have had Varicella in the past must have a titer drawn to determine immunity to Varicella. This will be validated by the Clinical Director upon hire. Existing employees not having the required documentation will receive an order to obtain a titer with testing completed by August 25, 2014. Responsible Person: Clinical Director, Connie Taylor RN, CGRN</p>	08/25/2014

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S001146	<p>Rubella, Rubeola, and Chicken Pox."</p> <p>4. At 2:30 PM on 07/08/14, staff member P1 indicated the facility followed the CDC (Centers for Disease Control) and OSHA guidelines regarding immunizations, but was not aware that self attestation of history of the disease was not sufficient. He/she indicated the facility had accepted the employee's verbal history of the disease.</p> <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 documentation review, observation and staff interview, the facility failed to follow the manufacturer's recommendations on flushing of eyes with water when chemicals come in direct</p>	S001146	The Eye Wash Station policy was changed to require a 20 minute eye flush for any splash to the eye. This was completed by the Clinical Director on 8/8/2014 Responsible Person: Clinical Director Connie Taylor, RN, CGRN	08/08/2014			

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	<p>contact with them.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. The Eye Wash Station policy, last approved 7/25/2012, stated, "Eyes should be flushed for approximately 5 minutes or until material cleared. Prolonged flushing may cause more injury to the eye."</li> <li>2. While touring the surgery center on 7/8/2014, the following chemicals were observed throughout the facility: Cidex OPA, Cavicide, Sani Cloth, Dispatch, and Protech-soft soft surface cleaner. The manufacturer label on the products require 15 to 20 minutes of continuous eye flushing with water if the product comes in direct contact with a person's eyes. The manufacturer label requires a longer length of flushing of eyes than noted in the surgery center's policy on eye wash stations.</li> </ol>						

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S001174	<p>3. At 1:30 PM on 7/8/2014, staff member #1 indicated the staff at Mooresville Endoscopy Center were trained to not exceed 5 minutes of flushing of eyes with water. The staff member confirmed the assorted chemicals in the surgery center require 10 to 15 minutes of eye flushing with water which conflicts with the facility's policy. The staff member confirmed the manufacturer's label supercedes the facility's policy on which the staff were trained.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(A)</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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept</p>						

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	<p>clean and orderly in accordance with current standards of practice, including the following:</p> <p>(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:</p> <p>(i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice.</p> <p>Based on review of cleaning logs, policy review, and interview, the infection control committee failed to ensure environmental services were provided to ensure the safety and well-being of the patients treated in the facility.</p> <p>Findings included:</p> <p>1. Review of the contracted cleaning company's Housekeeping Schedules indicated the following: A. April 2014- no documentation of cleaning on 04/25/14, 04/28/14, 04/29/14, and 04/30/14; 4. Dust all surfaces daily documented only on 04/03/14, 04/10/14, 04/17/14, and 04/24/14: B. Weekly- Wash laminate cabinets only documented for the first 2 weeks of the month. B. May 2014- no documentation of cleaning on 05/30/14; 4. Dust all surfaces daily documented only on</p>	S001174	Housecleaning staff was made aware of the omission of initialing the record of completed tasks and that this must be done on a daily basis as the tasks are completed. The document was revised to make the process easier. This was completed on 7/23/2014 by the Clinical Director. The task completion record will be monitored by the Clinical Director or charge person. This was initiated on 7/8/2014 by the Clinical Director The building manager, Kim Collins was notified of H1's (EMS cleaning supervisor's) inability to answer questions by the ISDH surveyor and notified of the discrepancies. Brian Wyatt (EMS Regional Manager) was also notified of the interview results with H1. Additional training with the cleaning supervisor (H1) and the cleaning crew occurred on 7/23/14 by EMS management. Copies of the training documents and Infection	08/25/2014

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	<p>05/01/14, 05/02/14, 05/07/14, 05/12/14, 05/13/14, 05/21/14, 05/22/14, 05/26/14, and 05/27/14: B. Weekly- Wash laminate cabinets only documented for the first and third weeks of the month. C. June 2014- no documentation of cleaning on 06/30/14; 4. Dust all surfaces daily documented only on 06/02/14, 06/03/14, 06/09/14, 06/12/14, 06/17/14, 06/18/14, 06/23/14, and 06/26/14: B. Weekly- Wash laminate cabinets only documented for the first and third weeks of the month.</p> <p>2. The facility policy "Housecleaning Schedule", last reviewed 07/25/12, indicated, "In order to maintain a clean environment, housekeeping will follow a schedule for cleaning the facility. All solutions used in cleaning the procedure area will be mixed specifically for the procedure area. No solutions used in cleaning the pre and post-procedure area will then be used to clean the procedure area. The procedure area will be cleaned before the pre and post-procedure area. Responsibility: Housecleaning Personnel. Procedure: A. Daily: ...2. Mop all floors ...4. Dust all surfaces ...B. Weekly: 1. Wash laminate cabinets."</p> <p>3. The facility policy "Cleaning of the Procedure Room Suite", last reviewed 07/25/12, indicated, "Procedure: A.</p>		Control/cleaning policies of Mooresville Endoscopy Center are included. The Clinical Director conducts quarterly observations of the cleaning staff and copies are included with the Plan of Correction. EMS will begin conducting quarterly observations and will provide documentation of these findings with the Clinical Director beginning this month. Responsible Person: Clinical Director Connie Taylor, RN, CGRN	

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	<p>Endoscopy Room: ...2. Use fresh water and a clean cloth daily. 3. Wash the room and equipment from cleanest to dirtiest. ...C. Floor: 1. Floor of procedure room will be dusted and wet mopped first, then the central area, then pre-procedure and post-procedure. Germicidal/virucidal/fungicidal solution is added to water used to mop in accordance with manufacturer's directions."</p> <p>4. The facility policy "Infection Control Plan", last reviewed 07/25/12, indicated, "5. Housekeeping performed according to pre-established worksheets. (See policy on Housekeeping Services)."</p> <p>5. Facility staff contacted the contracted cleaning service three times to request one cleaning staff member to come to facility or call to be interviewed by surveyor. At 3:20 PM on 07/08/14, H1, the Director of Operations of the cleaning company arrived at the facility. H1 deflected questions and informed surveyor that he/she was actually on vacation and was caught off-guard. It was unable to be determined if anyone from the cleaning company actually observed the staff cleaning at the facility to ensure compliance with all procedures. H1 indicated staff used paper towels to wipe the disinfectant off surfaces and</p>			

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	<p>equipment in the procedure rooms so that they could just be discarded. He/she also indicated staff used disposable mop heads on the floors, disinfected them at the facility, and changed them about every 3 days.</p> <p>6. At 3:45 PM on 07/08/14, staff member P1 confirmed the discrepancies with the information provided by H1 and the expectations of the facility. He/she indicated he/she had observed a staff member cleaning the facility and a clean mop head was used each time and paper towels were not used in the procedure rooms. P1 indicated he/she did not have documentation of the observations and confirmed the cleaning logs were incomplete.</p>				