

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001169	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2013
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NAME OF PROVIDER OR SUPPLIER INDIANA SPECIALTY SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 W ARCH HAVEN AVE BLOOMINGTON, IN 47403
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Q000000	<p>This visit was for a re-certification survey.</p> <p>Facility Number: 011996</p> <p>Survey Date: 11/4/2013 through 11/5/2013</p> <p>Surveyors: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Albert Daeger Medical Surveyor</p> <p>QA: 11/26/13</p>	O000000		

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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Q000081	<p>416.43(a), 416.43(c)(1) PROGRAM SCOPE; PROGRAM ACTIVITIES</p> <p>(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.</p> <p>(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.</p> <p>(c)(1) The ASC must set priorities for its performance improvement activities that -</p> <ul style="list-style-type: none"> (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. <p>Based on documentation review and staff interview, the facility failed to ensure action was taken and documented regarding opportunities for improvement found through the quality assessment and improvement program for 4 instances.</p> <p>Findings included:</p>	O000081	Documentation of discussion was inadvertently omitted in the Board of Manager minutes for exception occurrences in the QAPI program as noted. The Board (on 12-4-13) suggested that the Business Office Manager also review the minutes for clarity as a backup to the Administrator, who is responsible for writing the minutes. It should be noted that the Administrator does monitor the contracted housekeeping service who presents while the	12/04/2013			

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	<p>1. Quality Improvement and Performance Improvement Program (last approved 4/2/2013) indicated that the center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program from the outcomes of the documented actions that were taken.</p> <p>2. The 2013 Indiana Specialty Surgery Center Quality Monitoring Elements dashboard was reviewed for the first quarter of 2013. Critical Care Item, Patient Injury standard was not met. The Remarks on the dashboard stated, "Witnessed Patient fall, no injury." The Board of Manager meeting minutes, the Medical Staff Minutes, and Quality Council Meeting minutes for 2013 were reviewed. None of the meeting minutes discussed the outcome of the patient injury or how to reduce the likelihood of</p>		<p>Admin is in the building at the end of the day at least weekly; the question asked of the Administrator was whether she "drops in" for surprise evaluations and the answer was no. The Center monitor "facility will appear clean" is a recognized measure of environmental cleaning according to "Guidelines for Environmental Infection Control in Health-Care Facilities, Recommendations of CDC and the Healthcare Infection Control, Practices Advisory Committee (HICPAC), 2003", which states "Keep housekeeping surfaces (e.g., floors, walls, and tabletops) visibly clean on a regular basis and clean up spills promptly.954 Category II".The Administrator maintains responsibility for evaluation of the contracted housekeeping service and reports of its compliance to the Board.</p>		

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	<p>that incident to happen again. An action plan with follow-up was not created.</p> <p>3. The 2013 Indiana Specialty Surgery Center Quality Monitoring Elements dashboard was reviewed for the first quarter of 2013. Environmental Safety element, Employee Injury standard was not met. The Remarks on the dashboard stated, "Employee needle stick." The Board of Manager meeting minutes, the Medical Staff Minutes, and Quality Council Meeting minutes for 2013 were reviewed. None of the meeting minutes discussed the outcome of the patient injury or how to reduce the likelihood of that incident to happen again. An action plan with follow-up was not created.</p> <p>4. The 2013 Indiana Specialty Surgery Center Quality Monitoring Elements dashboard was reviewed for the first quarter of 2013. Environmental Safety</p>			

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	<p>Element, Housekeeping was reviewed. The Standard on the dashboard stated, "Facility will appear clean. Contracted service employees will review & follow facility policy & procedures." Staff member #1 could not provide documented evidence that the contracted housekeeping service was being monitored per dash board Standard requirements. The surgery center did not ensure the effectiveness, continued follow-up, and the impact as it had to patient care.</p> <p>5. Indiana Specialty Surgery Center Facility Temperature and Humidity Log had 23 days recorded for October 2013. The two operating rooms each had 23 of 23 days recorded temperatures below the recommended temperature of 68 degrees Fahrenheit. The recorded temperature averaged 61.9 degrees Fahrenheit for the two operating rooms. The 2 PACU suites monitor the temperature for 3</p>			

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	<p>rooms each. The recorded temperatures for the two PACU suites were below 70 degrees Fahrenheit: 23 of 23 days for PACU suite #1 and 22 of 23 days for PACU suite #2. The surgery center did not identify or create an action plan on the temperature violation of the Operating and PACU Rooms.</p> <p>6. At 4:00 PM on 11/4/2013, staff member #1 confirmed the patient and staff injuries in Quarter #1 of 2013 were not addressed in the Quality Council. The staff member confirmed the temperature issues that were discovered on the October logs for the Operating and PACU Rooms were not brought to the attention of the Quality Council to discuss. Staff member #1 indicated he/she does not monitor the effectiveness of the contracted housekeeping service. The only monitoring was the following morning if everything appears clean. The staff member confirmed he/she</p>			
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Q000101	<p>can not confirm if the contracted service was properly disinfecting the operating rooms per policy.</p> <p>416.44(a)(1) PHYSICAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services. Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. Based on documentation review and staff interview, the facility failed to ensure 2 of 2 operating rooms and 2 of 2 PACU suites temperatures were maintained between the recommended temperature range per surgery center's policies and procedures and failed to maintain the cleanliness of the room where the microwave was used for preparing meals for extended stay patients.</p>	Q000101	Please refer to correction S 1146.	12/24/2013

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	<p>Findings included:</p> <ol style="list-style-type: none"> 1. Indiana Speciality Surgery Center Facility Temperature and Humidity Log indicated the operating room recommended temperature range was 68 to 73 degrees Fahrenheit and the recommended temperature range for the 2 PACU suites was 70 to 75 degrees Fahrenheit. 2. Indiana Speciality Surgery Center Facility Temperature and Humidity Log had 23 days recorded for October 2013. The two operating rooms each had 23 of 23 days recorded temperatures below the recommended temperature of 68 degrees Fahrenheit. The recorded temperature averaged 61.9 degrees Fahrenheit for the two operating rooms. The 2 PACU suites monitor the temperature for 3 rooms each. The recorded temperatures for the two PACU suites were below 70 degrees 			
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	<p>Fahrenheit: 23 of 23 for PACU suite #1 and 22 of 23 for PACU suite #2</p> <p>3. At 2:40 PM on 11/4/2013, staff member #1 confirmed the recorded temperatures for the two operating rooms and the 2 PACU suites were not meeting the minimum temperature requirement per policy.</p> <p>4. Extended Stay Nutrition policy (last approved 1/28/2013) stated, "Local health department guidelines for food preparation and handling will be followed."</p> <p>5. Retail Food Establishment Sanitation Requirements 410 IAC 7-24-173 notes that food being prepared must be done where there would be no chance of cross-contamination."</p> <p>6. At 11:00 AM on 11/5/2013, the staff lounge was toured. The counter with the microwave was observed soiled with assorted</p>						

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	<p>debris and there was at least 12 dirt cups and utensils stored on the counter. The microwave was observed with soil residue on the inside and outside surface of the microwave. The staff dining table was observed with dirty utensils on it and the table appeared to have a greasy film on it. The nutrient station for 23-hour stays had a refrigerator, hand washing sink; however, there was no cooking device located in the nutrient station.</p> <p>7. At 11:15 AM on 11/5/2013, staff member #1 indicated the microwave in the staff lounge was used for warming patient food during their 23-hour stay. The staff member indicated the staff lounge is cleaned by the overnight housekeeping service.</p>			

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Q000181	<p>416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. Based on documentation review, observation, and staff interview, the facility failed to ensure the handling of pharmaceutical supplies are received in a safe manner and failed to ensure staff cleansed the I.V. ports prior to medication administration for 1 patient observation (patient #4) and failed to discard single dose vials after use in the preoperative area.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Indiana Specialty Surgery Center Pharmaceutical policies (last approved 1/28/2013) indicated that all medications are to be received in a safe and sanitary manner. At 11:00 AM on 11/5/2013, the staff lounge was inspected. The surgery center stores health care supplies along the wall in the dining room. When a delivery 	O000181	Please refer to correction plan S 400.	11/05/2013			

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	<p>arrives to the facility, the receiving occurs in the staff lounge. Staff member #9 was observed unpacking assorted medications on the staff dining table. The staff dining table was observed with dirty utensils on it and the table appeared with a greasy film on it. The table had assorted dirty dishes on the table besides assorted food was also observed on the table. The unpacking of medication was done on an unsanitary environment.</p> <p>3. At 2:00 PM on 11/5/2013, staff member #9 indicated pharmaceuticals were received through the door to the staff lounge. The staff member confirmed assorted medications were unpacked from a Styrofoam cooler on the break room table.</p> <p>4. Anesthesia provider #1 was observed administering I.V. medications x 4 beginning at 12:30 p.m. on 11/04/13. He/she did not cleanse the I.V. port with alcohol prior to medication administration x 3.</p>			

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Q000202	<p>5. During observation of the preoperative area beginning at 2:00 on 11/4/13, two (2) partially used vials of .9% Sodium Chloride were observed on top of the medication cart. The vials were labeled as single dose vials.</p> <p>6. Staff member #N6 indicated in interview at 2:00 p.m. on 11/4/13 that the single dose vials are used to flush patients saline locks.</p> <p>7. Facility policy titled "MEDICATION ADMINISTRATION" last reviewed/revised 1/28/13 states under policy: "Single dose vials are to be used for only one patient....."</p> <p>8. Facility policy titled "MULTIDOSE VIALS" last reviewed/revised 1/28/13 states "3. Single use vials are opened and discarded after one time use."</p> <p>416.49(b) RADIOLOGIC SERVICES (1) The ASC must have procedures for obtaining radiological services from a Medicare approved facility to meet the needs of patients. Based on document and staff interview, the facility failed to ensure there were policies and</p>	O000202	Please refer to correction plan S 1222.	11/05/2013

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	<p>procedures for proper storage and handling of radiation monitoring badges (dosimetry badges) when not in use.</p> <p>Findings included:</p> <p>1. Indiana Administrative Code 410 IAC 5-5, Radiography indicates that radiation monitoring devices are to be stored outside the X-ray procedure rooms and the facilities need to have safety precautions on adequate shielding for patients, personnel, and facilities, as well as appropriate storage of dosimetry badges.</p> <p>1. The Radiology policies and procedures were reviewed on 11/5/2013 at 10:30 AM. The radiation safety precautions did not identify how to store dosimetry badges when they are not actively being used.</p> <p>2. At 12:00 PM on 11/5/2013, staff member #1 confirmed the radiation safety precaution</p>						

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Q000231	<p>policies did not reference the proper storage and handling of dosimetry badges when not in use.</p> <p>416.50(f)(1) PRIVACY The patient has the right to -</p> <p>(1) Personal privacy Based on observation, the facility failed to provide for patient privacy in the post operative/recovery area.</p> <p>Findings include:</p> <p>1. During observations in the post operative/recovery area beginning at 1:35 p.m. on 11/4/13 the following was observed:</p> <p>(A) The post operative area contained bays which were equipped with curtains. The beds were divided by curtains, however the curtains were left open at the end of the bays.</p> <p>(B) A patient was observed being discharged from the area and walking by the other bays and could see patients within the bays.</p> <p>(C) A family member was observed walking by the other patient bays and could see patients within the bays.</p> <p>(D) Care, including, but not limited to, removing the LMA from patient #4 was conducted with the curtain at the end of the bay open exposing the process to anyone walking in this area.</p>			0000231	<p>Staff was instructed following the exit survey and again during staff meeting 11-19-13 to maintain patient privacy by pulling curtains around bays. Monitoring will be done by the Safety Officer under the supervision of the Administrator and evaluated quarterly during the Safety Assessment.</p>		11/05/2013

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Q000241	<p>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.</p> <p>Based on document review, observation, and staff interview, the facility failed to ensure all areas of patient stretchers were disinfected, failed to address disinfection of the rails in policy and failed to use the appropriate dilution of cleaning solution for cleaning in the operating rooms (OR's).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "STRETCHER PREPARATION" last reviewed/revised 1/28/13 indicates the mattress is to be cleaned with germicidal spray. The policy does not address the rails of the stretcher. 2. Label instructions for Alpha-HP multi-surface disinfectant cleaner indicates that the product must be mixed at a 1:64 dilution to be effective against viruses including, but not limited to, Hepatitis B, Hepatitis C and HIV and bacterias including, but not limited to, Staphylococcus aureus (MRSA) and Enterococcus faecium (VRE). 	Q000241	Please refer to correction plan S 428.	11/05/2013

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Q000242	<p>3. During observations of stretcher cleaning beginning at 1:35 p.m. on 11/4/13, the following was observed: (A) Two (2) staff members were observed cleaning soiled stretchers in the recovery area. Both failed to wipe the small projections on the siderail which would be touched by both staff and the patient.</p> <p>4. Staff member #H1 indicated in phone interview beginning at 8:05 p.m. on 11/4/13 that he/she mixes the Alpha-HP solution at a 1:128 dilution for the OR floors.</p> <p>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 document review and staff interview, the facility failed to ensure documentation of disease history or immunization to Varicella for 2 of 7 staff members.</p>	Q000242	Please refer to correction plan S 442.	11/13/2013

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NAME OF PROVIDER OR SUPPLIER INDIANA SPECIALTY SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1380 W ARCH HAVEN AVE BLOOMINGTON, IN 47403
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S000000	<p>Findings include:</p> <ol style="list-style-type: none"> Staff members #N3 and N7 personnel file lacked evidence of immunity to Varicella. Staff member #1 verified the above at 11:45 a.m. on 11/05/13. <p>This visit was for a State licensure survey.</p> <p>Facility Number: 011996</p> <p>Survey Date: 11/4/2013 through 11/5/2013</p> <p>Surveyors:</p> <p>Albert Daeger, CFM, SFPIO Medical Surveyor</p> <p>Jennifer Hembree, RN Public Health Nurse Surveyor</p>	S000000		

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S000153	<p>QA: 11/26/13</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review and staff interview, the facility failed to provide evidence of job specific orientation for 1 of 2 surgical techs. (staff member #N3).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Staff member #N3 personnel file lacked evidence of orientation to job specific duties. Staff member #1 verified the above beginning at 11:45 a.m. on 11/05/13. 	S000153	The documentation of competency was completed and added to the employee's personnel file. The Administrator is responsible for employee files and will provide a review for completed documents at the end of each new employee's orientation period.	12/04/2013

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S000162	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(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.</p> <p>Based on documentation review and staff interview, the facility failed to ensure 4 of 7 physicians have cardiopulmonary resuscitation (CPR) competency (#2, 3, 4, and 5)</p> <p>Findings included:</p> <p>1. Medical Staff Bylaws (last approved 4/2/2013) stated, "It is the policy that the Anesthesia providers at ISSC be certified in Basic Life Support (BLS). If an anesthesia provider indicates Advance Cardiac Life Support certification, then BLS verification is not required."</p>	S000162	The Board approved (on 12-4-13) a requirement that all LIPs credentialed at Indiana Specialty show evidence of CPR certification either through documentation of basic CPR education or Advanced Cardiac Life Support education. The Administrator will monitor compliance as with all other credentialing requirements. The date for compliance has been extended 30 days so that the LIPs can complete a course to supply documentation.	01/05/2014

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	<p>2. Seven active medical staff member's files were reviewed. Four orthopedic physicians (#2, 3, 4, and 5) had no evidence in their files of CPR competency. The other three physicians were anesthesia providers.</p> <p>3. At 1:30 PM on 11/5/2013, staff member #1 indicated the facility does not have a policy on what health care providers are defined as providing direct patient care. The staff member indicated the 4 orthopedic physicians are surgeons who provide direct patient care. The policy referring to physicians was for the anesthesia providers relating to either BLS or ACLS competency requirements. The staff member indicated the physicians that are not anesthesia providers do not have evidence of CPR competency.</p>						

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S000328	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(b)</p> <p>(b) The center shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:</p> <p>(1) The action must be documented. (2) The outcome of the action must be documented as to its effectiveness, continued follow-up, and impact on patient care.</p> <p>Based on documentation review and staff interview, the facility failed to ensure action was taken and documented regarding opportunities for improvement found through the quality assessment and improvement program for 4 instances.</p> <p>Findings included:</p> <p>1. Quality Improvement and Performance Improvement Program (last approved 4/2/2013) indicated that the center shall take appropriate action to address the opportunities for improvement found through the quality</p>	S000328	Please refer to correction plan O 0081.	12/04/2013

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	<p>assessment and improvement program from the outcomes of the documented actions that were taken.</p> <p>2. The 2013 Indiana Specialty Surgery Center Quality Monitoring Elements dashboard was reviewed for the first quarter of 2013. Critical Care Item, Patient Injury standard was not met. The Remarks on the dashboard stated, "Witnessed Patient fall, no injury." The Board of Manager meeting minutes, the Medical Staff Minutes, and Quality Council Meeting minutes for 2013 were reviewed. None of the meeting minutes discussed the outcome of the patient injury or how to reduce the likelihood of that incident to happen again. An action plan with follow-up was not created.</p> <p>3. The 2013 Indiana Specialty Surgery Center Quality Monitoring Elements dashboard was reviewed for the first quarter</p>			

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	<p>of 2013. Environmental Safety element, Employee Injury standard was not met. The Remarks on the dashboard stated, "Employee needle stick." The Board of Manager meeting minutes, the Medical Staff Minutes, and Quality Council Meeting minutes for 2013 were reviewed. None of the meeting minutes discussed the outcome of the patient injury or how to reduce the likelihood of that incident to happen again. An action plan with follow-up was not created.</p> <p>4. The 2013 Indiana Specialty Surgery Center Quality Monitoring Elements dashboard was reviewed for the first quarter of 2013. Environmental Safety Element, Housekeeping was reviewed. The Standard on the dashboard stated, "Facility will appear clean. Contracted service employees will review & follow facility policy & procedures." Staff member #1 could not provide documented evidence that</p>			

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	<p>the contracted housekeeping service was being monitored per dash board Standard requirements. The surgery center did not ensure the effectiveness, continued follow-up, and the impact as it had to patient care.</p> <p>5. Indiana Specialty Surgery Center Facility Temperature and Humidity Log had 23 days recorded for October 2013. The two operating rooms each had 23 of 23 days recorded temperatures below the recommended temperature of 68 degrees Fahrenheit. The recorded temperature averaged 61.9 degrees Fahrenheit for the two operating rooms. The 2 PACU suites monitor the temperature for 3 rooms each. The recorded temperatures for the two PACU suites were below 70 degrees Fahrenheit: 23 of 23 days for PACU suite #1 and 22 of 23 days for PACU suite #2. The surgery center did not identify or create an action plan on the temperature</p>			

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	<p>violation of the Operating and PACU Rooms.</p> <p>6. At 4:00 PM on 11/4/2013, staff member #1 confirmed the patient and staff injuries in Quarter #1 of 2013 were not addressed in the Quality Council. The staff member confirmed the temperature issues that were discovered on the October logs for the Operating and PACU Rooms were not brought to the attention of the Quality Council to discuss. Staff member #1 indicated he/she does not monitor the effectiveness of the contracted housekeeping service. The only monitoring was the following morning if everything appears clean. The staff member confirmed he/she can not confirm if the contracted service was properly disinfecting the operating rooms per policy.</p>				

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S000400	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)</p> <p>(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.</p> <p>Based on observation, staff interview, and document review the facility failed to ensure staff cleansed the I.V. ports prior to medication administration for 1 patient observation (patient #4).</p> <p>Findings include:</p> <p>1. Anesthesia provider #1 was observed administering I.V. medications x 4 beginning at 12:30 p.m. on 11/04/13. He/she did not cleanse the I.V. port with alcohol prior to medication administration x 3.</p>	S000400	<p>The practitioner was aware that the ports had not been touched or wiped between sequential injections on the day of performance. The practitioner was reminded of the practice to wipe injection ports prior to any injection and verbalized agreement with this practice. Monitoring of this practice will fall to the Safety Officer under the supervision of the Administrator and practice will be observed as part of a quarterly safety assessment.</p>	11/05/2013	

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S000428	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</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>(i) Sanitation.</p> <p>Based on document review, observation, and staff interview, the facility failed to ensure all areas of patient stretchers were disinfected, failed to address disinfection of the rails in policy and failed to use the appropriate dilution of cleaning solution for cleaning in the operating rooms (OR's).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled "STRETCHER PREPARATION" last reviewed/revised 1/28/13 indicates the mattress is to be cleaned with germicidal spray. The policy does not address the rails of the stretcher. 2. Label instructions for Alpha-HP multi-surface disinfectant cleaner indicates that the product must be mixed at a 1:64 dilution to be effective against 	S000428	All staff were re-educated following closing remarks from the survey and again at staff meeting 11-19-13 regarding correct cleaning of all high-touch surfaces. Monitoring will be by the Safety Officer under the supervision of the Administrator as part of the quarterly safety monitoring survey. The contracted janitorial company's Owner/Operator re-educated the facility's janitor on the proper dilution of cleanser to use on floors in the operating room. Monitoring will be done by the Administrator during quarterly spot-checks on the performance of the contracted company.	11/05/2013			

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	<p>viruses including, but not limited to, Hepatitis B, Hepatitis C and HIV and bacterias including, but not limited to, Staphylococcus aureus (MRSA) and Enterococcus faecium (VRE).</p> <p>3. During observations of stretcher cleaning beginning at 1:35 p.m. on 11/4/13, the following was observed: (A) Two (2) staff members were observed cleaning soiled stretchers in the recovery area. Both failed to wipe the small projections on the siderail which would be touched by both staff and the patient.</p> <p>4. Staff member #H1 indicated in phone interview beginning at 8:05 p.m. on 11/4/13 that he/she mixes the Alpha-HP solution at a 1:128 dilution for the OR floors.</p>			

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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 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 document review and staff interview, the facility failed to ensure documentation of disease history or immunization to Varicella for 2 of 7 staff members.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Staff members #N3 and N7 personnel file lacked evidence of immunity to Varicella. 2. Staff member #1 verified the above at 11:45 a.m. on 11/05/13. 	S000442	Both staff members had documentation of varicella immunization completed and placed in their personnel files. Responsible party is the Administrator who will review each personnel file prior to the completion of an employee's orientation period.	11/13/2013			

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S000620	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(5)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(5) Plain paper facsimile orders, reports, and documents are acceptable for inclusion in the medical record if allowed by the center policies.</p> <p>Based on documentation review and interview, the facility failed to provide a policy or procedure for all facsimile orders, reports and any other medical records document be submitted on plain paper.</p> <p>Findings included:</p> <p>1. The facility's policies and procedures were reviewed on 11/5/2013; the facility lacked a policy that detailed all facsimile orders, and other documents to be placed in the patient's medical records on plain paper and not on thermal facsimile paper.</p>	S000620	The policy "Medical Records Policies/Procedures" was revised to specify: "Fax transmission must be on plain paper (not thermal paper) to be included as a permanent part of the medical record." This revised policy was approved by the Board of Managers 12-4-13. Monitoring for compliance falls to the Business Office Manager who is in charge of Medical Records.	11/05/2013	

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S001000	<p>2. At 1:00 PM on 11/5/2013, staff member #1 confirmed the surgery center does not have a written policy not allowing thermal facsimile paper be made part of a patient's medical record.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6</p> <p>The center shall provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services. Pharmaceutical services must have the following: Based on documentation review, observation, and staff interview, the facility failed to ensure the handling of pharmaceutical supplies are received in a safe manner.</p> <p>Findings included:</p> <p>1. Indiana Specialty Surgery Center Pharmaceutical policies (last approved 1/28/2013 indicated that all medications are</p>	S001000	<p>As the back portion of the staff lounge is also the facility's receiving area of the Center, boxes are routinely opened in the back portion of the lounge, not wanting to move cardboard boxes into the clinical areas. Therefore, a table separate from the dining table was placed in the receiving area for opening boxes, as was suggested by the surveyor. Staff was instructed on this practice 11-19-13 during staff meeting. Monitoring will be done by the Safety Officer under the direction of the Administrator, in a spot-check manner for the first month of this practice change.</p>	11/05/2013			

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	<p>to be received in a safe and sanitary manner.</p> <p>2. At 11:00 AM on 11/5/2013, the staff lounge was inspected. The surgery center stores health care supplies along the wall in the dining room. When a delivery arrives to the facility, the receiving occurs in the staff lounge. Staff member #9 was observed unpacking assorted medications on the staff dining table. The staff dining table was observed with dirty utensils on it and the table appeared with a greasy film on it. The table had assorted dirty dishes on the table besides assorted food was also observed on the table. The unpacking of medication was done on an unsanitary environment.</p> <p>3. At 2:00 PM on 11/5/2013, staff member #9 indicated pharmaceuticals were received through the door to the staff lounge. The staff member confirmed assorted medications</p>						

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S001010	<p>were unpacked from a Styrofoam cooler on the break room table.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, staff interview, and document review the facility failed to discard single dose vials after use in the preoperative area.</p> <p>Findings include:</p> <p>1. During observation of the preoperative area beginning at 2:00 on 11/4/13, two (2) partially used vials of .9% Sodium Chloride were observed on top of the medication cart. The vials were labeled as single dose vials.</p> <p>2. Staff member #N6 indicated in interview at 2:00 p.m. on 11/4/13 that</p>	S001010	<p>Staff recognized on the day of survey that the vials were labeled single dose only. Staff was re-educated at staff meeting 11-19-13 that single dose vials were to be utilized per one patient only and discarded. Monitoring will be performed by the Safety Officer with reporting to the Administrator, performed as part of the quarterly safety monitoring.</p>	11/05/2013

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S001146	<p>the single dose vials are used to flush patients saline locks.</p> <p>3. Facility policy titled "MEDICATION ADMINISTRATION" last reviewed/revised 1/28/13 states under policy: "Single dose vials are to be used for only one patient....."</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 and staff interview, the facility failed to ensure 2 of 2 operating rooms and 2 of 2 PACU suites temperatures were maintained between the recommended temperature range per surgery center's policies and procedures.</p>	S001146	The temps will continue to be monitored during days of business and the temperatures adjusted to meet the recommended ranges identified. This process was approved by the Board 12-4-13, and staff instructed on adjustment and remeasurement of the temps. Monitoring will be done by the Safety Officer under the direction of the Administrator. The correction date has been extended additional days to allow	12/24/2013			

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	<p>Findings included:</p> <ol style="list-style-type: none"> 1. Indiana Speciality Surgery Center Facility Temperature and Humidity Log indicated the Operating Room recommended temperature range was 68 to 73 degrees Fahrenheit and the recommended temperature range for the 2 PACU suites were 70 to 75 degrees Fahrenheit. 2. Indiana Speciality Surgery Center Facility Temperature and Humidity Log had 23 days recorded for October 2013. The two operating rooms each had 23 of 23 days recorded temperatures below the recommended temperature of 68 degrees Fahrenheit. The recorded temperature averaged 61.9 degrees Fahrenheit for the two operating rooms. The 2 PACU suites monitor the temperature for 3 rooms each. The recorded temperatures for the two PACU suites were below 70 degrees Fahrenheit: 23 of 23 for PACU 		the staff the opportunity to refine the problem-solving and remeasurement part of the process.		

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S001222	<p>suite #1 and 22 of 23 for PACU suite #2</p> <p>3. At 2:40 PM on 11/4/2013, staff member #1 confirmed the recorded temperatures for the two operating rooms and the 2 PACU suites were not meeting the minimum temperature requirement per policy.</p> <p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(e)</p> <p>(e) Safeguards for patients, personnel, and public must be specified, including, but not limited to, the following:</p> <p>(1) Proper safety precautions must be maintained against radiation hazards in accordance with the center's radiation and safety program(s).</p> <p>(2) Hazards and faulty equipment identified must be promptly corrected in accordance with current standards of practice and applicable federal and state rules, including, but not limited to, collimation and filtration and evaluations of equipment performance.</p> <p>Based on document and staff interview, the facility failed to</p>	S001222	As the Center's current practice for storage of radiation monitoring badges was to maintain them in a radiation free area, only the	11/05/2013			

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	<p>ensure there were policies and procedures for proper storage and handling of radiation monitoring badges (dosimetry badges) when not in use.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Indiana Administrative Code 410 IAC 5-5, Radiography indicates that radiation monitoring devices are to be stored outside the X-ray procedure rooms and the facilities need to have safety precautions on adequate shielding for patients, personnel, and facilities, as well as appropriate storage of dosimetry badges. 1. The Radiology policies and procedures were reviewed on 11/5/2013 at 10:30 AM. The radiation safety precautions did not identify how to store dosimetry badges when they are not actively being used. 2. At 12:00 PM on 11/5/2013, staff member #1 confirmed the 		<p>written policy needed to be revised. The policy "Radiation Protection Plan" and "Radiology" were both updated to state that "dosimetry badges will be maintained in a radiation free area." These policy revisions were approved by the Board of Managers 12-4-13. Monitoring for compliance falls to the Safety Officer under the supervision of the Administrator.</p>	

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S001300	<p>radiation safety precaution policies did not reference the proper storage and handling of dosimetry badges when not in use.</p> <p>410 IAC 15-2.6-1 DIETARY SERVICES 410 IAC 15-2.6-1(a)</p> <p>(a) If nourishments and other dietary needs of the patients are provided in the center, the center shall comply with 410 IAC 7-24.</p> <p>Based on documentation review, observation, and staff interview, the facility failed to ensure the Dietary Service for extended stay patients comply with 410 IAC 7-24.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Extended Stay Nutrition policy (last approved 1/28/2013) states, "Local health department guidelines for food preparation and handling will be followed." Retail Food Establishment Sanitation Requirements 410 IAC 	S001300	A microwave exclusive for the use of patient nourishments will be purchased and placed in the nourishment area of the PACU. The Administrator is responsible for this tag.	12/16/2013			

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	<p>7-24-173 notes that food being prepared must be done where there would be no chance of cross-contamination."</p> <p>3. At 11:00 AM on 11/5/2013, the staff lounge was toured. The counter with the microwave was observed soiled with assorted debris and their were at least 12 dirt cups and utensils stored on the counter. The microwave was observed with soil residue on the inside and outside surface of the microwave. The staff dining table was observed with dirty utensils on it and the table appeared with a greasy film on it. The nutrient station for 23-hour stays had a refrigerator, hand washing sink; however, there was no cooking device located in the neutrient station.</p> <p>4. At 11:15 AM on 11/5/2013, staff member #1 indicated the microwave in the staff lounge was used for warming up patient food during their 23-hour stay. The</p>			

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	staff member indicated the staff lounge is cleaned by the overnight housekeeping service.			