

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001025	X2) MULTIPLE CONSTRUCTION A. BUILDING: <u>00</u> B. WING: _____	X3) DATE SURVEY COMPLETED 09/01/2021
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NAME OF PROVIDER OR SUPPLIER MERIDIAN PLASTIC SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 170 W 106TH ST INDIANAPOLIS, IN 46290
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S 0000 Bldg. 00	<p>This visit was for a state licensure survey of an Ambulatory Surgery Center.</p> <p>Facility Number: 005406</p> <p>Survey Dates: 8-30-2021 to 9-1-2021</p> <p>QA: 9/8/21</p>	S 0000		
S 0110 Bldg. 00	<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 document review and interview, it could not be determined if the facility conducted a quarterly quality performance improvement report on transfers, discharges, infection control, medication errors, and response to patient emergencies in the last 12 calendar months.</p> <p>Findings include:</p> <p>1. No documents were provided detailing that a quarterly quality performance improvement report on transfers, discharges, infection control,</p>	S 0110	<p>1. Deficiency corrected by changing format of Quality Assurance/Improvement committee meeting minutes. Previously patient transfer, discharges, infection control, errors, incident reports were listed in outline manner. New template in place including all reports, future meetings to include quality improvement plan if deemed necessary.</p>	10/11/2021

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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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S 0172 Bldg. 00	<p>medication errors, and response to patient emergencies. No additional information was provided prior to exit conference.</p> <p>2. In interview on 9-1-2021 at 1307 hours, employee S1, Administrator, confirmed the no additional information was available on quarterly quality performance improvement report for facility transfers, discharges, infection control, medication errors, and response to patient emergencies was available for the last 12 calendar months.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review and interview, the facility failed to provide annual tuberculosis testing in 9 of 9 personnel files reviewed (N1, N2, N3, N4, N5, N6, N7, N8 and N9).</p>	S 0172	<p>2. This template will be followed each quarterly meeting therefore should not recur.</p> <p>3. Person responsible for this correction is Surgery Center Director.</p> <p>4. a. Template change is put in place immediately. b. quality improvement plan to area if deemed necessary to be included at next quarterly meeting 10/11/2021.</p> <p>1. Deficiency to be corrected immediately with any staff unable to prove immunity. titers will be</p>	10/11/2021	

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S 0320 Bldg. 00	<p>Findings Include:</p> <ol style="list-style-type: none"> Review of policy titled TB/Communicable Diseases (10.06) last approved 02/24/21 indicated that employees will be tested for TB (tuberculosis) on an annual basis. Review of 9 (N1 [Registered Nurse {RN}], N2 [Certified Surgical Technologist {CST}], N3 [RN], N4 [CST], N5 [CST], N6, N7, N8 and N9 [RN's]) personnel files lacked documentation of annual TB testing. Interview on 08/31/21 with S1 (Administrator) at 12:00 pm confirmed lacked of documentation of annual TB testing. <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.</p>		<p>drawn to measure immunity, followed by annual questionnaire mirrored by St. Vincent Ascension Health.</p> <p>2. with titers in place and annual questionnaire in place this should not recur.</p> <p>3. the Surgery Center Director is responsible for this correction.</p> <p>4. a. this correction will be in place by 10/11/2021.</p> <p>!</p>	

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S 0428 Bldg. 00	<p>(B) Infection control. (C) Medication errors. (D) Response to patient emergencies. Based on document review and interview, it could not be determined if the facility provided a monitor and standard for performance improvement review of facility discharges, infection control, medication errors, and response to patient emergencies over the last 12 months.</p> <p>Findings include:</p> <p>1. No documents were provided detailing a monitor and standard for performance improvement review of facility transfers discharges, infection control, medication errors, and response to patient emergencies in the last 12 months.</p> <p>2. In interview on 9-1-2022 at 1307 hours, employee S1, administrator, indicated no monitors and standards for performance improvement review of facility transfers, discharges, infection control, medication errors, and response to patient emergencies in the last 12 months were available.</p> <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</p>	S 0320	<p>1. Please see response to S110 and Quality Assurance Committee meeting minutes template improvement. Patient transfers, discharges, infection control, medication errors and response to patient emergencies are reviewed. These reviews by the committee will be in a more clear format with changes in place.</p> <p>2. With changes in place to template and adding a quality improvement plan if deemed necessary to next quarterly meeting minutes, this correction should not recur.</p> <p>3. The surgery Center Director is responsible for this correction.</p> <p>4. a. Quality Assurance meeting minutes template has been adjusted with Quality Assurance Plan of Improvement to occur at next quarterly meeting 10/11/2021.</p>	10/11/2021

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	<p>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. Based on document review, observation and interview, the facility failed to ensure the cleanliness of 2 of 3 areas toured (pre-operative and surgery).</p> <p>Findings Include:</p> <p>1. Review of policy titled: Housekeeping Services (11.01) last approved 02/24/21, indicated that the pre-operative area and janitorial closet are to be cleaned daily.</p> <p style="padding-left: 20px;">a. Pre-operative area: clean exposed surfaces of cabinets and countertops with disinfectant.</p> <p style="padding-left: 20px;">b. Janitorial closet: Remove mop head and wipe down with germicidal cleaner; wipe and sanitize floor with cleaning/sanitizing agent; remove all wiping cloths and mop heads for laundering.</p> <p>2. Tour of the pre-operative area on 09/01/21 at 9:00 am with S2 (Registered Nurse), this surveyor observed visible and wipeable dust on top of blanket warmer, ledge above chair #2 and #3, top of filing cabinets and windowsills.</p> <p>3. Tour of the surgery hallway janitorial closet on 09/01/21 at 9:15 am with S3 (Registered Nurse), this surveyor observed copious amount of dust and dirt on the floor of the janitorial closet, walls with drip marks and a dust mop head leaning against the wall with copious amounts of dust attached.</p> <p>4. Interview with S2 and S3 confirmed findings as</p>	S 0428	<p>1. Request for Janitor closet to be cleaned ASAP. Staff requested to thoroughly clean the area they staff daily, in addition to cleaning crew. These steps have been taken.</p> <p>2. Check list created for each area for staff members to check off at the end of shift, check list also requested by cleaning company to check each day of service to prevent recurrence of this correction.</p> <p>3. Surgery Center Director is responsible for this correction.</p> <p>4. All of the corrections completed or to be completed by 10/11/2021.</p>	10/11/2021

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S 1010 Bldg. 00	<p>above for respective area.</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 document review, observation and interview, the facility failed to provide safe handling of medications at the bedside in 1 of 2 pre-operative areas toured.</p> <p>Findings Include:</p> <p>1. Review of policy titled: Expiration Limits of Intravenous Fluids (5.31) last approved 02/24/21, indicated that IV (intravenous) fluids will be spiked right before use and IV bag will have a label with date, time and initials.</p> <p>2. Review of policy titled: IV Therapy/Injections (5.30) last approved 02/24/21, indicated medications should be drawn up and used as soon as possible; should all be labeled with date, time and initials.</p> <p>3. Tour of pre-operative area on 09/01/21 at 9:00 am with S2 (Registered Nurse), this surveyor observed a spiked IV bag and a syringe labeled XYLO on counter next to chair #3 awaiting the</p>	S 1010	<p>1. Policy and procedure reviewed with staff, with emphasis on labeling name, date, and time. Surgery Center Director reviewed with staff not spiking IV bags early or pre drawing up medications.</p> <p>2. Check list to be added to self audit worksheet as reminder to each individual staff member.</p> <p>3. Surgery Center Director responsible for this correction.</p> <p>4.a This correction was made immediately and is ongoing.</p>	10/11/2021

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S 1146 Bldg. 00	<p>next patient; both lacked documentation of date, time and initials of person drawing up medication.</p> <p>4. Interview on 09/01/21 at 9:00 am with S2 (Registered Nurse) confirmed that a spiked IV bag and a syringe labeled XYLO on counter next to chair #3 awaiting the next patient; both lacked documentation of date, time and initials of person drawing up medication.</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 observation, the facility failed to ensure no condition was created which may result in a hazard to employees in 1 instance.</p> <p>Findings include:</p> <p>1. On 9-1-2021 at 1220 hours, in the presence of employee S1, Administrator, a small compressed gas cylinder was observed standing upright on the floor, and was unsecured by chain or hook.</p> <p>2. An unsafe event could have occurred if the gas cylinder fell, or struck another gas cylinder.</p>	S 1146	<p>1. this deficiency was corrected immediately. The unsecured gas cylinder was remove form the premise by the medical gas contractor.</p> <p>2. This is not a typical gas used at this facility so this should not recur, however a secondary checklist has been added to view that all medical gases are secure.</p> <p>3. The Surgery Center Director is responsible for this correction.</p> <p>4. a this correction has been immediately resolved and will have</p>	10/11/2021	

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

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