

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
--	---

(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
S 0000  Bldg. 00	This visit was for a State licensure survey of an ambulatory surgery center. Dates of survey: 5/6/15 to 5/7/15 Facility number: 012278  QA: cjl 05/20/15	S 0000		
S 0103  Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(a)(1)(B)  The governing body shall do the following:  (1) Ensure that the center: (B) makes available to the commissioner or representatives of the department upon request all reports, records, minutes, documentation, information, and files required for licensure. Based on document review and interview, the facility failed to make available the Governing Body (GB) Bylaws.  Findings:  1. Review of facility documents lacked evidence of GB Bylaws.	S 0103	Governing Board Bylaws were located after survey. GB Bylaws were reviewed on 05/11/15. Governing Board Bylaws were approved by the GB and signed on 05/20/15. Bylaws will be reviewed as needed, and will not be reviewed any later than 05/2018. Heather Cox, RN Administrator is responsible for making sure this is completed and reviewed per State	05/20/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
--	---

(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
S 0106 Bldg. 00	<p>2. On 5/7/15 at 2:30 pm, A1, Administrator, confirmed GB Bylaws could not be located and were unavailable for review.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Review the bylaws at least triennially.</p> <p>Based on document review and interview, the Governing Body (GB) failed to review its Bylaws in the past 3 years.</p> <p>Findings:</p> <p>1. Review of GB meeting minutes indicated Bylaws were adopted 6/15/11. Review of meeting minutes from 6/15/11 to 3/31/15 lacked evidence of the Bylaws having been reviewed.</p> <p>2. On 5/7/15 at 11:40 am, A1, Administrator, confirmed meeting minutes lacked documentation of GB review of GB Bylaws. No further documentation was provided prior to exit.</p>	S 0106	<p>guidelines.</p> <p>It was noted that the Governing Body approved the GB Bylaws on 06/15/11, but the Medical Staff Bylaws were attached to the meeting minutes; not the GB Bylaws. GB Bylaws have been located, reviewed, signed and approved on 05/20/15. Next review will be as needed, but no later than 05/2018. This date has been placed in the administrative binder on a reminder due date list. Heather Cox, RN Administrator is responsible for making sure that this is complete and compliant with State guidelines.</p>	05/20/2015
S 0110 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015	
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716			
(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			
S 0122 Bldg. 00	<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 Governing Body (GB) failed to review, at least quarterly, reports of quality assessment and improvement (QAPI).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of GB meeting minutes dated 3/31/15, 1/17/15, and 9/24/14 lacked documentation of QAPI report review.</li> <li>2. On 5/7/15 at 1:30 pm, A2, Registered Nurse Administrator, indicated CQI (Continuous Quality Improvement/QAPI) only report identified problems to the GB.</li> </ol> <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</p>	S 0110	<p>It is noted that GB failed to review at least quarterly, the reports of QAPI. Staff, Infection Control, Safety, and CQI meetings are set for 07/01/15, 08/05/15, 09/02/15, 10/07/15, and 12/02/15. The results of the meetings and reports will be reviewed in the GB meetings scheduled for 06/30/15, 9/30/15, and 12/30/15. The first meeting was held on 6/4/15 and the first official full report will be in the 6/30/15 GB meeting minutes. Heather Cox, RN is responsible for making sure this is covered in the GB meetings.</p>	06/30/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015	
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716			
(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			
	<p>approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body.</p> <p>Based on document review and interview, the Governing Body (GB) failed to ensure Medical Staff (MS) Bylaws and Rules were approved/reviewed within the past 3 years.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of GB meeting minutes from 6/15/11 to 3/31/15 lacked evidence of the Bylaws having been reviewed.</li> <li>2. On 5/7/15 at 11:40 am, A1, Administrator, confirmed meeting minutes lacked documentation of GB review of MS Bylaws and or Rules. No further documentation was provided prior to exit.</li> </ol>	S 0122	<p>Medical Staff Bylaws were not approved/revised in the last three years. On 5/11/15 this was completed and approved by the GB on 5/20/15.</p> <p>The following changes noted are: previous Bylaws, under Article III- Appointment and Applications- Section A-Terms of Appointments-#2 stated that "Medical Staff and all initial Clinical Privileges, unless otherwise provided by the Governing Board in accordance with Indiana Law, shall be for a period of three (3) years"; this was changed to two (2) years. Under same section #3 "All appointments and re-appointments to the Medical Staff will be for a period of three (3) years"; this was changed to two (2) years.</p> <p>Article V. Procedural Rights-Fair Hearing Plan-Section C, #3-Appointment of Hearing Committee. This section was deleted, per Dr. Sanapati, as he will handle Medical Staff adverse actions.</p> <p>Section D, #2-Presiding Officer. This was also deleted, due to there not being a "Hearing Committee" to have a presiding officer. Dr. Sanapati will handle Medical Staff issues as he is the Medical Director and Governing Body.</p> <p>Rules and Regulations-Section B-Anesthesia. Categories were a) Moderate Sedation/Analgesia b) minimal sedation c) Local or Topical Anesthesia. This was changed to a) General b) Monitored Anesthesia Care c) Moderate Sedation/Analgesia</p>	05/20/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716		
(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	
S 0216  Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(d)(4)</p> <p>In accordance with center policy, the governing body shall do the following:</p> <p>(4) Ensure that there is a center-wide, quality assessment and improvement program that evaluates the provision of patient care and outcome.</p> <p>Based on document review and interview, the Governing Body (GB) failed to ensure there was a center-wide quality assessment and improvement (QAPI) program.</p> <p>Findings:</p>	S 0216	<p>d) Minimal Sedation e) Local or Topical Anesthesia.</p> <p>Rules and Regulations-SectionI-Medical Staff Requirements was added. In review, it was noticed that it wasmissing from the previous Bylaws that were adopted in 2011, but the templatethat was given to Heather Cox, RN Administrator when she took over had it, soit was left based on CMS requirement of physician being immediately available.</p> <p>Thesechanges were completed and approved by GB on 5/20/15. Bylaws will be reviewedas needed, but no later than 5/2018. Heather Cox, RN Administrator isresponsible for ensuring that this is completed</p> <p>QAPI Program was reviewed, revised, and approved By the GB for implementation on 6/5/15. The program will be reviewed in the staff meeting on 7/1/15. Heather Cox, RN Administrator is responsible for overseeing this program and notifying GB of any problems. QAPI reports will be</p>	06/05/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
--	---

(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
S 0228 Bldg. 00	<p>1. Review of facility documents lacked evidence of a center-wide QAPI program. Documentation dated 3/31/15 indicated an evaluation of housekeeping activities, but lacked evidence of any other type of QAPI review.</p> <p>2. On 5/7/15 at 1:30 pm, A2, Nurse Administrator, indicated their Continuous Quality Improvement committee only looks at and reports problems.</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>		discussed in quarterly GB meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015	
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716			
(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			
S 0230	<p>Based on document review and interview, the Governing Body (GB) failed to ensure that 4 of 6 physicians maintain admitting privileges at 1 or more hospitals (MD#1, MD#3, MD#4, &amp; MD#6).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of 6 Medical Staff (MS) credential files lacked evidence of admitting privileges to an appropriate hospital for MD#1, MD#3, MD#4, &amp; MD#6. The files also lacked evidence of an admitting agreement with any other physician.</li> <li>Review of 6 facility documents received 5/7/15, indicated to be credential file documents for MD#1, MD#2, MD#3, MD#4, MD#5, &amp; MD#6, lacked evidence of admitting privileges to an appropriate hospital for MD#1, MD#3, MD#4, &amp; MD#6.</li> <li>On 5/7/15 at 3:00pm A1, Administrator, in the presence of A3, Owner/Medical Director, indicated evidence of admitting privileges was not in the files or facility.</li> </ol> <p>410 IAC 15-2.4-1</p>	S 0228	<p>It is agreed that the information was not in the medical staff files. Current privileges were obtained and placed in the files on 5/8/15. Physician files will be reviewed at least quarterly, so that this is not missed again. A complete list of what is needed in the Medical Staff file and review was added to the Medical Staff File policy on 6/17/15. This will be the responsibility of Heather Cox, RN Administrator. This is on the reminder list located in the administrative binder. Medical Staff files will be re-organized so that it is easier to navigate and locate information.</p>	05/08/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
--	---

(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
--------------------	--	---------------	---	----------------------

Bldg. 00	<p><b>GOVERNING BODY; POWERS AND DUTIES</b> 410 IAC 15-2.4-1(e)(5)</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>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the Governing Body (GB) failed to provide for periodic review of the center and its operation by a utilization review (UR) or other committee.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of facility documents lacked evidence of periodic review of operations by a UR or other committee.</li> <li>On 5/7/15 at 12:25 pm, A1, Administrator, indicated the facility did not implement use of a UR or other committee for review of operations.</li> <li>On 5/7/15 at 3:10 pm, A3, owner/medical director, confirmed the above.</li> </ol>	S 0230	Dr. Sanapati and Heather Cox, RN Administrator are currently looking for 3 physicians, who have no financial interest in the facility, to be a part of the UR Committee. UR P&P was reviewed and updated, forms were adopted, and approved for implementation by the GB on 6/5/15. Heather Cox, RN Administrator is responsible for overseeing that this is being accomplished and reporting any issues to the Governing Board.	08/01/2015
----------	---	--------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015	
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716			
(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			
S 0300  Bldg. 00	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)</p> <p>(a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the center failed to develop, implement and maintain an effective center-wide quality assessment and improvement (QAPI) program with a written plan of implementation.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of facility documents lacked evidence of a written QAPI plan.</li> <li>2. On 5/7/15 at 2:00 pm A1, Administrator, and A2, Nurse Administrator, confirmed the center did not have a written QAPI plan. No further documentation was provided prior to exit.</li> </ol>	S 0300	<p>QAPI Plan was reviewed and implemented on 6/5/15. Administrator and Nurse Administrator does not recall confirming that we did not have a written QAPI Plan, we did have one, it just was not in writing that the plan was implemented. This was done just before survey came in and documentation of it had not been completed. However, after survey and having a better understanding it was reviewed again and new forms were adopted that made more sense for what we do. The forms include: 1-Medical Record Audit Form 2-Peer Chart Review-Anesthesia 3-Peer Chart Review-Surgeon/Physician 4-Anesthesia PR/UR Monitoring Form 5-Surgeon/Physician PR/UR Monitoring Form 6-Peer Review/Utilization Review Quarterly Log 7-Peer</p>	06/05/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
--	---

(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
S 0400 Bldg. 00	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 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 document review, observation and interview, the facility failed to provide an environment that minimizes infection exposure and a means for staff to follow accepted infection control standards by having no sink for staff to wash hands in or near the pre-operative dressing rooms where intravenous (IV) lines for medication administration are started.</p>	S 0400	<p>Review/Utilization Review Quarterly Report 8-Peer Review Committee Case Review 9-Physician Reappointment Profile Clinical Performance (This will include a neon yellow sheet that reads "Peer Review Confidential-Internal Use Only-Not to be Released". This will be placed in the physician's file that is kept in a locked file cabinet in the Administrator's office). Forms will be implemented ASAP. Heather Cox, RN Administrator is responsible for overseeing that forms are being utilized appropriately and that confidentiality is maintained on Peer Reviews.</p> <p>Adding sinks in the pre-op rooms will take time; due to planning, lack of space in Pre-op 2, and having to close the center while it is being completed; we have come up with the following solution: The facility has purchased new fluoro stretchers and the current tables will be coming out of the OR's. Since this was brought up in the exit interview, we are implementing</p>	06/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716		
(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	
	<p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Surgery center policy X. Infection Prevention and Control Program (reviewed date unknown) indicates: Hand Hygiene; Sinks are available in all areas as needed.</li> <li>2. On 5/7/2015 at 1000 hours, it was observed that there were no sinks in or near the preop dressing rooms. Staff member #6 was observed starting an IV line without washing hands before gloving or after starting the IV. Staff member handled bloodied gauze sponges and was unable to wash hands.</li> <li>3. On 5/7/2015 at 1500 hours, staff member #2 concurred with these findings.</li> </ol>		<p>that IV's are to be started in the PACU/Holding area. Patient will change, have vitals taken, and appropriate paper work completed in the pre-op room. Patient will then be walked back to the fluoro stretcher that they will stay on until discharge. Once they get on the stretcher, the nurse will finish with getting the IV and/or Blood Glucose. Patient will be taken into the OR, have procedure, brought back to same PACU/Holding bay until patient is stable for discharge. Sinks are immediately available in the PACU/Holding area. We will also be changing our IV catheters to a bloodless catheter. We currently are using the BD Insyte Autoguard. We will be using the BD Insyte Autogurd BC that is designed to reduce blood exposure by stopping the blood at the hub. Once the tubing is attached to the hub, the safety will be eliminated allowing fluid to flow through. The cost of the IV catheter is the same as the IV catheter we are currently using, so the facility will not incur any additional costs. Training on this new catheter was completed on 6/16/15 by the BD rep. Haley Whitfield, RN, Cathy Glassco, RN, Heather Cox, RN, and Jeff Fischer LPN were present for the training. In addition, hand hygiene education will be completed with staff, including contracted CRNA's. This tag and correction will be monitored,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
--	---

(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
S 0526 Bldg. 00	410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)  (h) All nursing and other center personnel performing laboratory testing shall have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed. Based on policy review, employee file	S 0526	re-evaluated and discussed at next GB meeting. On 6/17/15, all IV catheters and supplies to start IV's were removed from Pre-op and placed in PACU/Holding. Review and revision of Infection Control Section X was completed and approval is requested. Section 3.Letter H. Roman Numeral VIII-Hand Hygiene-was revised to include that "Any procedure that could potentially cause blood or body fluid exposure will be completed in the PACU/Holding area. Sinks are immediately available in the PACU/Holding area. IV starts and blood glucose checks will be completed in the PACU/Holding area." This was also added in Policy Section 3. Letter J-Safe injection practices, Roman Numeral III-Intravenous Therapy. Heather Cox, RN Administrator is responsible for overseeing further issues with this process. Discussion regarding placing sinks in the pre-op rooms will be revisited if this solution creates a safety issue in another area.  The CLIA waived testing that is	06/12/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015	
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716			
(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			
	<p>review and interview, the facility failed to ensure that 4 (#N5, N6, N8 and N10) of 4 nursing staff who perform laboratory testing of blood sugar, hemoglobin (hemostat) and pregnancy tests have competency assessed annually with documentation of assessment maintained in the employee file for the procedures performed.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>The facility policy "CLIA Waived Testing", approved July, 2014, indicated: <ol style="list-style-type: none"> <li>The following CLIA waived tests are performed within the surgery center: Blood Glucose, Urine pregnancy tests and Blood hemoglobin testing</li> <li>All staff performing CLIA waived testing will receive initial and follow-up competency education.</li> </ol> </li> <li>Employee files for staff members #N5, N6, N8 and N10 lacked documentation of annual competency assessment for the CLIA waived tests for 2014 or 2015.</li> <li>At 1500 hours on 5/7/20105, staff member #1 concurred with these findings.</li> </ol>		<p>performed in the facility are Capillary Blood Glucose and Urine Pregnancy Tests. On 6/12/15, Haley Whitfield, RN performed Glucose and Urine Pregnancy Testing competency training for Heather Cox, RN Administrator, Cathy Glassco, RN Nurse Administrator, Jeff Fischer, LPN-Pre-Op, Carol Wilzbacher, CMA, and Marie O'Brian, CMA. This will be added to our annual training, which is due in January. Competency will also be completed upon hire for those employees who will be performing, or may be performing the tests.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
--	---

(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
S 0668 Bldg. 00	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(11)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(11) Condition on discharge, disposition of the patient, and time of dismissal.</p> <p>Based on policy review, medical record review and interview, the facility failed to ensure that patient medical records (MR) were complete and that patients were discharged according to policy for 3 (#6, #7, #9) of 16 medical records reviewed.</p> <p>Findings:</p> <p>1. Facility policy VIII. Medical Records, 2. Medical Record Management, B. Form and Content, Section 1. (review date unknown) indicated: The Center follows uniform content and format for medical records; These medical records contain reports of history and physical examination, progress notes, and other materials such as laboratory reports, x-ray findings and consultations; A. Operative report D. Discharge/Disposition</p>	S 0668	<p>Heather Cox, RN Administrator is in contact with the outside retrospective chart reviewer; to set up a time for her to come in and review facility P&amp;P's for Medical Records. Until then, review of charts will be performed prior to patient being discharged to make sure that D/C instructions, D/C order, and condition at D/C is documented before patient is released. Turn-around time for dictation is 24 hours. Charts will be kept in a stack, on the shelf, in the chart room and not filed until the operative report comes back. Once the report is reviewed and signed, the report will be placed in the chart and then filed. Chart audits will be performed by the nursing staff, using the new form that was approved by GB on 6/5/15. This will continue and results will be reported in CQI. Medical Records P&amp;P's were reviewed again on 6/18/15 and no</p>	08/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015	
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716			
(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			
S 0704  Bldg. 00	<p>Status Instructions</p> <p>2. Sixteen medical records (MR) of patients who had received pain procedures at the facility between 9/1/2014 to 5/7/2015 were reviewed. Three of sixteen MRs were incomplete:</p> <p>a. Patient #6's MR lacked documentation of an operative report.</p> <p>b. Patient #7's MR lacked documentation of discharge instructions and a discharge order or condition on discharge.</p> <p>c. Patient #9's MR lacked documentation of a discharge order or condition on discharge.</p> <p>3. At 1515 hours on 5/7/2015, staff member #1 concurred with these findings.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(1)</p> <p>The medical staff shall do the following:</p>		changes are requested until the contracted chart reviewer is available to come in and review with us.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
--	---

(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
S 0732 Bldg. 00	<p>(1) Conduct outcome-oriented performance evaluations of its member at least biennially.</p> <p>Based on document review and interview, the Medical Staff (MS) failed to conduct biennial outcome-oriented performance evaluations for 2 of 2 reappointed members.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of documentation titled Medical Staff Bylaws indicated in Article VI - division of Medical Staff #2. All Medical Staff Members are subject to periodic review by the Medical Executive Committee and the Governing Board.</li> <li>Review of MS credential files indicated the following: MD#1 was reappointed 4/3/14 and MD#6 was reappointed 12/18/13; the files lacked documentation of performance review/evaluations or peer review in the past 2 years.</li> <li>On 5/7/15 at 11:30 am, A1, Administrator, indicated MS performance reviews were not being done.</li> </ol> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(2)</p> <p>These bylaws and rules must be as follows:</p> <p>(2) Be reviewed at least triennially.</p> <p>Based on document review and interview the Medical Staff (MS) failed to review their Bylaws and Rules within the past 3 years.</p> <p>Findings:</p>	S 0704	In review of the QAPI program, the Physician Reappointment Profile Clinical Performance form was adopted and approved for implementation on 6/5/15. This will be done on a quarterly basis and reviewed every two years for re-appointment. Heather Cox, RN Administrator will be responsible for getting this fully implemented. Dr. Sanapati and Heather Cox, RN Administrator are working on getting the 3 physicians who have no financial interest for UR and PR. Our goal date to have the physicians is 8/1/15.	09/30/2015
		S 0732	Medical Staff Bylaws were initially adopted on 6/15/11 and had not been approved/revised in the last three years. On 5/11/15 this was completed and approved by the	05/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716		
(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	
	<p>1. Review of facility documents indicated MS Bylaws, Rules and Regulations were initially adopted 6/15/11, no other MS review documentation was produced and review of Governing Body (GB)/MS meeting minutes 3/31/15, 1/17/15, and 9/24/14 lacked documentation of MS review of their Bylaws, Rules and Regulations.</p> <p>2. On 5/7/15 at 11:40 am, A1, Administrator, confirmed MS Bylaws, Rules and Regulations had not been reviewed by the MS since initial adoption 6/15/11.</p>		<p>GB on 5/20/15. The following changes noted are: previous Bylaws, under Article III-Appointment and Applications-Section A-Terms of Appointments-#2 stated that "Medical Staff and all initial Clinical Privileges, unless otherwise provided by the Governing Board in accordance with Indiana Law, shall be for a period of three (3) years"; this was changed to two (2) years. Under same section #3 "All appointments and re-appointments to the Medical Staff will be for a period of three (3) years"; this was changes to two (2) years. Article V. Procedural Rights-Fair Hearing Plan-Section C, #3-Appointment of Hearing Committee. This section was deleted, per Dr. Sanapati, as he will handle Medical Staff adverse actions. Section D, #2-Presiding Officer. This was also deleted, due to there not being a "Hearing Committee" to have a presiding officer. Dr. Sanapati will handle Medical Staff issues as he is the Medical Director and Governing Body. Rules and Regulations-Section B-Anesthesia. Categories were a) Moderate Sedation/Analgesia b) minimal sedation c) Local or Topical Anesthesia. This was changed to a) General b) Monitored Anesthesia Care c) Moderate Sedation/Analgesia d) Minimal Sedation e) Local or</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716
--	---

(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
S 1196 Bldg. 00	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAc 15-2.5-7(c)(5)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(5) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with center policy and state and local regulations.</p> <p>Based on document review and interview, the safety management program failed to maintain written evidence of regular inspection by a state or local fire control agency.</p> <p>Findings:</p>	S 1196	<p>Topical Anesthesia. Rules and Regulations-Section I-Medical Staff Requirements was added. In review, it was noticed that it was missing from the previous Bylaws that were adopted in 2011, but the template that was given to Heather Cox, RN Administrator when she took over had it, so it was left based on CMS requirement of physician being immediately available. These changes were completed and approved by GB on 5/20/15. Bylaws will be reviewed as needed, but no later than 5/2018. Heather Cox, RN Administrator is responsible for seeing that this is completed according to State guidelines.</p> <p>Heather Cox, Administrator, did fail to ensure that this was completed in 2014. After this was realized during survey on 5/7/15, the Fire Inspector was notified and the inspection was completed on 5/11/15. Due date of next</p>	05/11/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015	
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716			
(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			
S 1210 Bldg. 00	<p>1. Review of facility documents indicated the most recent year of a fire inspection by a state or local fire control agency was 2013.</p> <p>2. On 5/7/15 at 12:45 pm A1, Administrator, confirmed the most recent fire inspection was in 2013 and there had been no correspondence in attempt to coordinate an inspection.</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, the facility failed to have radiology services supervised by a radiologist or radiation oncologist.</p> <p>Findings:</p> <p>1. Review of 6 medical staff (MS) credential files (MD#1 - MD# 6) and 1 MS Allied Health (AH#1) file lacked evidence of any being a radiologist or radiation oncologist and each lacked evidence of a job description for radiology director.</p> <p>2. On 5/7/15 at 11:30 am, A1, Administrator, indicated employee P1 was intended to be the radiology director.</p>	S 1210	<p>inspection is documented in the Administrative binder as a reminder. Heather Cox, RN Administrator is responsible for ensuring that this is completed on a yearly basis, according to State guidelines.</p> <p>Dr. Sanapati has found a Radiologist, Dr. Kavita Erickson. A meeting is being scheduled for the first week of July, date is to be determined. Paper work is in process, there will be a file completed with required documentation; approval will be documented in MEC and GB meeting minutes. P1 is no longer associated with the facility, as of 6/1/15. We will be electing a RT as the Radiation Safety Officer. Our one and only RT will be leaving, due to moving, the facility in July or August. We do have a RT who will be joining us. She has completed her employee physical and began training on</p>	08/03/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001175	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  05/07/2015
NAME OF PROVIDER OR SUPPLIER  ADVANCED AMBULATORY SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 PROFESSIONAL BLVD SUITE 104 EVANSVILLE, IN 47716		
(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	
	<p>3. Review of the personnel file for P1 lacked evidence of a job description for radiology director and indicated P1 to hold a license as a radiology technician.</p> <p>4. Review of facility contracts lacked evidence of a director of radiology consultant.</p>		<p>6/16/15. Once she is fully employed with us and training is completed, we will be making her the Radiation Safety Officer. Radiology Technologist and Radiation Safety Officers job description will be placed in the employee file once it is reviewed and signed by employee.</p>		