

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001144	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2014
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NAME OF PROVIDER OR SUPPLIER COLUMBUS PAIN INSTITUTE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 N PARK STE 20 COLUMBUS, IN 47203
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S000000	<p>This visit was for a standard licensure survey.</p> <p>Facility Number: 004546</p> <p>Survey Date: 8/11/14 to 8/12/14</p> <p>Surveyors: Trisha Goodwin, RN BSE Public Health Nurse Surveyor/Administrator Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 08/28/14</p>	S000000		
S000104	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(a)(2)</p> <p>The governing body shall do the following:</p> <p>(2) Adopt bylaws and function accordingly.</p> <p>Based on document review and interview, the surgery center failed to show evidence of adopting and reviewing</p>	S000104	The Clinical Manager met with the Board of Directors informing of the cited deficiency, and requested the Board of Directors	09/17/2014

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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S000192	<p>governing body bylaws.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of facility documents indicated no adoption of bylaws by the governing body at any time. 2. Review of the facility administrative policy and procedure (P&P) manual indicated no P&P or other documents for governing board bylaws. 3. In interview on 8/12/14 at 4:00pm, employee #A3 indicated some, but not all, P&Ps refer to the governing board in the responsibility section and confirmed governing board bylaws were not available. No further documentation was provided prior to exit <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c)(5)(P)(iv)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>Development, implementation, and</p>				<p>to create Bylaws for the Center. The Board of Directors are creating Governing Bylaws for the Center, and will present them at the next Board Meeting 9/17/2014. The Governing Bylaws will then be added to the Policy and Procedure Book. The Clinical Manager will be responsible for ensuring the Governing Bylaws are added to the Policy and Procedure Book.</p>		

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	<p>monitoring of a safety management program include, but not be limited to, the following:</p> <p>(iv) Chemical substances use and storage. Based on observation and interview, the center failed to implement safety management for chemical use and storage in one (1) instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During tour of the facility on 8/12/14 from 3:25pm to 4:00pm, in the presence of employee A2, in the housekeeping closet, six (6), five (5) gallon bottles of Stay bathroom disinfectant cleaner were noted with labels indicating first aid need for eye contact as a 15-20 minute water flush. An eye wash station was not noted in that area. 2. In interview on 8/12/13 at 3:45pm, employee A2 indicated a shower to be available for eye wash. 3. Observation of the shower, indicated by A2, was noted to be through a hall leading to a door into a storage area that led to a second door into a bathroom with locking doors. 	S000192	The Clinical Manager contacted Barr Plumbing Services about installing an Eyewash Station on the Center sink at their earliest availability. A policy and procedure will be added to the Policy and Procedure Book in regards to the Eyewash Station. Proper use of the Eyewash Station will be discussed at the next staff meeting 9/16/14. The Clinical Manager will be responsible for guaranteeing the eyewash station is installed and properly working.	09/24/2014			

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S000400	<p>4. In interview on 8/12/14 at 5:00pm, employee A2 confirmed the above and indicated an eyewash station would be installed.</p> <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 and observation, the facility failed to follow policy related to recapping needles in 2 instances.</p> <p>Findings include:</p> <p>1. Facility policy titled "BLOOD BORNE DISEASE EXPOSURE CONTROL PLAN" last reviewed/revised 8/1/13 states on page 4: "F. Needles <u>shall not</u> be recapped, bent or broken prior to disposal except that needles may be recapped with the use of a mechanical device or the one-handed method."</p> <p>2. During observation in the operating room at 10:25 a.m. on 8/12/14, staff</p>	S000400	Clinical Manager held in-service 9/10/2014 with all clinical staff on Blood Borne Pathogens, specifically addressing recapping needles. Information Packets handed out to all staff with a quiz following. This education will be added to our yearly education calendar. Clinical Manager will also be observing Clinical staff to monitor compliance and will report to the Quality Assurance who will continue to randomly audit for 100% compliance. The Clinical Manager will be responsible for staff compliance.	09/10/2014			

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S000428	<p>member #N1 (RN) recapped a needle in 2 instances using both hands after administering medication to the patient. He/she then removed the cap at the sharps container and disposed of the syringe and needle.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(i)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(i) Sanitation. Based on observation, document review, and interview, the facility failed to ensure all areas of the operating room (OR) were clean and dust free for 1 OR toured.</p> <p>Findings include:</p> <p>1. During observation in the OR beginning at 10:20 a.m. on 8/12/14, the following was observed:</p> <p>(A) The window blinds and the wall vent behind the medication cart were soiled</p>	S000428	<p>Clinical Manager reviewed housekeeping policy with staff on 9/9/14. Current housekeeping services will be terminated, and new housekeeping services will be started. Housekeeping checklist reviewed and updated. A copy of this list placed in the housekeeping communication log book. Housekeeping duties reviewed with new contracted service. Infection control will monitor performance, and report to Quality Assurance. Quality Assurance Committee will then</p>	09/30/2014			

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S000442	<p>with dust.</p> <p>2. Facility policy titled "HOUSEKEEPING SERVICES" last reviewed/revised 8/1/13 indicates on page 4 that the window blinds and walls are cleaned with disinfectant on a monthly basis. The policy included a 3 page check list.</p> <p>3. The housekeeping binder lacked evidence that the check list was completed by the housekeeping company. The checklist were blank in the binder.</p> <p>4. Staff member #2 (Practice Manager) indicated in interview at 12:00 p.m. on 8/12/14 that the contracted housekeeping does not complete the cleaning checklist provided by the facility and does not follow-up on request made by the facility as evidenced by a written request made in July that had not been followed up on.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are</p>		<p>make recommendations to the Board as needed. The Clinical Manager will be responsible for assuring the housekeeping improvements are completed.</p>				

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	<p>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>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on document review and interview, the facility failed to include all employees in their new employee and ongoing health program in one (1) instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the personnel file for employee A2, date of hire 8/1/13, failed to include documentation of the employee communicable disease history for Rubella, Rubeola, Varicella, Tuberculosis (TB) and Hepatitis B and ongoing TB testing. 2. Review of facility policy and procedure (P&P) titled SUBJECT: EMPLOYEE PHYSICAL EXAMINATION indicates " The pre-employment 	S000442	The Clinical Manager will meet with the Infection Control Committee on 9/16/14. Infection Control Committee will monitor all new hire employee health records to ensure 100% compliance of communicable diseases including Rubella, Rubeola, Varicella, Hepatitis B and Tuberculosis within one month of hire date. Findings will be reported to Quality Assurance for all new hires. The Clinical Manager will be responsible for verifying we initiate this new process.	09/16/2014			

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S000446	<p>examination shall include the following: - PPD (chest X-ray, if positive) - Hepatitis B, These tests shall be performed annually, as indicated.</p> <p>3. In interview on 8/12/14 at 5:00pm, employee A2 confirmed the above and no further documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(x)</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>(x) A program of linen management. Based on observation, the facility failed to ensure clean patient gowns were stored in an environment that minimized possible contamination.</p> <p>Findings include:</p>	S000446	The Clinical Manager removed all gowns from patient bathroom and sent them to be laundered. Clinical Manager instructed staff on 8/14/14 of new location clean gowns will be stored. Policy and Procedure amended in manual to	08/14/2014			

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S000672	<p>1. During observation beginning at 10:15 a.m. on 8/12/14, clean patient gowns were observed protruding from an unlocked cabinet across from the commode within the patient restroom. The gowns could be handled by any patient utilizing the restroom and become contaminated.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(13)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(13) A copy of the transfer form, if the patient is referred to a hospital or other facility.</p> <p>Based on document review and staff interview, the facility failed to ensure a transfer form was completed for 1 of 3 patient transfers (patient #29).</p> <p>Findings include;</p> <p>1. Review of patient #29 medical record indicated the following: (A) Operative note addendum dated 6/2/14 at 11:32 a.m. states "Following the</p>	S000672	<p>include 'no linen to be stored in patient bathroom'. Amendment reported to Infection Control Committee, and this Committee will monitor compliance. The Clinical Manager will be responsible for checking this adjustment remains in effect.</p> <p>The Clinical Manager will meet with staff on 9/16/14 to discuss the transfer policy improvements. Upon discharge of patients with emergent and/or non-emergent medical issues requiring further evaluation, patients must have a signed transfer order by physician. This information will be part of the patient's medical record. Policy and Procedure amended to reflect this modification. The Clinical</p>	09/16/2014

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S000862	<p>above procedure the patient was found to have an irregular heart rate. Rhythm strip revealed the patient to be in atrial fibrillation with an overall rate of 133. This is a new problem for him. I spoke with his primary care physician, (MD #1) who asked that he be evaluated and initially treated in the emergency department of (acute care facility #1). The patient was discharged in stable condition to that location by private vehicle."</p> <p>2. Staff member #1 (Clinical Manager) indicated in interview at 4:30 p.m. on 8/12/14 that the facility did not consider the above a transfer.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(C)</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>(C) A provision for the following</p>				<p>Manager will be responsible for validating this new policy. The Quality Assurance Committee will continue to monitor transfers monthly & ensure new documentation is completed.</p>		

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	<p>equipment and supplies to be available to the surgical and recovery areas:</p> <p>(i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff.</p> <p>Based on observation, document review and staff interview, the facility failed to provide a tracheostomy set for 1 crash cart observed.</p> <p>Findings include:</p> <p>1. During facility tour beginning at 10:15 a.m. on 8/12/14, it was noted that there was no tracheostomy set available with the emergency equipment.</p> <p>2. Review of facility policy titled "CRASH CART CONTENT" last reviewed/revised 8/1/13 states under policy on page 1: "The crash cart shall be stocked with the supplies and medications as determined by the medical staff that may be required in the event of a Code." Page 2 titled "CRASH CART INVENTORY LIST" states the 2nd drawer will contain a "Cricothyrotomy kit".</p>	S000862	The Clinical Manger ordered a Tracheostomy kit and placed it in the crash cart. Staff notified on 9/9/14 that a non-expired trach kit must be a permanent part of the crash cart as indicated in our policy and procedure book. The Clinical Manager will be responsible for making sure the trach kit was placed in the cart. The trach kit was also added to the weekly checked expiration list of drugs/supplies in the code cart to ensure always non-expired.	09/09/2014			

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S000888	<p>2. Staff member #1 (Clinical Manager) verified in interview at 3:45 p.m. on 8/12/14 that the facility did not have a tracheostomy set at this time.</p> <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.</p> <p>Based on observation, document review and interview, the facility failed to ensure operative reports were not dictated prior to surgery for 1 patient observation (patient #30).</p> <p>Findings include:</p>	S000888	The Practice Manger contacted our IT Specialist and EMR vendor to notify of this malfunction. The date and time is no longer attached to provider signature upon opening of patient note. The patient note will convey the date and time the physician dictates and completes the note. The Clinical Manager will be	09/02/2014	

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S001006	<p>1. The surgical procedure for patient #30 was observed beginning at 10:25 a.m. on 8/12/14.</p> <p>2. Review of the medical record for patient #30 indicated the following: (A) The patient was in the operating room from 10:25 a.m. until 10:47 a.m. on 8/12/14. (B) The operative report stated "The patient was taken to the recovery area and watched for an appropriate amount of time and discharged home in stable condition." The document was dictated and signed at 10:10 a.m. on 8/12/14, prior to the surgery.</p> <p>3. Staff member #1 (Clinical Manager) verified the above at 3:50 p.m. on 8/12/14.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(2)</p> <p>Pharmaceutical services must have the following:</p> <p>(2) Records of stock supplies of all scheduled substances, including an accounting for all items purchased and dispensed.</p> <p>Based on document review and staff</p>	S001006	<p>responsible for confirming this modification. Quality Assurance will begin a new QA project checking dictation at the end of each work day verifying time of note is after time of procedure.</p> <p>The Clinical Manger will address at the staff meeting 9/16/14 the</p>	09/16/2014	

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	<p>interview, the facility failed to ensure scheduled substances were accounted for per facility policy.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Facility policy titled "PHARMACY SERVICES" last reviewed/revised 8/1/13 states on page 2: "A daily verified count of narcotic drugs us (known spelling error) required. The Registered nurse and another nurse individually count the quantity of each narcotic drug and initial the count on the Narcotic Inventory Record Form." Review of Narcotic log sheets indicated the following: <ol style="list-style-type: none"> On 7/23/14, 250 mg of Fentanyl was wasted and only one (1) nurse initialed the wastage. The column titled "signature/witness" lacked a witness to the wastage. On 7/29/14, 200 mg of Fentanyl was wasted and only one (1) nurse initialed the wastage. The column titled "signature/witness" lacked a witness to the wastage. On 8/5/14 and 8/12/14, the a.m. narcotic count was completed by only one (1) nurse. Staff member #1 (Clinical Manager) verified the above at 4:00 p.m. on 		<p>requirement of 2 nurse signatures when verifying the daily narcotic count. Quality Assurance will perform random monthly audits to ensure 100% compliance. The Clinical Manager will be responsible for validating accordance.</p>				

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S001010	<p>8/12/14.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on observation, interview, and document review, the facility failed to ensure pharmacy policies include directions for labeling syringes and failed to ensure syringes were labeled according to standard of practice.</p> <p>Findings include:</p> <p>1. During tour of the operative area beginning at 10:15 a.m. on 8/12/14, the following observation was made:</p>	S001010	The Clinical Manger will review with clinical staff the '6 Key Medication Safety Concepts' with emphasis on proper labeling practices. Pre-Printed labels with medication name, concentration, and dose were created and will be put into use. Nurse drawing up the medication will add expiration date and his/her initials to each label. The Clinical Manager will observe staff to ensure compliance. The Clinical Manager will be responsible for making sure this is getting done by all	09/16/2014	

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	<p>(A) Two (2) syringes containing a clear solution were observed in the top drawer of the medication cart within the operating room. The syringes had a piece of tape on them that stated "Fent"</p> <p>2. Staff member #N1 (RN) indicated at time of observation that the medication in the syringes was Fentanyl and later indicated that he/she draws up several doses of Fentanyl from a multi-dose vial.</p> <p>3. Facility policy titled "PHARMACY SERVICES" last reviewed/revised 8/1/13 lacks direction for labeling of syringes for later use.</p> <p>4. AORN document titled "6 Key Medication Safety Concepts" published 5/1/13 states ".....Perioperative professionals must make sure to always follow proper labeling practices. The use of preprinted labels that includes basic information, such as strength/potency of the drawn medication, is an easy step to support these efforts, Sones says. But placing a preprinted label on a medication is just the first step. "It is critical that the writing on the label is legible, and the label needs to be filled out completely," Sones advises. "While you need to include the name of the drug as part of medication labeling, this cannot be the only piece of</p>		clinical staff.				

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S001028	<p>information included. You need the medication's strength, date it was mixed, time and by whom."</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)(ii)</p> <p>Pharmaceutical service must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(E) Drugs must be accurately and clearly labeled and stored in specially-designed, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(ii) Drug cabinets for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse must be permanently affixed compartments that are separately locked.</p> <p>Based on observation, interview, and document review, the facility failed to ensure controlled substances were stored per policy in 1 instance.</p> <p>Findings include:</p> <p>1. During tour of the pre/post operative</p>	S001028	The Clinical Manager reviewed with clinical staff on 9/16/14 the policy and procedure of controlled substances. Scheduled drugs shall be stored in a locked cabinet within the locked pharmacy storage cabinet. On the occasion larger vials of medicine do not fit in the regular storage lock box, we must use the larger safe.	09/16/2014

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S001148	<p>area at 11:00 a.m. on 8/12/14 the following observation was made:</p> <p>(A There were > 20 vials of Fentanyl in a cardboard box within a single locked cabinet in the pre/post operative area.</p> <p>2. Staff member #N1 (RN) indicated in interview at 11:00 a.m. on 8/12/14 that the Fentanyl vials would not fit in the locked box within the locked cabinet.</p> <p>3. Facility policy titled "PHARMACY SERVICES" last reviewed/revised 8/1/13 states on page 2: "Scheduled drugs shall be stored in a locked cabinet within the locked pharmacy storage cabinet."</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(A)</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 pf patients are assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p>		Random audits will be performed on a monthly basis to ensure 100% compliance. The Clinical Manager will be responsible for certifying this regulation.		

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	<p>(A) Operation, maintenance, and spare parts manuals must be available, along with training or instruction, or both, of the appropriate center personnel, in the maintenance and operation of fixed and movable equipment.</p> <p>Based on document review and interview, the center failed to provide maintenance services by qualified person(s) in one instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the facility generator inspection documentation dates 6/2013 to 6/2014 indicated A3 to be performing monthly generator inspections. 2. Review of facility policy and procedure (P&P) 13.01 titled SUBJECT: MAINTENANCE SERVICES, under Practice and Procedure B, last reviewed 8/1/13. indicated the maintenance of selected equipment that is critical to the Center's function and/or the safety of patients/personnel is provided for by agreement with companies that specialize in such services. These agreements provide for both preventive maintenance inspections and repair services. 	S001148	Clinical Manager contacted Generator Contractor and changed bi-annual generator maintenance to quarterly inspections. Quality Assurance will monitor inspection compliance. Clinical Manager also scheduled in-service for generator maintenance instruction for clinical manager and additional RN. Generator company will also provide owner's manual to be kept on site. The Clinical Manager will be responsible for ensuring this adaptation is completed.	09/30/2014			

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	<p>3. Review of the facility generator contract indicates the contractor will provide quarterly and annual inspections per manufacturer guidelines in addition to needed repairs.</p> <p>4. In interview on 08/12/14 at 3:00pm, employee A2 indicated all maintenance to be subcontracted as need. A2 indicated monthly generator inspections and other small maintenance to be responsibility of A1 and him/herself (A2). After noting signature of A3 on monthly generator inspection logs, A2 further indicated A3 as the person responsible for generator inspection maintenance. A2 indicated none (A1, A2 nor A3) had documentation of maintenance training or experience and no further documentation was provided prior to exit.</p> <p>5. Review of personnel files for employees A2 and A3 failed to include evidence of training, experience or a job description for</p>						

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S001198	<p>maintenance services.</p> <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, the facility failed to coordinate emergency disaster and preparedness with an appropriate governmental agency in any instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> Review of facility documents for calendar year 2013 and the first 2 quarters of 2014 indicated no documentation for coordination of emergency disaster and preparedness with an appropriate governmental agency. In interview on 8/12/14 at 3:00pm, employee A3 indicated the ASC is on a list with the local hospital, but has no documentation of participation 	S001198	<p>Clinical Manager contacted Mindy Baker, Preparedness Coordinator of District 8, at Bartholomew County Health Department. She was notified of Center's willingness to participate in disaster training. She instructed Clinical Manager and additional RN to register at serv-in.org. She informed us of additional training information at the following sites. https://training.fema.gov/IS/NIMS.aspx https://training.fema.gov/EMIWeb/IS/courseOverview.aspx?code=IS-700.a The Clinical Manager will be responsible for guaranteeing the Center is coordinated properly for an emergency disaster and preparedness.</p>	09/30/2014			

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	coordinated with an appropriate agency. No further documentation was provided prior to exit.				