Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) LICENSE NUMBER	SURVEYOR ID	(X3) DATE SURVEY COMPLETED
	7003183	39802, 19843	6/11/19

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Western Diversey Surgical Center	2744 N. Western Ave., Chicago, IL 60647

(X4) PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY IDENTIFYING INFORMATION)	PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
000	A licensure survey was conducted on 6/11/19. The Facility was not in compliance with Title 77: Public Health, Chapter 1: Department of Public Health, Subchapter b: Hospital and Ambulatory Care Facility, Part 205: Ambulatory Surgical Treatment Center Licensing requirements, as evidenced by:			

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE [redacted] Julie Swanson 7/2/19 Administrator

TITLE

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000	A licensure survey was conducted on 6/11/19. The Facility was not in compliance with Title 77: Public Health, Chapter 1: Department of Public Health, Subchapter b: Hospital and Ambulatory Care Facility, Part 205: Ambulatory Surgical Treatment Center Licensing requirements, as evidenced by:	205.230	On June 26, 2019, 9:00AM - an emergency Consulting Committee meeting was conducted to formally document vote and elect for CEO and members of a Consulting Committee. see attachement A. (Quarterly Consulting Committee Minutes) On the minutes, responsibilities of the consulting committee are discussed and delineated. The minutes of the meeting format are also ammended which more in detail represents the entirity of the organization agenda covering aspects such as credentialing, aprroval of new and changes in policies and procedures, tissue review report, QA/PI report, Infection prevention and control, environment of care, and other organizational activities. The Consulting Committee will be responsible in the documentation and record keeping of the minutes of the meeting. The Consulting Committee will meet on a regular basis (quarterly) at a minimum. A quorum may be called upon 50% or more of the memebers are present. Attached: Consulting Committee Minutes, ByLaws of the Medical Staff, AHCC Organizational Structure	6/27/2019

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TITLE Administrator

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205.230 a) 2	Section 205.230 a) 2) Standards of Professional Work a) A qualified consulting committee shall be appointed in writing by the management or owner of the ambulatory surgical treatment center and shall establish and enforce standards for professional work in the facility and standards of competency for physicians. The qualified consulting committee shall meet not less than quarterly and shall document all meetings with written minutes. The minutes shall be maintained at the facility and shall be available for Department inspection. 2) The qualified consulting committee shall review the development and content of the facility's written policies and procedures, including the details of the quality assessment and performance improvement program, the infection control program, the patient rights plan, the disaster preparedness plan, the procedures for granting privileges, and the quality of the surgical procedures performed. The reviews shall be documented in the minutes. This Regulation is not met as evidence by: Based on document review and interview, it was determined that the Facility failed to ensure that detailed reviews of the quality assessment and performance program, the infection control program, the patient rights plan, the disaster preparedness plan, granting of privileges, and the quality of the surgical procedures performed were documented in the governing body meeting minutes. This could potentially affect the average 65 procedures performed at the Facility every month.			

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[redacted]	Julie Swanson Administrator	7/2/19

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205.230 a) 2	Section 205.230 a) 2 (continued) Findings include: 1. The Facility's bylaws regarding responsibilities of the Consulting Committee were requested from the Administrator (E#1) on 6/10/19, at approximately 2:00 PM. On 6/11/19, at approximately 10:20 AM, E#1 stated that there were no written bylaws regarding oversight by the Consulting Committee. E#1 stated that the Consulting Committee is the Governing Body and is responsible for oversight of all facility operations including quality assurance and performance improvement (QAPI), medical staff credentialing, infection control, patient rights, and disaster planning. 2. The quarterly Consulting Committee meeting minutes from January 2017 to April 2019 were reviewed on 6/10/19. The minutes failed to include documentation of any discussions regarding QAPI, credentialing, infection control program, patient rights plan, and the disaster preparedness plan. 3. An interview was conducted with the Administrator (E#1) on 6/10/19, at approximately 3:30 PM. E#1 reviewed the meeting minutes from January 2017 to April 2019 and could not find documentation of discussions, actions and/or activities made by the Governing Body during the quarterly meetings. E#1 stated that the meeting minutes used to be written on a more detailed template that included sections about credentialing, policies and procedures, QAPI, and infection control; however, the Medical Director (MD#1) and Office Manager (E#4) "thought it was okay" to not have the details for each section written out.			

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205.550 b)	Section 205.550 b) Infection Control b) Each ASTC shall maintain a written, active and effective facility-wide infection control program. A system designed for the identification, surveillance, investigation, control, and prevention of infectious and communicable diseases in patients and health care workers shall be included in this program. This Regulation is not met as evidence by: A. Based on document review, observation, and interview, it was determined that for 1 of 2 Physicians (MD#1) observed, the Facility failed to ensure that personal clothing was not exposed in the restricted perioperative area (OR). Findings include: 1. On 6/10/19 at approximately 8:45 AM, the Facility's "Surgical Attire" policy was requested. The policy was not found. 2. On 6/11/19, at 12:15 PM, the "Association of periOperative Registered Nurses [AORN] 2018 Edition Guidelines for Perioperative Practice," was reviewed. The Guidelines included, "Guidelines for Surgical Attire... Recommendation I: Clean surgical attire should be worn in the semi-restricted and restricted areas of the perioperative setting... 1.b.5. Personal clothing that cannot be contained within the scrub attire either should not be worn or should be laundered in a health care accredited laundry facility..." 3. On 6/10/19 at 9:00 AM, an observational tour was conducted in the perioperative area (OR). The Surgeon (MD#1), who performed a pain procedure in OR suite #1, wore a tee shirt under his scrub shirt that was exposed at the neck level.	205.550 b)	On June 24, 2019, A Policy for Infection Control was drafted. Policy # 07.04.20 Titled Surgical Attire. The policy provides for guidance to perioperative personnel for surgical attire, including scrub attire, shoes, jewelry, head coverings, and surgical masks worn in the semi-restricted and restricted areas, which has an expected outcome that the patient will be free from signs and symptoms of infection. The drafted policy was cross referenced from OSHA, and AORN. (see attached Policy#07.04.20 Surgical Attire) The aforementioned Policy was presented and discussed in an emergency Consulting Committee meeting on June 26, 2019 was approved and inserviced to the staff on and other perioperative personnel for immediate implementation 6/27/19. (see attched Policy#07.04.20 Surgical Attire); Surgical Attire In-service Log.) see also attached tool used for Competency verification on Surgical Attire.	6/27/2019

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205.550 b)	Section 205.550 b) (continued) 4. On 6/10/19 at 3:55 PM, an interview was conducted with the Infection Control Officer (E #2). E #2 stated that the Facility follows AORN Guidelines and that MD #1's tee shirt should have been covered by the scrubs. B. Based on document review and interview, it was determined that for 1 of 1 sterilizer log reviewed, the Facility failed to ensure that daily biological indicator test (a process used to test the effectiveness of sterilization). This could potentially affect the average 65 procedures performed at the Facility every month. Findings included: 1. The Facility's Policy titled, "Sterilizer Monitoring" (revised 4/2/18), was reviewed on 6/10/19 and required, "...Spore [biological indicator] testing will be conducted daily when sterilizer is in use and on every load for implantable. (See accompanying inserts for manufacturers instructions for use).." 2. The manufacturer's guidelines for the biological indicator, were reviewed on 6/10/19 and required, "...Record the processed and control biological indicator results..."	205.550 b)	On June 21, 2019, Policy # 07.04.07 Titled: Sterilizer Monitoring was reviewed with the staff as part of an in-service under Infection Control Plan. see attached sign in log for in-service, Policy on Sterilizer Monitoring, 3M attest Biological IFU. To guarantee the success of Performance Improvement of such activities, the Sterilizer Monitoring activities will be included in the performance improvement activities which will be collected daily and evalauated monthly for improvement for the next 6 months. The Performance Improvement actities will also be reported to the consulting committee on a quarterly basis. (see attached Performance Activities Indicator)	6/21/2019

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	Section 205.550 b) (continued)			
205.550 b)	3. The sterilization logs from 3/1/19 to 5/1/19, were reviewed on 6/10/19 and indicated: - On 3/22/19, two loads of surgical instruments were sterilized. Load #1 contained 2 video cases (camera equipment inserted in the body during surgery), a hand tray (surgical instruments used to repair the hand), and a laryngoscope blade (used to open the airway when viewing the throat). Load #2 contained an Arthrex Power Tray (instruments used to saw or drill bone) and an Arthrex hand instrument (surgical instrument used to repair the hand). The log lacked documentation of the results of the biological indicator tests for both loads. - On 3/27/19, one load of surgical instruments was sterilized. The load contained dilators (surgical instrument used to expand an opening or passage), forceps (a pair of pincers or tweezers used in surgery), curettes (surgical instrument used to remove material by a scraping action), and speculums (instrument used to dilate an opening or canal in the body to allow inspection). The log lacked documentation of the result of the biological indicator test. 4. An interview was conducted with a Surgical Technician (E#5) on 6/10/19, at approximately 1:15 PM. E#5 stated that biological indicator testing is required daily. E#5 verified that no results were marked for loads performed on 3/22/19 and 3/27/19 and stated, "It should have been documented, we have no record of the results for those days."			

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205.550 j)	Section 205.550 j) Infection Control - Hand Hygiene j) Thorough hand hygiene shall be required after touching any contaminated or infected material. This Regulation is not met as evidence by: Based on document review, observation, and interview, it was determined that for 1 of 1 Housekeeper (E#3) observed, the Facility failed to ensure that hand hygiene was performed after removing gloves. Findings include: 1. On 6/11/19, the Facility's "Infection Prevention Program and Plan," (undated), was reviewed. The Plan included, "...Hand Hygiene will be performed for... After removing gloves..." 2. On 6/10/19 at 9:00 AM, an observational tour was conducted in the operating area (OR). At 10:00 AM, a Housekeeper (E#3), in the Holding/ Post Operative Area, disposed of a cleaning cloth, removed gloves, did not disinfect hands, and left the room. 3. On 6/10/19 at 3:55 PM, an interview was conducted with the Infection Control Officer (E#2). E#2 stated that hand hygiene should be performed after gloves are removed.	205.550 (j)	On June 20, 2019, A facility wide in-service was conducted to all personnel. Title: Guideline Implementation: Hand Hygiene (see attached brochure) A post evaluation was also conducted at this time and Competency Verification was also conducted on June 24, 25, and 27 following the in-service. (see attached sample of tool used in comptency verification) (see also log of attendance on Hand Hygiene in-service)	6/27/2019

AGENCY MANAGER/REPRESENTATIVE'S SIGNATURE [redacted] Julie Swanson — TITLE Administrator — DATE 7/2/19