

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001070	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/04/2015
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NAME OF PROVIDER OR SUPPLIER ADVANCED SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 TEAL RD STE 7 LAFAYETTE, IN 47905
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S 000 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 009776</p> <p>Survey Date: 3/3/2015 through 3/4/2015</p> <p>Surveyors: Albert Daeger, BS, CFM, SFPIO Medical Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 03/20/15</p>	S 000		
S 010 Bldg. 00	<p>410 IAC 15-2.2-1 COMPLIANCE WITH RULES 410 IAC 15-2.2-1 (a)</p> <p>Sec.1.(a) All centers shall be licensed by the department and shall comply with applicable federal, state, and local laws and rules.</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>Based on document review and interview, the facility failed to comply with all applicable state laws for 2 of 2 unlicensed Operating Room Technicians' employee files that were reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. IC 16-28-13-4, a health care facility shall apply within three (3) business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry report from the state department and a limited criminal history from the Indiana central repository for criminal history information under IC 5-2-5 or another source allowed by law. 2. Review of employees #13 and #14's (Operating Room Technicians) employee files indicated that they were not certified nor licensed in the State of Indiana. Both employee files lacked documentation of a nurse 	S 010	<p>On 3/3/15 Both employees' (#13,#14) files were updated with the documentation of a nurse aide registry report verification from the State of Indiana. To Prevent the deficiency from recurring in the future every new hire that doesn't have an Indiana State License will have a nurse aide registry report ran for verification within three business days from the date a person is employed as a nurse aide or other unlicensed employee. The Director of Nursing will be responsible for running the nurse aide registry report.</p>	03/04/2015

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S 110 Bldg. 00	<p>aide registry report for verification.</p> <p>3. At 11:45 AM on 3/4/2015, staff member #1 (Director of Nursing) indicated he/she was unaware that a state nurse aide registry report was to be run on all unlicensed and non-certified health care personnel that have direct patient contact. Therefore, a state nurse aide registry report was not run on either staff member #13 or #14.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up.</p> <p>Based on documentation review and staff interview, the governing</p>	S 110	The Governing Body met in January 2015 under	03/04/2015	

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	<p>board failed to ensure the facility standing committees met quarterly for 2014 as defined in the Governing Board By-laws.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Advanced Surgery Center Governing Board By-laws (last approved 12/1/2014) indicated the standing committees are: Governing Body, Medical Staff, Quality Assurance, and Credentialing Committee. Each committee shall meet quarterly. Staff member #1 (Director of Nursing) provided documented committee minutes for the Advanced Surgery Center Governing Body. The documentation provided did not evidence any Governing Body Committee minutes for 2014. Staff member #1 provided documented committee minutes for the Advanced Surgery Center Medical Staff. The documentation 		<p>the new Director of Nursing and noted that the previous Director of Nursing didn't keep records of the Governing Body Meeting Notes for 2014. An action plan was then implemented in January to make sure that the meetings were held quarterly and the Director of Nursing documented the meetings. The Governing Body will meet quarterly to review reports of management operations to stay compliant. The Director of Nursing will be responsible for the Governing Body notes documentation.</p>		

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	<p>provided did not evidence any Governing Body Committee minutes for 2014.</p> <p>4. Staff member #1 provided documented committee minutes for the Advanced Surgery Center Quality Assurance. The documentation provided did not evidence any Quality Assurance Committee minutes for 2014.</p> <p>5. Staff member #1 provided documented committee minutes for the Advanced Surgery Center Credentialing Committee. The documentation provided revealed documented committee meetings on: 12/3/2014, 12/9/2014, and 12/17/2014. There were no documented Credentialing Committee Meeting minutes for the first, second and third quarter of 2014.</p> <p>6. At 12:10 PM on 3/4/2014, staff member #1 (Director of Nursing) indicated there were no documented meeting minutes of</p>			

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S 152 Bldg. 00	<p>the Governing Body, Medical Staff, and Quality Assurance committees for the year 2014. The staff member indicated the Governing Body, Medical Staff, and Quality Assurance meetings are held the same meeting. The staff member indicated only three Credentialing Committee meeting minutes could be located and all three meetings were held in December of 2014.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c) (5) (B)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(B) Ensuring that during the center's operational hours that staffing requirements are met for quality patient care and that employees do not provide services in an adjacent office, clinic, hospital, or other facility at the same time.</p> <p>Based on documentation review, observation, and staff interview, the Chief Executive Officer failed to ensure during the center's operational hours that employees</p>	S 152	The Advanced Surgery Schedule was corrected on 03/04/15 to reflect the operating room assistants and surgical	03/04/2015

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	<p>do not provide services in an adjacent office, clinic, hospital, or other facility at the same time.</p> <p>Findings included:</p> <ol style="list-style-type: none"> The Advanced Surgery Center February employee schedule and Time Card Reports were reviewed. It was evidenced that Operating Room Assistants (ORA) and Surgical Scrub Technicians (CST) that worked in the operating rooms were not scheduled by the surgery center and it could not be determined the employees are working in both facilities during the same operational hours. On 3/3/15 through 3/4/2015, the Advanced Surgery Center was toured. The surgery center was adjacent to its corporate office/clinic. At 1:35 PM on 3/4/2015, staff member #4 (Registered Nurse) indicated he/she would help over at the clinic when he/she has time at 		<p>scrub technician's schedule for surgery days. The time clock settings were changed on 03/04/15 to reflect employee hours in the Advanced Surgery Center. Employees now have a Williamson Eye Institute card for the office side and an Advanced Surgery Center card for the surgery side. To prevent this deficiency from occurring again employees were in-serviced on clocking-in and clocking-out using two different cards. Reports are now able to be ran to distinguish between Williamson Eye Institute and Advanced Surgery Center hours. The Director will be responsible for making sure that hours are being recorded properly.</p>	

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S 310 Bldg. 00	<p>the surgery center. The staff member confirmed that he/she does not record the time when she was working at the clinic and not at the surgery center.</p> <p>4. At 1:45 PM on 3/4/2015, staff member #1 (Director of Nursing) indicated there was not a clear separation from working within the clinic or the surgery center.</p> <p>5. At 2:15 PM on 3/4/2015, staff member #21 (MIV - Supervisor) indicated there was not a separation of time worked for the clinic and the surgery center.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p>			

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	<p>(1) All services, including services furnished by a contractor. Based on document review and staff interview, the facility failed to ensure 12 services provided by the contractors and internal services were part of its comprehensive quality assessment and improvement (QA&I) program: bioengineering, biohazardous waste, housekeeping, laboratory, laundry/linen, maintenance, medical records, nursing, pharmacy, radiology, security, and tissue transplant.</p> <p>Findings included:</p> <p>1. Quality Improvement Risk Improvement Plan (last approved 12/1/2014) indicates all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. The Quality Assurance Committee shall coordinate all activities designed to promote and attain the objectives of the Quality Assurance Plan. The Quality Committee serves as</p>	S 310	Quality Assurance committee that was held on 01/07/15 noted the previous Director of Nursing didn't document meeting that were held in 2014. On 03/10/15 Contracts were reviewed for evaluation. To prevent this deficiency from recurring the Quality Assurance Committee is going to continue to meet quarterly and monitor/evaluate internal and contracted services. The Director of Nursing will be responsible for documentation of meetings and ensuring meetings are being held.	03/10/2015			

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	<p>the focal point for integration of the quality activities conducted in the Center. It shall receive sufficient information from all sectors related to patient care and its evaluation to permit intelligent deliberation and to achieve the objectives of the Quality Assurance Plan.</p> <p>2. Staff member #1 (Director of Nursing) failed to provide documented quality assurance committee minutes or monitoring criteria for 2014. The center did not have evidence of quality assurance monitoring and evaluating of the following internal and contracted services: bioengineering, biohazardous waste, housekeeping, laboratory, laundry/linen, maintenance, medical records, nursing, pharmacy, radiology, security, and tissue transplant.</p> <p>3. At 1:45 PM on 3/4/2015, staff member #1 confirmed there were no documented quality assurance</p>			

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S 320 Bldg. 00	<p>committee meetings or evaluation reports that evidence of quality monitoring of all services that directly or indirectly impact patient care.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and staff interview, the facility failed to ensure 4 ambulatory surgical functions as part of its comprehensive quality assessment and improvement (QA&I) program: Discharges and Transfers; Infection Control;</p>	S 320	Quality Assurance committee that was held on 01/07/15 noted the previous Director of Nursing didn't document meeting that were held in 2014. To prevent the deficiency from recurring	03/04/2015	

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	<p>Medication Errors; and Response to Patient Emergencies.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Quality Improvement Risk Improvement Plan (last approved 12/1/2014) indicates all service with direct or indirect impact on patient care quality shall be reviewed under the quality improvement program. The Quality Assurance Committee shall coordinate all activities designed to promote and attain the objectives of the Quality Assurance Plan. The Quality Committee serves as the focal point for integration of the quality activities conducted in the Center. It shall receive sufficient information from all sectors related to patient care and its evaluation to permit intelligent deliberation and to achieve the objectives of the Quality Assurance Plan. Staff member #1 (Director of Nursing) failed to provide 		<p>the Quality Assurance Committee will meet quarterly and evaluate discharge and transfers, Infection Control, Medication Errors, Response to patient emergencies. The Director of Nursing will be responsible for documentation of the meetings and ensuring meetings are being held quarterly.</p>	

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S 414 Bldg. 00	<p>documented quality assurance committee minutes or monitoring criteria for 2014. The center did not have evidence of quality assurance monitoring and evaluating of the following facility functions: Discharges and Transfers; Infection Control; Medication Errors; and Response to Patient Emergencies.</p> <p>3. At 1:45 PM on 3/4/2015, staff member #1 confirmed there were no documented quality assurance committee meetings or evaluation reports that evidence of quality monitoring of all functions that directly impact patient care.</p> <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</p>			

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	<p>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 facility document review and interview, the facility failed to ensure the infection control committee met quarterly, and included the appropriate membership, to ensure all aspects of the Infection Prevention Program were reviewed.</p> <p>Findings included:</p> <p>1. Review of facility committee meeting minutes indicated no specific Infection Control Committee meeting minutes for 2014, but minutes for the Quality Assurance Meeting in January 2015 which included a brief discussion of any infection issues. The person responsible for the Infection Prevention Program was not a member, and not in attendance, at</p>	S 414	Infection control meeting notes are combined with Quality Assurance notes on 01/07/15. Previous records were not documented in 2014 from previous Director of Nursing. To prevent the deficiency from recurring the On 3/11/15 the Infection Control Nurse was appointed to the Director of Nursing to ensure attendance to meetings, d/t previous Infection Control Nurse is part-time. Infection Control meeting will be	03/11/2015			

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S 432 Bldg. 00	<p>the QA Meeting.</p> <p>2. At 3:00 PM on 03/03/15, staff member #2, the Infection Control Nurse, was interviewed and indicated he/she had been in this position since November 2013. He/she indicated he/she met monthly with staff member #1, the DON (Director of Nursing), to review any infection control issues. He/she indicated he/she did not have any documentation or minutes of these meetings. He/she indicated staff member #1 reported this information to the physician at the QA meeting and confirmed he/she did not attend these meetings.</p> <p>3. At 3:30 PM on 03/03/15, staff member #1 indicated he/she had just assumed the DON role December 1, 2014 and was unable to locate any previous committee meeting minutes. He/she indicated he/she was just trying to get things organized and was unaware of the committee membership.</p> <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</p>		held on a quarterly basis to ensure patient patient safety. The Director of Nursing will be responsible for documentation of the meetings.				

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	<p>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 observation, manufacturer's directions, and interview, the infection control committee failed to ensure the appropriate rinsing procedures for high level disinfection were followed in the substerile room.</p> <p>Findings included:</p> <ol style="list-style-type: none"> During the tour of the surgical area at 9:20 AM on 03/04/15, accompanied by staff member #1, the DON (Director of Nursing), a small covered metal container of fluid, labeled Metricide Plus 30, 02/23/15- 03/23/15, was observed on the counter of the substerile room. The only tests strips in the area were a container of Cidex OPA strips. The manufacturer's directions for Metricide/ Metricide 28/Metricide Plus 30 indicated, "c). Rinsing Instructions: Following immersion in Metricide, Metricide 28, or Metricide Plus 30 Solution, thoroughly rinse the equipment or medical device by immersing it 	S 432	Policy 10.26 Glutaraldehyde was created on 3/06/15. The policy and procedure reviews the proper way to use glutaraldehyde for a sterilant and high level disinfectant. In the policy it addresses how to rinse the equipment in three copious volumes of water. The policy also states precautions, monitoring, and storage. The Cidex OPA test strips were discarded and replaced with Metricide 1.8% Glutaraldehyde. To prevent this deficiency from recurring employees have reviewed the new policy 10.26. Employee in-services were completed on 3/19/15. Yearly staff will be in-serviced on use, precautions, monitoring, and storage of glutaraldehyde. The Director of Nursing will be responsible for overseeing that employees are demonstrating the proper techniques for the use of glutaraldehyde. The Director will also be responsible for in-servicing staff on glutaraldehyde.	03/19/2015			

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	<p>completely in three separate copious volumes of water. Each rinse should be a minimum of one minute in duration unless otherwise noted by the device or equipment manufacturer. Use fresh portions of water for each rinse. Discard the water following each rinse. Do not reuse the water for rinsing or any other purpose, as it will be contaminated with gluteraldehyde. ...4. Monitoring of Germicide to Ensure Specifications are Met: ...During the usage of Metricide 28 or Metricide Plus 30 solution, as a high-level disinfectant and/or sterilant, it is recommended that a thermometer and timer be utilized to ensure that the optimum usage conditions are met. In addition, it is recommended that the Metricide 28 or Metricide Plus 30 solution be tested with a 1.8% gluteraldehyde concentration indicator prior to each usage." The directions indicated this indicator was labeled MetriTest 1.8% and were supplied as 60 test strips per container.</p> <p>3. Review of the label directions for the Cidex OPA test strips did not indicate any information regarding the guteraldehyde concentration or whether the strips could be used with anything other than Cidex OPA solution.</p> <p>4. At 9:30 AM on 03/04/15, staff</p>			

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S 526 Bldg. 00	<p>member #1 indicated laryngoscope blades and lenses were soaked in the disinfectant and indicated the facility used to use Cidex OPA and he/she was unsure about whether or not the Cidex OPA test strips could be used with the Metricide Plus 30 that was now used.</p> <p>5. At 10:10 AM on 03/04/15, staff member #3, a CST (Cerified Surgery Tech), indicated he/she used the Metricide Plus 30 twice a month for lenses for a specific physician. He/she indicated he/she mixed the chemical and labeled it for 28 days. He/she confirmed he/she was using the Cidex OPA test strips that were used when the Cidex OPA chemical was used previously. He/she indicated he/she rinsed the lenses one time in a basin, not three separate rinses, then dried them.</p> <p>6. At 11:00 AM on 03/04/15, staff member #1 indicated he/she could not find a specific policy for the use of the gluteraldehyde solution.</p> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <p>(h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of</p>			

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	<p>assessment maintained in the employee file for the procedures performed.</p> <p>Based on policy review, employee files review, and interview, the facility failed to ensure 5 of 5 nurses (# 1, 2, 4, 5, and 6), who performed out-of-lab testing on patients of the center, had initial and annual competency for the testing.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Review of the facility policies "Employee Orientation" and "Continuing Education Service Training" failed to indicate any documentation that out-of-lab/glucometer training was provided or required during orientation or annual in-servicing. Review of the personnel file for staff member #1, the DON (Director of Nursing), with a hire date of 09/28/12, lacked documentation of any orientation or annual competency for the McKesson True result glucometer used for patients in the facility. Review of the personnel file for staff member #2, an RN (Registered Nurse), with a hire date of 10/17/13, lacked documentation of any orientation or annual competency for the McKesson True result glucometer used for patients in the facility. 	S 526	<p>Policy and Procedures 3.025 Employee Orientation and 3.026 Continue Education/In-service Training was updated on 03/12/15 to reflect glucometer testing and controls as part of new hire training and annual training. On 03/11/15 all Nursing staff was in-serviced on glucometer testing, control testing, cleaning glucometer, and demonstrated correct use of glucometer. To prevent this deficiency from recurring staff will be in-serviced upon hire and yearly. The Director of Nursing will ensure that employees are trained on how to use the glucometer correctly.</p>	03/12/2015

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S 174 Bldg. 00	<p>4. Review of the personnel file for staff member #4, an RN, with a hire date of 09/27/13, lacked documentation of any orientation or annual competency for the McKesson True result glucometer used for patients in the facility.</p> <p>5. Review of the personnel file for staff member #5, an RN, with a hire date of 11/15/12, lacked documentation of any orientation or annual competency for the McKesson True result glucometer used for patients in the facility.</p> <p>6. Review of the personnel file for staff member #6, an RN, with a hire date of 01/02/15, lacked documentation of any orientation for the McKesson True result glucometer used for patients in the facility.</p> <p>7. At 1:00 PM on 03/03/15, staff member #1 indicated new nurses would be shown how to use the glucometer upon hire, but confirmed there was no documentation of any training or competency in its use.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(A)</p>			

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	<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 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 policy review, document 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 facility policy "Housekeeping Policy", last reviewed 12/01/14, indicated, "All areas of the Center shall be maintained at an appropriate level of cleanliness relative to its function. Contract services shall be</p>	S 174	Employee File was completed for #20 MJV Staff member including quizzes from MJV training. Staff member # 20 also completed competent testing for housekeeping regarding cleaning technique and proper chemicals used for cleaning. Observed staff #20 on 03/04/15 @ 1700 using proper technique cleaning and using correct labeled chemicals. The janitor's cleaning list was updated to change the frequency of cleaning the OR from 3 times per week to 5 times per week to match the housekeeping policy and procedure. To prevent this deficiency from recurring on	03/06/2015

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	<p>monitored to assure their performance is consistent with accepted standards.</p> <p>Responsibility: The Director is responsible for maintaining agreements for housekeeping services. The Director is responsible for monitoring contracted housekeeping services that are provided to assure accepted levels of cleanliness.</p> <p>...Practices and Procedures: A. Contracted service company shall be provided with appropriate procedural guides for cleaning all areas of the Center. Such procedures to be considered as an addendum to the contract. B. Director shall confirm with contract service that employees are instructed in proper procedures. ...H. Cleaning Tasks & Frequency (Note 'Daily' refers to days the facility is operational) 1. Operating Rooms: a. Wipe equipment- daily b. Wet mop floors- daily c. Empty waste containers and wipe- daily d. Clean lights, mayo, tables, stools- daily."</p> <p>2. Review of the facility policy "Environmental Control", last reviewed 12/01/4, indicated, "1. Housekeeping services are monitored to assure that cleaning standards are followed including the use of appropriate germicidal cleaning agents."</p> <p>3. Review of "Janitorial Services</p>		<p>3/11/15 the Infection Control Nurse was appointed to the Director of Nursing to ensure adequate monitoring, in-services, and correct documentation. A safety/infection control check list was made to ensure patient safety and to prevent potential hazards. An observation form was made to evaluate the techniques used by the housekeeper. The Director of Nursing will oversee and be responsible for housekeeping (Contract, performance/evaluation, chemical knowledge, proper labeling, education ect.)</p>	

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	<p>Inspection Form", dated 02/13/15, indicated a satisfactory check-off list for Office Areas, Restrooms, Lobby/Entrances, Breakrooms, Floorcare, and Custodial Closet. The form was signed by #21, the supervisor for the contracted cleaning company. The form lacked any specific check-off areas for the operating or procedure rooms.</p> <p>4. Review of a specific task list found hanging in the janitor's closet indicated a line item, "OR's [operating rooms] cleaning frequency, 3 days per week."</p> <p>5. At 11:45 AM on 03/03/15, staff member #1, the DON (Director of Nursing), indicated he/she had worked as a nurse at the facility, but just assumed the DON role Dec. 1, 2014. He/she indicated the facility had employed the same contracted cleaning company since 1997 and there had been one full-time staff member, #22, who recently retired and a new person, #20, had only been doing the cleaning for a couple of months. He/she indicated he/she was not aware of the facility keeping any personnel files for these staff members. He/she also confirmed facility staff had not provided any training or orientation to the staff members. He/she indicated monthly walk-throughs were conducted with #21, the contracted company's</p>			

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S 188 Bldg. 00	<p>supervisor, but confirmed the facility staff did not actually observe the staff cleaning. He/she did not know why the cleaning sheet in the janitor's closet indicated the ORs should only be cleaned 3 times a week instead of 5 times.</p> <p>6. At 3:00 PM on 03/03/15, staff member #2, the Infection Control Nurse, indicated he/she was not aware of which chemicals the contracted cleaning company used in the surgical areas, did not provide any training or orientation to that staff, and did not do any observations of the staff.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p>			

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	<p>Based on document review and staff interview, the facility failed to conduct quarterly fire drills as defined by the facility's policies and procedures.</p> <p>Findings included:</p> <ol style="list-style-type: none"> Emergency Operations policy #14.22 (Last revised 12/1/2014) stated, "Fire drills for all staff are conducted quarterly." The facility quarterly fire drills were reviewed for 2014. The facility only provided two fire drills for 2014: 6/20/2014 and 10/28/2014. Therefore, the documentation provided evidenced the first and third quarter of 2014 lacked a fire drill. At 10:30 AM on 3/4/2015, staff member #1 (Director of Nursing) confirmed there were no more documented fire drills for 2014 except the two that were provided. 	S 188	The current Director of Nursing (hired 12/01/14) became aware of 2014 missing proper fire drill documentation. A fire drill was then preformed on 01/19/15. Fire Drills were then scheduled in January for April, July, and October of 2015. To prevent this deficiency from recurring fire drills will be preformed and documented quarterly. The Director will be responsible for implementing and documentation of the fire drills.	03/04/2015	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2015

FORM APPROVED

OMB NO. 0938-0391

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