

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001097	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2014
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NAME OF PROVIDER OR SUPPLIER PANKRATZ EYE INSTITUTE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3135 MIDDLE RD COLUMBUS, IN 47203
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S000000	This visit was for a State licensure survey. Date of Survey: 07/07-08/14 Facility #: 002663 Surveyors: Trisha Goodwin, RN Public Health Nurse Surveyor Jennifer Hembree, RN Public Health Nurse Surveyor QA: cloughlin 07/21/14	S000000	Due to technical difficulties experienced within the ISBH Survey Reporting System, the non-compliance notifications for the July 7-8 survey were inaccessible until August 7, 2014. For this reason, corrective actions could not be implemented within the required 30 day post-survey timeframe	
S000188	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c)(5)(P)(ii) Require that the chief executive officer develop and implement policies and programs for the following: Development, implementation, and monitoring of a safety management program to include, but not be limited to, the following: (ii) Insect, rodent, or other vermin control. Based on document review and interview, the center failed to develop and implement a policy or program for pest control. Findings:	S000188	To satisfy adherence to and implementation of a safety management program which includes insect, rodent, and/or other vermincontrol, the ASC has contracted with Burt's Termite and Pest Control, Inc. to provide quarterly preventative	08/19/2014

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>1. Review of facility documents 7/7/14 through 7/8/14 failed to show evidence of pest control.</p> <p>2. In interview on 7/8/14 at 11:15am, employee A2, executive director, confirmed the facility had no policy, program or documentation for pest control.</p> <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 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, material safety data sheets (MSDS) and interview, the center failed to implement general housekeeping precautions in one area.</p> <p>Findings:</p> <p>1. During tour of the facility on 7/8/14 from 10:35am to 11:15am,</p>	S000192	<p>extermination. Additional applications will be procured as necessary amid these routinely scheduled visits to maintain a pest free environment. Initial application 8/19/14. The Executive Director will be responsible for ensuring quarterly pest control application completion in addition to service notification for retreatment if necessary.</p> <p>To preserve compliance with the safety management program requiring general housekeeping precautions to be employed in accordance with MSDS recommendations for chemical substance use and storage, specifically stating that an eye wash station and other protective equipment must be</p>	08/13/2014

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	<p>in the presence of employee A2, executive director, in the housekeeping closet, HDQ Neutral disinfectant and Poly Ortho 23.9% HCl were noted with labels indicating first aid recommended for eye contact as a 15-20 minute water flush. An eye wash station was not noted in that area. Material safety data sheets (MSDS) were requested of A2.</p> <p>2. Review of the MSDS for HDQ Neutral indicates in section VIII: SPECIAL PROTECTION INFORMATION, Other Protective Equipment: Eye wash stations and washing facilities should be readily accessible in areas where undiluted product is handled. The MSDS for Poly Ortho indicates in section IV - SPECIAL PROTECTIVE EQUIPMENT, OTHER PROTECTIVE EQUIPMENT: Sufficient to prevent skin contact. Eyewash and shower located near the workplace.</p> <p>3. In interview on 7/8/14 at 11:15am, employee A2 confirmed</p>		<p>readily accessible in areas where undiluted product is handled; gloves and protective eyewear are now available for use and housed within the housekeeping chemical storage and preparation closet. Additionally, an eyewash station has been installed in the bathroom in closest proximity to the housekeeping closet (approximately 10 feet). The ASC Director is responsible for ensuring protective equipment is available for all housekeeping staff. Functionality of the eye wash station will ascertained weekly through documented inspections performed by Center personnel.</p>	

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S000216	<p>the center did not have an eye wash station readily available in that area.</p> <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 failed to ensure a center-wide quality assessment and improvement (QAPI) program in four (4) instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of governing board minutes and committee reports date range 06/01/13 to present 7/8/14 failed to show evaluation of the three (3) directly provided services of maintenance, nursing and discharge and the one (1) 	S000216	In order to ascertain that policies enacted to ensure Center-wide quality assessment and improvement programs evaluating provision of patient care and outcomes are continuously monitored; the ensuing areas of focus: maintenance, nursing, discharge and bio-medical engineering, have been identified as deficient within QAPI due to the absence of ongoing evaluative processes. Rectification within the arenas of nursing and discharge necessitates continued quarterly assessment, evaluation and documentation of variously	08/11/2014

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	<p>contracted services of bio-medical engineering.</p> <p>2. In interview on 7/8/14 at 5:45pm, employee A1, director, confirmed the above and no further documentation was provided prior to exit.</p>		<p>chosen aspects of each service as defined by Center standards of care articulated within the policies and procedures. This process will entail selecting and monitoring a specific standard per service every quarter through random chart selection and/or patient contact observations. 10% of monthly case volume (20 charts or patient interactions) will be examined with findings documented and presented to the QA committee and Board of Directors at their regularly occurring meetings with the first study to commence Sept. 2 Facility maintenance and bio-medical engineering comprise the employment of contracted services thus QAPI for these entities will be addressed through the Center's "quarterly assessment tool for contracted services" (attachment A) which compares and contrasts service provided against Center standards to ensure preservation of quality care and rapid identification and mitigation of issues per occurrence. These documented findings are reviewed by the QA committee and Board of Directors. the QA committee and Board of Directors. The ASC Director will be responsible for study conduction and contracted service evaluations, submitting all findings to the QA Committee quarterly. 8/11/14 (approved by QA Committee) 8/15/14</p>		

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S000310	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based document review and interview, the center failed to include three (3) directly provided functions (maintenance, nursing, and discharge) and one (1) contracted service (bio-medical engineering) in their quality assessment and performance improvement program (QAPI).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the center's QAPI reports date range 6/5/13 to 6/4/14 failed to show inclusion of the directly provided functions of maintenance, nursing, and discharge and the contracted service of bio-medical engineering. 2. In interview on 7/8/14 at 5:45pm, employee A1, director, confirmed the above and no further 	S000310	<p>(approved by Board)</p> <p>In order to ascertain that policies enacted to ensure Center-wide quality assessment and improvement programs evaluating provision of patient care and outcomes are continuously monitored; the ensuing areas of focus: maintenance, nursing, discharge and bio-medical engineering, have been identified as deficient within QAPI due to the absence of ongoing evaluative processes. Rectification within the arenas of nursing and discharge necessitates continued quarterly assessment, evaluation and documentation of variously chosen aspects of each service as defined by Center standards of care articulated within the policies and procedures. This process will entail selecting and monitoring a specific standard per service every quarter through random chart selection and/or patient contact observations. 10% of monthly</p>	08/11/2014			

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S000400	documentation was provided prior to exit. 410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a) (a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and		case volume (20 charts or patient interactions) will be examined with findings documented and presented to the QA committee and Board of Directors at their regularly occurring meetings with the first study to commence Sept. 2 Facility maintenance and bio-medical engineering comprise the employment of contracted services thus QAPI for these entities will be addressed through the Center's "quarterly assessment tool for contracted services" (attachment A) which compares and contrasts service provided against Center standards to ensure preservation of quality care and rapid identification and mitigation of issues per occurrence. These documented findings are reviewed by the QA committee and Board of Directors. The ASC Director will be responsible for study conduction and contracted service evaluations, submitting all findings to the QA Committee quarterly. 8/11/14 (approved by QA Committee), 8/15/14 (approved by Board). First study for nursing and discharge will ensue 9/2/14.		

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	<p>visitors.</p> <p>Based on observation, document review, and staff interview, the facility failed to ensure equipment was disinfected between patients per manufactures recommendations, failed to use equipment that could be appropriately disinfected between patients, failed to replace expired emergency trach set, and failed to perform hand hygiene after patient contact.</p> <p>Findings include:</p> <p>1. During observations beginning at 2:40 p.m. on 7/8/14, the following observations were made:</p> <p>(A) Staff member #N1 performed pre-operative vital signs and administered pre-operative eye ointment to patient #30. He/she then assisted with the laser procedure performed on same patient, discharged the patient and cleaned the procedure room. No hand hygiene was observed by staff member #30.</p> <p>(B) A VOLK lens was utilized during a laser procedure on patient #30. The lens was wiped off after use with a Kleenex by M.D. #1 and placed on the counter. Staff member #N1 placed the lens back in the case after the procedure. There was no cleaning/disinfection performed on the lens.</p> <p>(C) A plastic type icepack with a cloth</p>	S000400	<p>Standards of practice require the Center to provide an environment which minimizes infection exposure and risk to customers, visitors and staff. Compliance deficiencies have been identified within the following modalities: hand hygiene, Volk lens cleaning between laser cases, reuse of icepacks with elastic straps which cannot be effectively disinfected and retention of an expired tracheotomy set in the Center crash cart. Each of these issues has been addressed with reconciliation delineated below.</p> <p>1.Hand Hygiene. All Center staff have completed an in-service which entailed thorough review of Center Hand Hygiene policy and CDC recommendations regarding hand hygiene in ambulatory care settings.</p> <p>2.Volk lenses. Manufacturer recommendations, for cleaning of lenses between patients receiving non-sterile laser treatments for various retinal conditions, have been posted and are clearly visible at the site established for completion of the specified requirements. All staff participated in an educational session which consisted of review and demonstration of the cleaning procedure designated by the manufacturer instructions.</p> <p>3.Reusable ice packs have been removed from the Center and replaced with a disposable</p>	08/13/2014			

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	<p>elastic strap was observed in the storage cabinet. The cloth elastic strap on the pack could not be cleaned/disinfected between patients.</p> <p>(D) An emergency trach set with an expiration date of 2/14 was observed in the crash cart.</p> <p>2. Review of facility infection control meeting minutes indicated the facility has selected CDC as the nationally recognized infection control guidelines to follow.</p> <p>3. CDC document titled "GUIDE TO INFECTION PREVENTION IN OUTPATIENT SETTINGS" states on page 9: "Key recommendations for hand hygiene in ambulatory care settings: 1. Key situations where hand hygiene should be performed include: a. Before touching a patient.....b. Before exiting the patient's care area after touching the patient or the patient's immediate environment." Page 12 of same document states "Semi-critical itemscontact mucous membranes or non-intact skin and require, at a minimum, high-level disinfection prior to reuse....."</p> <p>4. Review of manufacturer's guidelines for the Volk optical product provided by the facility states "1. Using a mild,</p>		<p>version to be employed on a per patient basis then discarded.</p> <p>4.The expired tracheotomy set has been removed and replaced. As per previous practice, all supplies will be examined and eliminated, if outdated, by Center staff the first Tuesday of every month.</p> <p>Periodic monitoring of each mitigating strategy within the confines of quarterly QAPI is essential for ensuring sustained practice standard fulfillment. The ASC Director retains responsibility for ensuring adherence.</p>	

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	<p>nearly neutral pH detergent at room temperature, clean the entire surfaces of the lens with a clean, soft cotton cloth, paying special attention to crevices and other hard to reach areas. 2. Rinse thoroughly by immersing the lens in room-temperature, distilled water for a least one minute and agitating the lens under water. Bring the lens up out of the water and resubmerge under the water. Repeat 2 additional times.....Disinfection: Reusable surgical devices require full sterilization."</p> <p>5. Review of the manufacturer's guidelines for the Volk optical lens obtained online states under disclaimer: "1. Reprocessing of Volk Optical product should follow a two-step process in all situations. The device should be (1) thoroughly cleaned then (2) either disinfected <u>OR</u> sterilized."</p> <p>6. Staff member #N1 indicated during observations beginning at 2:40 p.m. on 7/8/14 that the Volk optical lens is cleaned at times, however he/she was not sure of specifics. He/she also indicated that the ice pack is cleaned with the bleach solution between patients.</p> <p>7. Staff member #N6 indicated in interview beginning at 5:00 p.m. on 7/8/14 that the Volk optical lens used for</p>			

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S000428	<p>the laser procedures in the procedure room is not disinfected or sterilized between patients. He/she indicated that a lens is sterilized only if used within the operating room.</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 document review and observation, the facility failed to follow manufacturer's recommendations for cleaning surfaces after a procedure in 1 instance.</p> <p>Findings include;</p> <p>1. Label instructions for Bleach germicidal cleaner indicated the product should be sprayed on and the surface is to remain visibly wet for 1 minute for the product to be effective.</p>	S000428	Adherence to infection control policies demands disinfection of Center surfaces following each patient encounter in accordance with manufacturer cleaning instructions as outlined in the directions printed upon the cleaning product utilized. The Center currently employs a bleach based germicidal (Dispatch) which necessitates complete wetting of the contaminated surface, to remain untouched for a minimum of one minute prior to towel drying. To ensure compliance, Center staff	08/13/2014

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S000624	<p>2. Observation of cleaning of the procedure room beginning at 3:00 p.m. on 7/8/14 indicated the following:</p> <p>(A) Staff member #N1 was observed spraying the product on a dry towel and wiping surfaces off. The surfaces cleaned were not visibly wet for 1 minute per product recommendations.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(7)</p> <p>An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(7) The center shall ensure the confidentiality of patient records. The center must develop, implement, and maintain the following:</p> <p>(A) A procedure for releasing information or copies of records only to authorized individuals, in accordance with federal and state laws.</p> <p>(B) A procedure that ensures that unauthorized individuals cannot gain access to patient records. Based on document review and interview, it could not be determined that the center implemented a procedure for ensuring against unauthorized access to</p>	S000624	<p>has been in-serviced regarding the manufacturer's directions for achievement of product effectiveness and minimization of infection through undeterred practice of this procedure. The ASC Director will conduct periodic monitoring of each mitigating strategy within the confines of quarterly QAPI to ensure sustained practice standard fulfillment.</p> <p>In accordance with medical record storage requirements for upholding confidentiality of patient data through the prevention of unauthorized computer access,</p>	07/18/2014			

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S000826	<p>patient electronic records in three (3) instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of 3 of 3 medical staff (MS) credential files indicated no provision for protection of computer password for medical record entry by MD1, MD2 or MD3. 2. In interview on 7/8/14 at 2:15pm, employee A1, director, confirmed the above and provided no further documentation prior to exit. 		<p>Center electronic records are available to personnel through utilization of individually specific passwords which grant varying degrees of admittance based upon position of employment within the facility. To ensure passwords remain unknown to all but the designated user, the following declaration has been added to the medical staff initial and re-appointment applications to be signed by the physician:</p> <ol style="list-style-type: none"> 1.prior to consideration for appointment to the medical staff 2.every two years thereafter when re-appointment is requested <p>"I affirm that my computer password affording access to all Center electronic patient information including but not limited to: demographics, insurance carriers and medical records will remain strictly confidential." All Center physicians have signed this document. In similar fashion, the same statement will be included in the orientation packet for all Center employees to be signed upon hire then annually thereafter during completion of mandatory competency training. The ASC Director will confirm a signed electronic security affirmation statement is contained within each Center personnel file to be updated biennially by physicians and annually by staff.</p>		

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	<p>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 center medical staff (MS) failed to write and implement policies and procedures for safety training of MS personnel.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of the center policy #2.02, titled RULES AND REGULATIONS OF THE MEDICAL STAFF, last revised 6/10/13, failed to include requirements for safety training. 2. Review of 3 of 3 MS credential files failed to show evidence of safety training for MD1, MD 2 and MD3. 3. In interview on 7/8/14 at 2:15pm, employee A1, director, confirmed the above and no further documentation was provided prior to exit. 	S000826	To satisfy medical staff anesthesia requirements for the completion of safety training by practitioners, all Center physicians will be required to view an anesthesia patient safety program presented at the next scheduled convergence of the medical staff in October. Newly appointed physicians will achieve this requirement during their on-boarding process. The Center does not retain general anesthesia capabilities, thus information will be limited to regional, local, topical and IV administration safety. Evidence of participation and comprehension will be confirmed through successful completion (score of 100%) of a brief exam with results included within each practitioner's staff file. This process will be repeated annually during the third quarter medical staff meeting to ensure competency is maintained. 9/2/14 (Center specific safety program developed) 9/10/14 (competency exam created) 10/27/14 (program	09/02/2014

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S000932	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)(6)</p> <p>(b) Written patient care policies and procedures shall be available to personnel and shall include, but not be limited to, the following:</p> <p>(6) A provision that a registered nurse assigns the care of each patient to patient care personnel in accordance with the patient's need and the specialized qualifications and competence of the patient care personnel available.</p> <p>Based on document review and interview, the facility failed to ensure personnel performing conscious sedation had evidence of competency based training per policy for 5 of 5 Registered Nurse files reviewed.</p> <p>Findings include:</p> <p>1. Facility policy titled "CONSCIOUS SEDATION" last reviewed/revised 6/15/12 states on page 1: "2.....A.</p>	S000932	<p>and exam presented at medical staff meeting) The ASC Director will retain responsibility for ensuring this safety program is viewed and comprehensive testing completed by all physicians annually with documentation verification included in each medical staff file.</p> <p>In accordance with patient care service requirements and Center policy which dictates personnel assisting with conscious sedation must receive "appropriate training demonstrated through competency based review" all RNs will be obligated to complete Center specific conscious sedation education consisting of: policy and procedure review, utilization of appropriate monitoring tools, identification of when and how to employ emergency equipment,</p>	09/10/2014

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	<p>Personnel assisting with the procedure must have received appropriate training demonstrated through competency-based review....."</p> <p>2. Staff members #N1, N4, N5, N6, and N7 personnel files lacked evidence of training demonstrated through competency based review for conscious sedation.</p> <p>3. Staff member #N7 indicated in interview at 10:00 a.m. on 7/8/14 that all RN's perform conscious sedation.</p> <p>4. Staff member #N6 verified in interview at 11:00 a.m. on 7/8/14 that there was no evidence of competency per policy for staff members #N1, N4, N5, N6, and N7.</p>		<p>knowledge of medication dosage administration, recognition of potential adverse reactions and the succeeding corrective measure implementation sequence. This training will be incorporated into the orientation process and repeated annually thereafter. Competency will be evidenced by successful completion (score of 100%) of a comprehensive exam. Failure will require immediate remediation and second testing opportunity. RNs unable to pass the second endeavor must attend additional remedial training with no more than two additional exam attempts within 30 days following the initial training/testing period. RNs will not be permitted to assist with conscious sedation until an examination score of 100% is achieved. RNs unable to attain this standard after four attempts will not be authorized to administer conscious sedation until successful retraining and testing are completed during the Center's annual mandatory competency assurance program. RNs who demonstrate proficiency within the aforementioned guidelines will be permitted to administer conscious sedation at the Center. The ASC Director will be responsible for the annual conscious sedation training and competency examination off all RNs. 9/10/14 (scheduled staff meeting)</p>	

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S001000	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6</p> <p>The center shall provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services. Pharmaceutical services must have the following: Based on observation and document review, the facility failed to remove expired medication from stock for 1 crash cart and 1 narcotic storage area observed.</p> <p>Findings include:</p> <p>1. During tour beginning at 3:00 p.m. on 7/8/14, the following expired medications were observed: (A) One (1) bottle of Valium tablets with an expiration date of 4/14 was observed in the narcotic cabinet. (B) Three (3) vials of Flumazenil .5 mg/5 ml with an expiration date of 6/14 were observed in the crash cart. (C) Four (4) boxes of Epinephrine 1 mg/10 ml with an expiration date of 6/14 were observed in the crash cart.</p> <p>2. Facility policy titled "PHARMACY SERVICES" last reviewed/revised 8/6/12 states on pages 3 and 4: "The Pharmacist shall make a quarterly inspection of the</p>	S001000	To satisfy pharmaceutical service requirements which necessitate Pharmacist generated quarterly inspections of all drug cabinets and crash cart for the removal of outdated medications stored in the Center, a second page has been added to the pharmacy inspection tool (attachment B). This document provides incremental listing opportunities for all drugs which will expire within 30, 60 or 90 days succeeding the current inspection and therefore prior to the next quarterly Pharmacist review. This document also affords an ongoing list of approaching outdates to be utilized by Center staff during their scheduled monthly assessment of medications and supplies thereby guaranteeing timely removal of all expired items. The ASC Director will be responsible for ensuring quarterly completion of this tool, providing this information data to Center personnel to be utilized during monthly outdate inspections.	08/18/2014

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S001148	<p>drug storage cabinets and crash cart using the inspection checklist.....No outdated or otherwise unusable drugs are stored in the Center....."</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 of 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> <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 two (2) instances.</p> <p>Findings:</p> <ol style="list-style-type: none"> In interview on 7/7/14 at 4:15pm, employee A2, executive director, was indicated, by A2, as the 	S001148	To assure physical plant and equipment maintenance compliance which requires inspections, prevention and repairs are performed by qualified personnel; the following corrective actions have been developed. 1.A comprehensive list of providers has been compiled representing all areas of	08/18/2014

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	<p>person responsible for general maintenance and employee A1, director, as performing the weekly and monthly back-up generator inspections.</p> <p>2. Review of the back-up generator preventative maintenance (PM) logs indicate weekly and monthly maintenance/inspections performed by employee A1.</p> <p>3. Review of personnel files for employees A1 and A2 failed to include evidence of training, experience or a job description for maintenance services.</p> <p>4. Interview on 7/8/14 at 5:45pm, employee A1 confirmed the above and no further documentation was provided prior to exit.</p>		<p>plant/equipment maintenance and delineated by specialty including but not limited to: Electrical, Plumbing, Biomedical, Generator, Fire and Safety, Building Construction, Computers, etc...(attachment C). Inspection and preventative maintenance of these systems are provided routinely within contract specifications in accordance with manufacturer recommendations. Repairs required prior to a scheduled PM necessitate immediate notification of the Executive Director who sustains responsibility for scheduling a service call with the appropriate supplier based upon his knowledge and professional experience/training (attachment D). The Executive Director does not attempt to resolve issues but rather fulfills the role of liaison between identification of physical plant or equipment failure and procurement of trained repair personnel.</p> <p>2.The Center's generator operational manual demarcates a monthly and quarterly PM monitoring schedule to be executed by an authorized operator. These functions have been previously performed by the Center Director without appropriate generator training. This deficiency has been rectified through an enhanced agreement with the manufacturer, EVAPAR, which incorporates these additional inspections into the</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, the facility failed to coordinate emergency disaster and preparedness with an appropriate governmental agency in any instance.</p> <p>Findings:</p> <p>1. 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</p>	S001198	<p>currently established preventative maintenance contract.</p> <p>The Executive Director will be responsible for ensuring the regularly scheduled completion of generator PM inspections in accordance with contract specifications. The Executive Director will also be obligated to acquire qualified support services to reconcile facility maintenance concerns as the occur.</p> <p>In accordance with development and implementation of a safety management program consisting of emergency disaster preparedness coordinated with appropriate community agencies, the Center has instituted a Memorandum of Understanding with the county hospital of nearest proximity, Columbus Regional, which mandates the Center to relinquish control of the facility and all resources including licensed personnel to Columbus Regional Hospital upon declaration of a community</p>	07/09/2014

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	with an appropriate governmental agency. 2. In interview on 7/8/14 at 1:45pm, employee A1, director, referred to a policy indicating the center did not participate in disaster preparedness with a governmental agency due to their size and confirmed non-participation in 2013 or 2014 to date.		disaster (attachment D). The hospital will determine and direct all activities within the Center as deemed necessary dependent upon the nature of the crisis. The ASC Director will be responsible for fulfilling this commitment.		