

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001142	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2013
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NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4715 STATESMEN DR STE A INDIANAPOLIS, IN 46250
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S000000	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 004157</p> <p>Survey Date: 10-15/16-13</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 10/23/13</p>	S000000		
S000122	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body.</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, it could not be determined the governing board reviewed and approved the medical staff bylaws and rules any time during the past three years.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 10-15-13 at 10:30 am, employee #A1 was requested to provide documentation of the governing board having reviewed and approved the medical staff bylaws and rules any time during the past three years. 2. Review of the governing board minutes and other facility documents indicated there was no documentation of the governing board having reviewed and approved of the medical staff bylaws and rules any time during the past three years. 3. In interview, on 10-16-13 at 5:15 pm, employee #A1 indicated the above documentation was unavailable and no other documentation was provided prior to exit. 	S000122	The Governing Board will review and vote to approve their bylaws as contained within our Operating Agreement at their next meeting on 2-26-14. The administrator will be responsible for this vote completion in order to avoid this tag in the future.	02/26/2014			

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S000153	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on document review and interview, the facility failed orientation of all new employees, including contract and agency personnel for 2 of 2 agency registered nurses' personnel files reviewed (Staff #9 & 10).</p> <p>Findings include:</p> <p>1. Review of staff #9 and 10's personnel files indicated lack of documentation of having completed orientation.</p> <p>2. On 10-16-13 at 1035 hours, staff #40 confirmed that staff #9 & 10's personnel files did not have orientation documentation.</p>	S000153	We have a new facility orientation for agency personnel to complete on their first day here at our center to avoid this tag in the future. The Administrator is responsible for this. This has been corrected as of 11-8-13	11/08/2013	

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S000164	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (H)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(H) A post offer physical examination and employee health monitoring in accordance with the center's infection control program.</p> <p>Based on document review and interview, the facility failed to ensure each employee had a post offer physical examination for 3 of 11 employee files reviewed (Staff #3, 5 and 11).</p> <p>Findings include:</p> <p>1. Review of policy / procedure Employee Physical indicated the following: "All employees will be given a post offer physical exam." This policy / procedure was last reviewed / revised on 02-08-12.</p> <p>2. Review of staff #3's personnel file indicated he/she was hired on 01-30-13 and lacked documentation of having a post offer physical exam.</p> <p>3. Review of staff #5's personnel file indicated he/she was hired on 09-22-11</p>	S000164	<p>A post offer physical will be completed by the listed employee's, by th2-28-14. The administrator is responsible for this employee action. In order to avoid this tag in the future, "employee physical" has been added to our orientation plan so orientation will not be complete until the employee gets their physical.</p>	02/28/2014			

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S000172	<p>and lacked documentation of having a post offer physical exam.</p> <p>4. Review of staff #11's personnel file indicated he/she was hired on 11-11 and lacked documentation of having a post offer physical exam.</p> <p>5. On 10-16-13 at 1035 hours, staff #40 confirmed that staff #3, 5 and 11's personnel files lacked documentation of having a post offer physical exam.</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 document tuberculin tests, per facility policy, for 1</p>	S000172	There will be a Hepatitis Declination form in this employee's file by 11-15-13. This	11/15/2013			

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	<p>of 1 health history file reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of a facility policy entitled EMPLOYEE HEALTH HEP B IMMUNIZATION GUIDELINES, approved 2-8-12, indicated the recombinant HB vaccine is given in a series of three doses over a 6-month period. At the time of the first vaccine, the Center will inform the employee when the next two injections should take place. On 10-15-13 at 10:30 am, employee #A1 was requested to provide documentation of the radiology tech's personnel and health history file. Review of the health history file of P#1 indicated the employee was hired in year 2011. Further review indicated there was no documentation of the Center having given or the person having received the three doses over a 6-month period, or a document indicating the employee, in writing, declining to receive the vaccination. In interview, on 10-16-13 at 4:30 pm, employee #A1 confirmed the above and no further documentation was provided prior to exit. 		<p>was an over sight only for this employee. This item is part of our orientation. The Administrator is responsible for this.</p>		

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S000176	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on document review and interview, the facility failed to ensure that staff demonstrated and documented personnel competency in fulfilling assigned responsibilities for 2 of 2 agency registered nurse personnel files reviewed (Staff #9 & 10).</p> <p>Findings include:</p> <p>1. Review of policy / procedure Skills Checklist indicated the following; "The skill checklist is a self-evaluation tool used to assess employees skills upon hire. A skills checklist will be initiated upon employment with the surgery center and updated yearly by all staff and placed in the employee's file." This policy / procedure was last reviewed / revised on 02-08-12.</p>	S000176	We have new facility orientatio forms to give to agency employee's upon their first day in our facility in order to avoid this tag in the future. The Administrator is responsible for this.	11/08/2013	

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S000228	<p>2. Review of staff #9 and 10's personnel files lacked documentation of having completed a skills checklist.</p> <p>3. On 10-16-13 at 1035 hours, staff #40 confirmed that staff #9 & 10's personnel files did not have orientation documentation.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located.</p> <p>Based on document review and interview, the governing board failed to assure that physicians and podiatrists performing surgery in the facility maintain admitting privileges at one (1) or more hospitals in the same county or</p>	S000228	The missing documentation of hospital admitting privileges will be in the cited files by 12-2-13 in order to avoid this tag in the future. A form is being developed for Medical Staff and Board approval in order to create a	12/02/2013

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	<p>in an Indiana county adjacent to the county in which the facility is located for 5 of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of 7 medical staff credential files indicated files MD#2, MD#4 and MD#5, MD#6, and MD#7 lacked documentation of admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located. 2. In interview, on 10-16-13 at 4:30 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit. 		mutual agreement between DPM's and MD's in the facility in order to admit for the DPM's if necessary. The Administrator is responsible for this.				

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S000444	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(ix)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on document review, observation and interview, the facility failed to ensure that facility staff followed established policy and procedures for attire in the restricted area in 1 instance.</p> <p>Findings include;</p> <p>1. Review of policy / procedure Attire in Patient Care Areas (Restricted, Semi-Restricted, Non-Restricted) indicated the following: "The restricted areas begin at the double doors leading into the surgical suites. B. As much head and facial as possible, including sideburns and necklines, should be covered while in the restricted areas of the surgical suite: 1. The surgical hat or hood should be clean, lint free and confine the hair."</p>	S000444	<p>Medical staff remedial education regarding the use of "skull cap" head wear will be conducted in by December 8, order to avoid this tag in the future. The Administrator is responsible for this.</p>	12/08/2013			

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	<p>This policy / procedure was last reviewed/revised on 02-08-12.</p> <p>2. On 10-16-13 at 1145 hours in operating room #1, a staff member was observed wearing a personal cap with 2-3 inches of hair exposed from back of left ear to right ear.</p> <p>3. On 10-16-13 at 1305 hours, staff #40 confirmed that a disposable cap should have been worn over the personal cap to cover exposed hair.</p>			

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S000710	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p>				

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	<p>(iv) Documentation of experience in the practice of medicine.</p> <p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on document review, for 2 of 7 medical staff credential files reviewed, the facility failed to document the physician had privileges to perform surgical procedures in at least one hospital within the county or an Indiana county adjacent to the county in which the ambulatory surgical center is located.</p> <p>Based on document review and interview, the facility failed to document a signed statement by the applicant to abide by the rules of the center.</p>	S000710	The hospital privileges for the cited doctors will be in there files by 11-30-13 in order to avoid this tag in the future. This was purely an oversight, not an intentional omission. The Administrator is responsible for this.	11/30/2013

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	<p>Findings:</p> <ol style="list-style-type: none"> 1. Review of 7 medical staff credential files indicated files MD#2 and MD#6 did not have documentation that the physician had privileges to perform surgical procedures from at least one hospital within the county or an Indiana county adjacent to the county in which the ambulatory surgical center is located. 2. Review of 7 medical staff credential files indicated file MD#6 lacked documentation the physician had a signed statement to abide by the rules of the center. 3. On 10-15-13 at 4:45 pm, employee #A1 was requested to provide the above documentation. None of the above-requested documentation was provided by exit. 				

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S000772	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p> <p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review and interview, the medical staff failed to ensure that each patient had a medical history and physical examination performed on each patient admitted by a physician or podiatrist who had been granted such privileges by the medical</p>	S000772	The center has obtained a stamp that will be affixed to H&P's that need to be updated for the doctor to sign and date that an update was performed in order to avoid this tag in the future. The Administrator is responsible for this as well as the front office of the center. The doctor that used	11/30/2013			

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	<p>staff and within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy for 5 of 30 medical records (MR) reviewed (Patient #2, 10, 11, 19 and 27).</p> <p>Findings include:</p> <p>1. Review of the Medical Staff Rules and Regulations indicated the following: "E. A history and physical examination shall be performed on all patients having surgery. The history and physical, if not completed on the day of surgery, shall be updated by the surgeon or anesthesiologist on the day of surgery. This entry should be authenticated and dated. The results of these examinations must be included in the patient's medical record before the procedure begins." The Medical Staff Rules & Regulations were last reviewed / revised on 02-08-12.</p> <p>2. Review of patient #2's MR indicated the patient had surgery on 08-06-13 and history & physical examination was done on 07-11-13 and lacked documentation of an update.</p>		<p>an H&P from an uncredentialed doctor has had remediation concerning this issue. We at the center are also going to screen patient information for information from uncredentialed doctors to avoid this tag in the future. The Administrator is ultimately responsible for this.</p>				

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	<p>3. Review of patient #10's MR indicated the patient had surgery on 07-12-13 and history & physical examination was done on 07-11-13 by MD #1 and lacked documentation of an update.</p> <p>4. On 10-16-13 at 1520 hours staff #40 confirmed that MD #2 was not a member of the facility's Medical Staff.</p> <p>5. Review of patient #11's MR indicated the patient had surgery on 07-17-13 and history & physical examination lacked documentation of the date completed.</p> <p>6. Review of patient #19's MR indicated the patient had surgery on 08-22-13 and history & physical examination lacked documentation of the date completed.</p> <p>7. Review of patient #27's MR indicated the patient had surgery on 09-17-13 and history & physical examination lacked documentation of the date completed.</p>			

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S000826	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(E)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following:</p> <p>(E) Safety training required of personnel. Based on document review and interview, the facility failed to provide documentation of safety training in areas where anesthetics are used for 4 (MD#3, MD#4, MD#6, and MD#7) of 7 medical staff credential files reviewed.</p> <p>Findings:</p> <p>1. Review of 7 medical staff credential files indicated files MD#3, MD#4, MD#6, and MD#7 lacked any documentation of safety training in areas where anesthetics are used.</p> <p>2. In interview, on 10-16-13 at 4:30 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</p>	S000826	The cited doctors will be given training for safety by 12-2-13 with documentation in their files in order to avoid this tag in the future. Annual training will be conducted next year with a list of doctors in order to avoid any omission's as with the cited doctors. The Administratro is responsible for this.	12/02/2013			

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S000888	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval. Based on document review and interview, the facility failed to ensure that operative reports were written or dictated immediately following surgery for 4 of 30 medical records (MR) reviewed (Patient #2, 3, 5 and 11).</p> <p>Findings include:</p> <p>1. Review of patient #2's MR indicated the patient had surgery on 08-06-13 and the operative report lacked documentation of a signature from the surgeon completing the report.</p>	S000888	Re-medial training on the timliness of op reports will be given to the entire medical staff present at our next meeting 12-4-13. Those not in attendance will get personal training. This training is to avoid this tag in the future. We are developing a policy that address's this issue and defines sanctions for continued untimliness. This policy will be reviewed and approved by the Board and the Medical Staff. The Administrator is responsible for this.	12/08/2013	

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	<p>2. Review of patient #3's MR indicated the patient had surgery on 09-13-13 and the operative report was dictated on 09-13-13 and lacked documentation of a signature from the surgeon completing the report.</p> <p>3. Review of patient #5's MR indicated the patient had surgery on 07-29-13 and the operative report was dictated on 08-06-13 and lacked documentation of a signature from the surgeon completing the report.</p> <p>4. Review of patient #11's MR indicated the patient had surgery on 07-17-13 and the operative report was dictated on 06-21-07.</p> <p>5. On 10-16-13 at 1545 hours, staff #40 confirmed that operative reports are to be dictated immediately after surgery.</p>				

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S001198	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 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, it could not be determined the facility coordinated emergency disaster and preparedness with an appropriate governmental agency in 1 instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On 10-15-13 at 10:30 am, employee #A1 was requested to provide documentation of the coordination of emergency disaster and preparedness with an appropriate governmental agency. 2. Review of facility documents indicated there was none regarding the coordination of emergency disaster and preparedness with an appropriate governmental agency. 3. In interview, on 10-16-13 at 5:30 pm, 	S001198	IDR--This tag should be omitted. We have been involved in the District 5 group for years. I was asked at the time of survey for disaster prep info one time. I apparently forgot to provide this information. I was never asked again. This was purely a forgetful act on my part and apparently the surveyors. I didn't hear about disaster prep again until the exit interview--too late. As you can see from attachments B, C, and D we continue to be extremely involved in disaster prep in our county. The Administrator is responsible for this.	11/08/2013

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S001210	<p>employee #A1 indicated there was such documentation but it had not been presented and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-8 RADIOLOGY SERVICES 410 IAC 15-2.5-8(c)(1)</p> <p>(c) All centers shall comply with all regulations set forth in this rule and with 410 IAC 5, when radiology services are provided on-site by the center, including, but not limited to the following:</p> <p>(1) Radiology services must be supervised by a radiologist or radiation oncologist.</p> <p>Based on document review and interview, it could not be determined if the facility had, for the most recent year, an annual supervision of radiology services conducted by a radiologist or radiation oncologist.</p> <p>Findings:</p> <p>1. On 10-15-13 at 10:30 am, employee #A1 was requested to provide documentation of the facility's radiology services having been supervised by a radiologist or radiation oncologist.</p>	S001210	Our consulting radiologist is scheduled to re-visit for his annual inspection by 12-8-13 in order to avoid this tag in the future. The current form documenting his most recent visit cannot be found. This is already a regularly scheduled visit. The Administrator is responsible for this.	12/08/2013	

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	<p>2. Review of a facility document entitled RESPONSIBILITIES OF CONSULTING RADIOLOGIST indicated a contracted licensed radiologist will consult in regards to radiologic services at least annually in order to provide oversight of the radiologic services provided in the center.</p> <p>3. Review of facility documents indicated the most recent time a consulting radiologist documented a general oversight was September 12, 2011.</p> <p>4. In interview, on 10-16-13 at 5:30 pm, employee #A1 indicated documentation of a more recent review was unavailable and no further documentation was provided prior to exit.</p>				