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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                 |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15C0001027 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |   | X3) DATE SURVEY COMPLETED<br><br>05/10/2012 |                      |
| NAME OF PROVIDER OR SUPPLIER<br><br>SURGERY CENTER OF EYE SPECIALISTS OF INDIANA |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 N MERIDIAN ST<br>INDIANAPOLIS, IN 46202 |   |   |                      |
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| Q0000  | <p>This visit was for a re-certification survey.</p> <p>Facility Number: 005408</p> <p>Survey Date: 5-7/10-12</p> <p>Surveyors:<br/>Jack I. Cohen, MHA<br/>Medical Surveyor</p> <p>John Lee, RN<br/>Public Health Nurse Surveyor</p> <p>QA: cloughlin 05/11/12</p> |   |  | O0000   |   |   |                      |

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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| Q0041  | <p>416.41(a)<br/>CONTRACT SERVICES<br/>When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.</p> <p>Based on document review and interview, the facility failed to ensure that when environmental services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner for 1 contracted environmental cleaning service (Staff #1) and failed to include a monitor and standard for 2 services furnished by a contractor and 1 directly-provided service, in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of staff #1's personnel file, a contracted housekeeper, lacked documentation of orientation on how to properly clean an operating room.</li> <li>2. On 05-09-12 at 1105 hours staff #41 confirmed that the facility did not have documentation that indicated that staff #1 had completed orientation on how to properly clean an operating room.</li> <li>3. Review of the facility's QAPI program indicated it did not include a monitor and</li> </ol> | O0041   | <p><b>Q 041</b> 1. Unable to correct previous personnel file/monitoring deficiencies. 2. In the future, all personnel files will contain the appropriate documentation. Specifically with regard to orientation for our contracted cleaning service and description of duties for our ophthalmic technicians. Additionally, new internal form "Contracted Services Evaluation" created and implemented. This form will be incorporated into our QAPI program for all contracted services to monitor and assess performance according to practice standards. 3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by 6/16/2012.</p> | 06/16/2012           |   |

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|                    | <p>standard for the contracted services of maintenance and occupational health and for the directly-provided service of nursing.</p> <p>4. In interview, on 5-10-12 at 11:30 am, employee #A2 indicated there was no documentation of inclusion of the above activities. No other documentation was provided prior to exit.</p> |               |   |                      |

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| Q0043  | <p>416.41(c)<br/>DISASTER PREPAREDNESS PLAN<br/>(1) The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC.<br/>(2) The ASC coordinates the plan with State and local authorities, as appropriate.<br/>(3) The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.</p> <p>Based on document review and interview, the facility failed to coordinate emergency disaster and preparedness with an appropriate governmental agency.</p> <p>Findings:</p> <p>1. Review of a facility document indicated in calendar year 2009, the facility had attempted to contact an appropriate governmental agency regarding coordination of emergency disaster and preparedness. The document also indicated a year later, in 2010, having had no response from the governmental agency, the facility would attempt other efforts to address the issue of coordination of emergency disaster and preparedness with an appropriate governmental agency. There was no</p> | Q0043   | <p><b>Q 043</b> 1. Sent communications to Thomas Huser (Emergency Management Coordinator at IU Health) and Jennifer Richardson (Indiana Department of Homeland Security) to try and incorporate SCESI into a governmental agency approved disaster preparedness plan.<br/>2. Awaiting response from both parties<br/>3. Nick Hunter (Administration) responsible.<br/>4. Communications sent on 5/22/2012. Deficiency correction date TBD. a. ADDENDUM: received response from Thomas Huser putting us in contact with Kathy Newman, chair of the District 5 ASC committee.</p> | 06/16/2012  |  |   |  |

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|  | <p>further documentation.</p> <p>2. In interview on 5-9-12 at 2:05 pm, employee #A1 indicated there was no documentation of other efforts of coordination of emergency disaster and preparedness with an appropriate governmental agency. No documentation was provided prior to exit.</p> |   |   |                      |   |

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| Q0084  | <p>416.43(e)<br/>GOVERNING BODY RESPONSIBILITIES<br/>The governing body must ensure that the QAPI program-</p> <p>(1) Is defined, implemented, and maintained by the ASC.<br/>(2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness.<br/>(3) Specifies data collection methods, frequency, and details.<br/>(4) Clearly establishes its expectations for safety.<br/>(5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.</p> <p>Based on document review and interview, the facility's governing board failed to review 2 contracted services and 1 directly-provided service during calendar year 2011 for quality assurance performance improvement (QAPI) activities.</p> <p>Findings:</p> <p>1. Review of the facility's governing board meeting minutes for calendar year 2011, indicated the governing board failed to review QAPI activities for the contracted services of maintenance and occupational health and the directly-provided service of nursing.</p> <p>2. In interview on 5-10-12 at 11:30 am, employee #A2 indicated there were no governing board minutes for calendar year</p> | 00084   | <p><b>Q 084</b> 1. As part of improvements to our QAPI program, more detailed records with regard to our contracted services will be maintained and sent to the governing board for their review. 2. Improved reporting to the governing body will prevent this deficiency in the future. 3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by the ongoing new process by 6/16/2012.</p> | 06/16/2012  |  |   |  |

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|                    | 2011 which included the above activities and no further documentation was provided by exit.                            |               |   |                      |

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| Q0101  | <p>416.44(a)(1)<br/>PHYSICAL ENVIRONMENT<br/>The ASC must provide a functional and sanitary environment for the provision of surgical services.<br/>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.</p> <p>Based on observation, document review and interview, the facility failed to ensure that staff follow manufacturer's recommendations for use of enzymatic solution and cleaning vents and failed to provide evidence of preventive maintenance (PM) on 3 of 9 pieces of patient care equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During the facility tour on 05-09-12 at 1200 hours in the Central Sterile clean work room, the vent in the ceiling next to the sterilizer was observed to be dirty with lent.</li> <li>2. On 05-09-12 at 1200 hours, staff #40 confirmed the vent needed cleaning.</li> <li>3. During the facility tour on 05-09-12 at 1205 hours in the Central Sterile dirty work room, a container of EM Power dual enzymatic solution was observed.</li> <li>4. On 05-09-12 at 1205 hours, staff #43</li> </ol> | O0101   | <p><b>Q 101</b> 1. Unable to correct previous physical environment deficiencies. 2. In the future, all areas of the ASC will be cleaned according to SCESI standards. This will be monitored by performing random spot checks on the ASC to evaluate the performance of our cleaning service. Additionally, the enzymatic solution will be discarded and replaced after each use of the ultrasonic cleaner. As part of improvements to our QAPI program, more detailed records with regard to our equipment checks, including preventive maintenance, will be maintained. 3. Nick Hunter (Administration) and Katie Ralston (D.O.N.) responsible. 4. These deficiencies will be corrected by 5/29/2012.</p> | 05/29/2012  |  |   |  |

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|  | <p>confirmed that he/she changes the enzymatic solution after 12 -15 uses in the ultrasonic cleaner.</p> <p>5. On 05-09-12 at 1355 hours, staff #40 confirmed that the manufacturer of the EM Power dual enzymatic solution recommends that the solution be changed after 1 use.</p> <p>6. Review of the facility's PM reports indicated there was no documentation of PM for an electrocardiograph machine, a laser and an ultrasonic sound cleaning machine.</p> <p>7. In interview, on 5-11-12 at 12:30 pm, employee #A1 indicated he/she could not provide documentation of PM for the the above-stated pieces of patient care equipment and none was received prior to exit.</p> |   |   |   |  |   |  |

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| Q0105  | <p>416.44(c)<br/>EMERGENCY EQUIPMENT<br/>Emergency equipment available to the operating rooms must include at least the following:</p> <ul style="list-style-type: none"> <li>(1) Emergency call system.</li> <li>(2) Oxygen.</li> <li>(3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator.</li> <li>(4) Cardiac defibrillator.</li> <li>(5) Cardiac monitoring equipment.</li> <li>(6) Tracheostomy set.</li> <li>(7) Laryngoscopes and endotracheal tubes.</li> <li>(8) Suction equipment.</li> <li>(9) Emergency medical equipment and supplies specified by the medical staff.</li> </ul> <p>Based on interview, the facility failed to have an approved policy for the provision of the number and location of an emergency call system, oxygen, mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator, cardiac defibrillator, cardiac monitoring equipment, tracheostomy set, laryngoscopes and endotracheal tubes, suction equipment an emergency medical equipment and supplies specified by the medical staff.</p> <p>Findings:</p> <p>1. In interview on 5-10-12 at 10:30 am, employee #A1 indicated there was not an approved policy for the provision of the</p> | 00105   | <p><b>Q 105</b> 1. SCESI "Policy 5.19" and "Policy – 5.21" amended to reflect the contents and location of emergency equipment for the facility. 2. Policy amendments prevent any future deficiencies. 3. Nick Hunter (Administration) responsible. 4. Deficiency corrected. Date completed 5/18/2012.</p> | 05/18/2012  |  |   |  |

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|                    | number and location of an emergency call system, oxygen, mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator, cardiac defibrillator, cardiac monitoring equipment, tracheostomy set, laryngoscopes and endotracheal tubes, suction equipment an emergency medical equipment and supplies specified by the medical staff. No documentation was provided prior to exit. |               |   |                      |

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| Q0121  | <p><b>416.45(a)</b><br/><b>MEMBERSHIP AND CLINICAL PRIVILEGES</b><br/>Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.</p> <p>Based on document review and interview, the governing board failed to ensure that criteria for selection for medical staff membership are individual character, competence and judgment for 3 of 3 (AH#1, AH#2 and AH#3) allied health credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of 3 allied health credential files indicated files AH#1, AH#2 and AH#3 did not contain any documentation in their files of initial appointment indicating their individual character, competence and judgment.</li> <li>2. In interview, on 5-10-12 at 12:30 pm, employee #A1 indicated there was no documentation, as requested above, in the above-stated credential files. No other documentation was provided by exit.</li> </ol> | Q0121   | <p><b>Q 121</b> 1. Documentation regarding a recommendation for individuals to be credentialed in the SCESI will be obtained and placed in the appropriate files.<br/>2. In the future, recommendations relating to an individual's character, competence and judgment will be required as part of the credentialing process.<br/>3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by 6/16/2012.</p> | 06/16/2012           |   |

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| Q0123  | <p>416.45(c)<br/>OTHER PRACTITIONERS<br/>If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities.</p> <p>Based on document review and interview, the governing body failed to have policies and procedures approved by the governing body for overseeing and evaluating clinical activities of practitioners other than physicians.</p> <p>Findings:</p> <p>1. On 5-7-12 at 10:00 am, employee #A1 was requested to provide documentation of the governing board having approved of a policy and procedure for overseeing and evaluating clinical activities of practitioners other than physicians.</p> <p>2. In interview, on 5-10-12 at 10:30 am, employee #A1 indicated there was no approved policy and procedure for the governing board to oversee and evaluate clinical activities of practitioners other than physicians. No documentation was provided prior to exit.</p> | O0123   | <p><b>Q 123</b> 1. Unable to correct previous personnel file deficiencies. 2. A policy and procedure will be created to establish standards for overseeing and evaluating practitioner's activities other than physicians. This process for evaluating allied health professionals will be concurrent with the review performed for our operating surgeon at the end of each calendar year. 3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by the end of the calendar year.</p> | 06/16/2012  |  |   |  |

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| Q0201  | <p>416.49(a)<br/>LABORATORY SERVICES</p> <p>If the ASC performs laboratory services, it must meet the requirements of Part 493 of this chapter. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of this chapter. The referral laboratory must be certified in the appropriate specialties and subspecialties of services to perform the referral test in accordance with the requirements of Part 493 of this chapter.</p> <p>Based on document review and interview, the facility failed to have policies and procedures that required the incorporation of laboratory reports into patient records and that employees performed laboratory tests according to manufacturer requirements/recommendations and/or standards of practice.</p> <p>Findings:</p> <p>1. On 5-7-12 at 10:00 am, employee #A1 was requested to provide documentation of policies and procedures that required the incorporation of laboratory reports into patient records and that employees performed laboratory tests according to manufacturer requirements/recommendations and/or standards of practice.</p> <p>2. In interview, on 5-10-12 at 12:10 pm,</p> | Q0201   | <p><b>Q 201</b> 1. SCESI "Policy 5.56 – Laboratory Services" created to address the issue of reporting lab results back into the patient chart. Also, this policy will specify proper use and maintenance of laboratory equipment. 2. New policy prevents future deficiencies. These policies will address demonstrating employee competency regarding the use, cleaning and maintenance of the equipment according to the manufacturer's recommendations. 3. Nick Hunter (Administration) responsible. 4. Deficiency corrected. Date completed 5/23/2012.</p> | 05/23/2012  |  |   |  |

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| Q0221  | <p>employee #A1 indicated there was no above-requested documentation. No other documentation was provided prior to exit.</p> <p>416.50(a)(1)<br/>NOTICE OF RIGHTS<br/>The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands.</p> <p>Based on document review the facility failed to document that it provided the patient or the patient's representative with verbal and written notice of the patient's rights prior to the procedure for 5 of 30 medical records (MR) reviewed (Patient #18, 20, 22, 25 and 29).</p> <p>Findings include:</p> <p>1. Review of patient #18, 20, 22, 25 and 29's MR lacked documentation the patient or the patient's representative received the facility's information on patient rights prior to the surgery.</p> | 00221   | <p><b>Q 221</b> 1. SCESI "Pre-op Call Sheet" modified to note whether patient has received patient rights, notification of physician ownership and policies on advance directives. This sheet will become part of the patient's medical record. 2. Amended form prevents future deficiencies. 3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by 6/16/2012.</p> | 06/16/2012           |   |

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| Q0223  | <p>416.50(a)(1)(ii)<br/>NOTICE - PHYSICIAN OWNERSHIP<br/>The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure.</p> <p>Based on document review the facility failed to ensure that it disclosed physician ownership in the ASC in writing prior to the date of the procedure for 5 of 30 medical records (MR) reviewed (Patient #18, 20, 22, 25 and 29).</p> <p>Findings include:</p> <p>1. Review of patient #18, 20, 22, 25 and 29's MR lacked documentation that the patient and or the the patient's representative was disclosed in writing of physician ownership prior to date of procedure.</p> | Q0223   | <p><b>Q 223</b> 1. SCESI "Pre-op Call Sheet" modified to note whether patient has received patient rights, notification of physician ownership and policies on advance directives. This sheet will become part of the patient's medical record. 2. Amended form prevents future deficiencies. 3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by 6/16/2012.</p> | 06/16/2012  |  |   |  |

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| Q0224              | <p>416.50(a)(2)<br/>ADVANCE DIRECTIVES<br/>The ASC must comply with the following requirements:</p> <p>(i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms.</p> <p>(ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care.</p> <p>(iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.</p> <p>Based on document review the facility failed to ensure that it provided the patient and or the patient's representative the facility's policy on advance directives prior to the procedure for 14 of 30 medical records (MR) reviewed (Patient #3, 5, 6, 7, 11, 18, 19, 20, 22, 23, 25, 27, 29 and 30).</p> <p>Findings include:</p> <p>1. Review of patient #18, 20, 22, 25 and 29's MR lacked documentation that the patient and or the patient's representative was informed prior to the procedure concerning the facility's policy on advance directives.</p> | O0224         | <p><b>Q 224</b> 1. SCESI "Pre-op Call Sheet" modified to note whether patient has received patient rights, notification of physician ownership and policies on advance directives. Additionally, the documentation for whether or not a patient has advance directives and if there is a copy on file will be changed. This sheet will become part of the patient's medical record.<br/>2. Amended form and documentation prevents future deficiencies. 3. Nick Hunter (Administration) responsible.<br/>4. This deficiency will be corrected by 6/16/2012.</p> | 06/16/2012           |

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|                    | 2. Review of patient #3, 5, 6, 7, 11, 18, 19, 23, 25, 27 and 30's MR was documented "Advance Directives Apply". Each MR lacked documentation of the patient's Advance Directive. |               |   |                      |

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| Q0225  | <p>416.50(a)(3)(i), (v), (vi), (vii)<br/>SUBMISSION AND INVESTIGATION OF GRIEVANCES</p> <p>(i) The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC.</p> <p>(v) The grievance process must specify timeframes for review of the grievance and the provisions of a response.</p> <p>(vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished.</p> <p>(vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.</p> <p>Based on document review and interview, the facility failed to, as part of its patient rights, indicate to whom the patient should contact to file a grievance.</p> <p>Findings:</p> <p>1. Review of a facility document entitled <u>Eye Specialists of Indiana Patient Rights and Responsibilities</u>, Section PATIENT RIGHTS, indicated notification of the grievance process includes: whom to contact to file a grievance.</p> | Q0225   | <p><b>Q 225</b> 1. Patient rights policy amended to include appropriate person (the ASC Administrator), process and time frame for a patient to file a grievance with SCESI.<br/>2. Amendment prevents future deficiencies. 3. Nick Hunter (Administration) responsible.<br/>4. Deficiency corrected. Date completed 5/18/2012.</p> | 05/18/2012  |  |   |  |

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|                    | 2. In interview, on 5-9-12 at 2:45 pm, employee #A1 indicated there was no patient rights documentation of whom the patient should contact to file a grievance and no other documentation was provided prior to exit. |               |   |                      |

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| Q0226  | <p>416.50(a)(3)(ii), (iii), (iv)<br/>GRIEVANCES - MISTREATMENT, ABUSE, NEGLECT</p> <p>(ii) All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented.</p> <p>(iii) All allegations must be immediately reported to a person in authority in the ASC.</p> <p>(iv) Only substantiated allegations must be reported to the State authority or the local authority, or both.</p> <p>Based on document review and interview, the facility failed to ensure a policy that all alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented, must be immediately reported to a person in authority in the facility and that substantiated allegations must be reported to the State authority.</p> <p>Findings:</p> <p>1. On 5-7-12 at 10:0 am, employee #A1 was requested to provide documentation of a policy that all alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented, must be immediately reported to a person in authority in the ASC and that substantiated allegations must be reported to the State authority.</p> | Q0226   | <p><b>Q 226</b> 1. SCESI "Policy 10.9 – Patient Grievance" amended to incorporate appropriate language and process for grievances relating specifically to mistreatment, neglect, verbal, mental, sexual or physical abuse. 2. Amendment prevents future deficiencies. 3. Nick Hunter (Administration) responsible. 4. Deficiency corrected. Date completed 5/18/2012.</p> | 05/18/2012  |  |   |  |

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|                          | 2. In interview, on 5-9-12 at 2:45 pm, employee #A1 indicated there was no documentation of as per the above-stated request and no other documentation was provided prior to exit. |                     |  |                            |

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| Q0230  | <p>416.50(b)(2), 416.50(b)(3)<br/><b>EXERCISE OF RIGHTS BY OTHERS</b><br/>(2) If a patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.<br/>(3) If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.</p> <p>Based on document review and interview, the facility failed to give to the patient prior to surgery, and post those rights, if the patient was incompetent, whether adjudged or not, and who could exercise the patient's rights.</p> <p>Findings:</p> <p>1. Review of a facility document entitled <u>Eye Specialists Of Indiana Patient Rights and Responsibilities</u>, given to the patient prior to surgery and posted in the facility's reception area, indicated it did not include those rights if the patient was incompetent, whether adjudged or not, and who could exercise the patient's rights.</p> <p>2. In interview, on 5-9-12 at 2:45 pm, employee #A1 indicated there was nothing given to the patient prior to surgery and not posted, indicating those rights if the patient was incompetent,</p> | Q0230   | <p><b>Q 230</b> 1. Patient rights policy amended to include appropriate clause to address patient incompetency. 2. Amendment prevents future deficiencies. 3. Nick Hunter (Administration) responsible. 4. Deficiency corrected. Date completed 5/18/2012.</p> | 05/18/2012  |  |   |  |

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|                    | whether adjudged or not, and who could exercise the patient's rights. No other documentation was provided prior to exit. |               |   |                      |

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| Q0233  | <p>416.50(c)(3)<br/>SAFETY - ABUSE/HARASSEMENT<br/>[The patient has the right to - ]<br/>Be free from all forms of abuse or harassment</p> <p>Based on document review and interview, the facility failed to have a currently approved policy, failed to include in the patient rights document given to the patient prior to surgery and failed to include in the posted document of patient rights, that patients are to be free from all forms of staff abuse, neglect or harassment.</p> <p>Findings:</p> <p>1. Review of currently approved facility policies, review of the patient rights document given to the patient prior to surgery and review of the posted document of patient rights, indicated they did not include that patients are to be free from all forms of staff abuse, neglect or harassment.</p> <p>2. In interview, on 5-9-12 at 2:45 pm, employee #A1 indicated there was no currently approved policy, did not include in the patient rights document given to the patient prior to surgery and did not include in the posted document of patient rights, that patients are to be free from all forms of staff abuse, neglect or harassment. No further documentation</p> | O0233   | <p><b>Q 233</b> 1. Patient rights policy amended to include patient right to be free from all forms of staff abuse, neglect or harassment. 2. Amendment prevents future deficiencies. 3. Nick Hunter (Administration) responsible. 4. Deficiency corrected. Date completed 5/18/2012.</p> | 05/18/2012  |  |   |  |

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| Q0241  | <p>was provided prior to exit.</p> <p>416.51(a)<br/>SANITARY ENVIRONMENT<br/>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 and interview, the facility had no policy for the collection, transportation, sorting, storage and disposal of refuse and garbage.</p> <p>Findings:</p> <p>1. Review of facility policies indicated there was no policy for the collection, transportation, sorting, storage and disposal of refuse and garbage.</p> <p>2. In interview, on 5-11-12 at 12:20 pm, employee #A1 indicated there was no policy for the collection, transportation, sorting, storage and disposal of refuse and garbage. No documentation was provided prior to exit.</p> | 00241   | <p><b>Q 241</b> 1. SCESI“ Policy 9.06 – Cleaning, Decontamination and Disposal of Waste” amended to be more specific with the collection, transportation, sorting, storage and disposal of refuse and garbage. 1. New policy amendment resolves future deficiencies. 2. Nick Hunter (Administration) responsible. 3. Deficiency corrected. Date completed 5/18/2012.</p> | 05/18/2012  |  |   |  |

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| S0110  | <p>410 IAC 15-2.4-1<br/>GOVERNING BODY; POWERS AND DUTIES<br/>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, the facility's governing board failed to review 2 contracted services and 1 directly-provided service during calendar year 2011 for quality assurance performance improvement (QAPI) activities.</p> <p>Findings:</p> <p>1. Review of the facility's governing board meeting minutes for calendar year 2011, indicated the governing board failed to review QAPI activities for the contracted services of maintenance (Frank Irish Co.) and occupational health and the directly-provided service of nursing.</p> <p>2. In interview on 5-10-12 at 11:30 am, employee #A2 indicated there were no governing board minutes for calendar year 2011 which included the above activities</p> | S0110   | <p><b>S 110</b> 1. As part of improvements to our QAPI program, more detailed records with regard to our contracted services will be maintained and sent to the governing board for their review. 2. Improved reporting to the governing body will prevent this deficiency in the future. 3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by the ongoing new process by 6/16/2012.</p> | 06/16/2012  |  |   |  |

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|                    | and no further documentation was provided by exit.   |               |   |                      |

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| S0126  | <p>410 IAC 15-2.4-1<br/>GOVERNING BODY; POWERS AND DUTIES<br/>410 IAC 15-2.4-1 (b)(5)</p> <p>The governing body shall do the following:</p> <p>(5) Ensure that criteria for selection for medical staff membership are individual character, competence, education, training, experience, and judgement.</p> <p>Based on document review and interview, the governing board failed to ensure that criteria for selection for medical staff membership are individual character, competence and judgment for 3 of 3 (AH#1, AH#2 and AH#3) allied health credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 3 allied health credential files indicated files AH#1, AH#2 and AH#3 did not contain any documentation in their files of initial appointment indicating their individual character, competence and judgment.</p> <p>2. In interview, on 5-10-12 at 12:30 pm, employee #A1 indicated there was no documentation, as requested above, in the above-stated credential files. No other documentation was provided by exit.</p> | S0126   | <p><b>S 126</b> 1. Documentation regarding a recommendation for individuals to be credentialed in the SCESI will be obtained and placed in the appropriate files.<br/>2. In the future, recommendations relating to an individual's character, competence and judgment will be required as part of the credentialing process.<br/>3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by 6/16/2012.</p> | 06/16/2012  |  |   |  |

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| S0153              | <p>410 IAC 15-2.4-1<br/>GOVERNING BODY; POWERS AND DUTIES<br/>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 interview the facility failed to ensure that the orientation of all new employees including contract to applicable center and personnel policies for 3 of 12 personnel files reviewed (Staff #1, 2 and 3).</p> <p>Findings include:</p> <p>1. Review of staff #1's personal filed indicated that he/she was hired to clean the facility, including the operating rooms. Review of staff #1's personnel file lacked documentation of being oriented to his/her responsibilities and facility policy/procedures.</p> <p>2. Review of staff #2 and 3's personal filed indicated that each was hired as ophthalmic techs. Review of staff #2 &amp; 3's personnel file lacked documentation of being oriented to his/her responsibilities</p> | S0153         | <p><b>S 153</b> 1. Unable to correct previous personnel file deficiencies. 2. In the future, all personnel files will contain the appropriate documentation. Specifically with regard to orientation for our contracted cleaning service and description of duties for our ophthalmic technicians. 3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by 6/1/2012.</p> | 06/01/2012           |

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|                    | <p>and facility policy/procedures.</p> <p>3. On 05-09-12 at 0905 hours, staff #41 confirmed that staff #1's personnel file did not have documentation of orientation to clean operating rooms.</p> |               |   |                      |

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| S0310  | <p>410 IAC 15-2.4-2<br/>QUALITY ASSESSMENT AND IMPROVEMENT<br/>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> <p>(1) All services, including services furnished by a contractor.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for 2 services furnished by a contractor and 1 directly-provided service, in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the contracted services of maintenance and occupational health and for the directly-provided service of nursing.</p> <p>2. In interview, on 5-10-12 at 11:30 am, employee #A2 indicated there was no documentation of inclusion of the above activities. No other documentation was provided prior to exit.</p> | S0310   | <p><b>S 310</b> 1. New internal form "Contracted Services Evaluation" created and implemented. 2. This form will be incorporated into our QAPI program for all contracted services to monitor and assess performance according to practice standards. 3. Nick Hunter (Administration) responsible. 4. Deficiency corrected. Date completed 5/18/2012</p> | 05/18/2012  |  |   |  |

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| S0400              | <p>410 IAC 15-2.5-1<br/>INFECTION CONTROL PROGRAM<br/>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 and interview, the facility failed to ensure that staff follow manufacturer's recommendations for use of enzymatic solution and cleaning vents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During the facility tour on 05-09-12 at 1200 hours in the Central Sterile clean work room the vent in the ceiling next to the sterilizer was observed to be dirty with lent.</li> <li>2. On 05-09-12 at 1200 hours staff #40 confirmed the vent needed cleaned.</li> <li>3. During the facility tour on 05-09-12 at 1205 hours in the Central Sterile dirty work room a container of EM Power dual enzymatic solution was observed.</li> <li>4. On 05-09-12 at 1205 hours, staff #43 confirmed that he/she changes the enzymatic solution after 12 -15 uses in the ultrasonic cleaner.</li> </ol> | S0400         | <p><b>S 400</b> 1. Unable to correct previous infection control deficiencies. 2. In the future, all areas of the ASC will be cleaned according to SCESI standards. This will be monitored by performing random spot checks on the ASC to evaluate the performance of our cleaning service. Additionally, the enzymatic solution will be discarded and replaced after each use of the ultrasonic cleaner. 3. Nick Hunter (Administration) and Katie Ralston (D.O.N.) responsible. 4. These deficiencies will be corrected by 5/29/2012.</p> | 05/29/2012           |

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|                    | 5. On 05-09-12 at 1355 hours, staff #40 confirmed that the manufacturer of the EM Power dual enzymatic solution recommends that the solution be changed after 1 use. |               |   |                      |

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| S0630  | <p>410 IAC 15-2.5-3<br/>MEDICAL RECORDS, STORAGE, AND ADMIN.<br/>410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient;<br/>(2) support the diagnosis;<br/>(3) justify the treatment; and<br/>(4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on interview and document review, the facility failed to ensure that the medical record (MR) contained sufficient information to document accurately the course of the patient's stay in the center and the results of medications administered for 17 of 30 MRs reviewed (Patient #1, 2, 3, 4, 5, 6, 7, 8, 10, 14, 15, 17, 26, 27, 28, 29 and 30's ).</p> <p>Findings include:</p> <p>1. On 05-09-12 at 1405 hours staff #40 confirmed that nursing staff give the following preoperative medications prior to cataract surgery:<br/>Tropicamide ophthalmic solution for dilation of the eye.<br/>Proparacaine Hydrochloide to dye the eye.<br/>Ofloxacin an antibiotic.<br/>Isopto Homatrophine for eye dilation.<br/>Viscous Xylocaine.</p> | S0630   | <p><b>S 630</b> 1. Unable to correct previous charting deficiencies.<br/>2. In the future, all patient charts will contain all medications administered prior to surgery and initialed by the appropriate individual(s). This will be monitored by our quarterly chart audits performed by a third party.<br/>3. Katie Ralston (D.O.N.) responsible. 4. This deficiency will be corrected by 5/29/2012.</p> | 05/29/2012           |   |

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|                    | Review of patient #1, 2, 3, 4, 5, 6, 7, 8, 10, 14, 15, 17, 26, 27, 28, 29 and 30's MR indicated that each had cataract surgery and lacked documentation of one or more being administered, Viscous Xylocaine, Tropicamide ophthalmic solution, Proparacaine Hydrochloride, Ofloxacin and Isopto Homatrophine. |               |   |                      |

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| S0780  | <p>410 IAC 15-2.5-4<br/>MEDICAL STAFF; ANESTHESIA AND SURGICAL<br/>410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on document review, the facility failed to ensure that the medical staff follow established policy/procedures on verbal orders for 7 of 30 medical records (MR) reviewed (Patient #1, 3, 4, 5, 8, 9 and 18).</p> <p>Findings include:</p> <p>1. Review of policy/procedure Medication Orders: Written or Verbal, indicated the following;<br/>"Verbal orders, including telephone orders, may only be received by a Registered Nurse and/or a Licensed Practical Nurse.<br/>The prescriber must date and countersign the order within 24 hours."</p> | S0780   | <p><b>S 780</b> 1. Unable to correct previous charting deficiencies.<br/>2. SCESI "Policy 5.30 – Medication Orders: Written or Verbal" amended to include that prescriber will date and time orders when countersigned. This will be monitored by our quarterly chart audits performed by a third party. 3. Nick Hunter (Administration) responsible<br/>4. Deficiency corrected. Date completed 5/18/2012.</p> | 05/18/2012           |   |

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|                    | <p>This policy/procedure was last reviewed/revised on 01-2012.</p> <p>2. Review of patient #1, 3, 4, 5, 8, 9 and 18's MRs indicated that each had verbal orders for versed and the prescriber signed the orders, but lacked documentation of date and time when orders were countersigned. It could not be determined the verbal orders were signed within 24 hours.</p> |               |   |                      |

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| S0912  | <p>410 IAC 15-2.5-5<br/>PATIENT CARE SERVICES<br/>410 IAC 15-2.5-5(a)(5)</p> <p>(a) Patient care services must require the following:</p> <p>(5) That an experienced registered nurse supervise all nursing personnel, including, but not limited to, registered nurses, licensed practical nurses, and surgical technologists, in surgical areas and recovery unit(s) as follows:</p> <p>(A) Licensed practical nurses, and surgical technologist may serve as scrub personnel under the supervision of a qualified registered nurse.</p> <p>(B) Circulating duties in the operating room shall be performed by a qualified registered nurse. Licensed practical nurses and surgical technologists may assist in circulating duties under the supervision of a qualified registered nurse who is immediately available to respond to emergencies, in accordance with applicable state law and approved medical staff policies and procedures.</p> <p>Based on document review, the facility failed to ensure that circulating duties in the operating room be performed by a qualified registered nurse (RN) for 14 of 30 medical records (MR) reviewed (Patient #1, 3, 4, 5, 8, 9, 14, 18, 19, 20, 21, 26, 29 and 30).</p> <p>Findings include:</p> | S0912   | <p><b>S 912</b> 1. SCESI "Superbill" will be modified to change the word choice from "Circulating RN" to "Circulating Nurse". 2. In the future, all patient charts will be signed or countersigned, as appropriate, to show that a RN is immediately available in the OR at all times. This will be monitored by our quarterly chart audits performed by a third party.</p> | 06/16/2012  |  |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>SURGERY CENTER OF EYE SPECIALISTS OF INDIANA |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1901 N MERIDIAN ST<br>INDIANAPOLIS, IN 46202  |                      |   |
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|  | 1. Review of patient #1, 3, 4, 5, 8, 9, 14, 18, 19, 20, 21, 26, 29 and 30's MR indicated each had surgery and each had a licensed practical nurse (LPN) document as being the circulating RN. It could not be determined that a RN was performing circulating duties. |   | 3. Katie Ralston (D.O.N.) responsible. 4. This deficiency will be corrected by 6/16/2012. NOTE: it is unknown how long it will take to phase the old form out of circulation. In the interim, the deficiency will be corrected by having an RN countersign all charts. |                      |   |

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| S1166  | <p>410 IAC 15-2.5-7<br/>PHYSICAL PLANT, EQUIPMENT MAINTENANCE,<br/>410 IAC 15-2.5-7(b)(4)(B)(ii)</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>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on document review and interview, the facility failed to provide evidence of preventive maintenance (PM) on 3 of 9 pieces of patient care equipment</p> <p>Findings:</p> <p>1. Review of the facility's PM reports indicated there was no documentation of PM for an electrocardiograph machine, a laser and an ultrasonic sound cleaning machine.</p> <p>2. In interview, on 5-11-12 at 12:30 pm, employee #A1 indicated he/she could not provide documentation of PM for the the</p> | S1166   | <p><b>S 1166</b> 1. As part of improvements to our QAPI program, more detailed records with regard to our equipment checks, including preventive maintenance, will be maintained. 2. New processes for equipment PM checks and documentation are now in place. 3. Nick Hunter (Administration) responsible. 4. This deficiency will be corrected by the ongoing new process by 6/16/2012.</p> | 06/16/2012  |  |   |  |

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|                    | above-stated pieces of patient care equipment and none was received prior to exit.                                     |               |   |                      |

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| S1178  | <p>410 IAC 15-2.5-7<br/>PHYSICAL PLANT, EQUIPMENT MAINTENANCE,<br/>410 IAC 15-2.5-7(b)(5)(B)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following:</p> <p>(B) Refuse, biohazards, infectious wastes, and garbage must be collected, transported, sorted and disposed of by methods that will minimize nuisances or hazards according to federal, state, and local laws and rules.</p> <p>Based on document review and interview, the facility had no policy for the collection, transportation, sorting, storage and disposal of refuse and garbage.</p> <p>Findings:</p> <p>1. Review of facility policies indicated there was no policy for the collection, transportation, sorting, storage and disposal of refuse and garbage.</p> <p>2. In interview, on 5-11-12 at 12:20 pm, employee #A1 indicated there was no</p> | S1178   | <p><b>S 1178</b> 1. SCESI“Policy 9.06 – Cleaning, Decontamination and Disposal of Waste” amended to be more specific with the collection, transportation, sorting, storage and disposal of refuse and garbage. 2. New policy amendment resolves future deficiencies. 3. Nick Hunter (Administration) responsible. 4. Deficiency corrected. Date completed 5/18/2012.</p> | 05/18/2012  |  |   |  |

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|                          | policy for the collection, transportation, sorting, storage and disposal of refuse and garbage. No documentation was provided prior to exit. |                     |  |                            |

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| S1198  | <p>410 IAC 15-2.5-7<br/>PHYSICAL PLANT, EQUIPMENT MAINTENANCE,<br/>410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, the facility failed to coordinate emergency disaster and preparedness with an appropriate governmental agency.</p> <p>Findings:</p> <p>1. Review of a facility document indicated in calendar year 2009 the facility had attempted to contact an appropriate governmental agency regarding coordination of emergency disaster and preparedness. The document also indicated a year later, in 2010, having had no response from the governmental agency, the facility would attempt other efforts to address the issue of coordination of emergency disaster and preparedness with an appropriate governmental agency. There was no further documentation.</p> <p>2. In interview on 5-9-12 at 2:05 pm,</p> | S1198   | <p><b>S 1198</b> 1. Sent communications to Thomas Huser (Emergency Management Coordinator at IU Health) and Jennifer Richardson (Indiana Department of Homeland Security) to try and incorporate SCES1 into a governmental agency approved disaster preparedness plan.<br/>2. Awaiting response from both parties<br/>3. Nick Hunter (Administration) responsible.<br/>4. Communications sent on 5/22/2012. Deficiency correction date TBD. a. ADDENDUM: received response from Thomas Huser putting us in contact with Kathy Newman, chair of the District 5 ASC committee.</p> | 06/16/2012           |   |

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|                    | employee #A1 indicated there was no documentation of other efforts of coordination of emergency disaster and preparedness with an appropriate governmental agency. No documentation was provided prior to exit. |               |   |                      |