

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001171	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  05/01/2015
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NAME OF PROVIDER OR SUPPLIER  EYE CARE SURGERY CENTER OF EVANSVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6540 LOGAN DRIVE, SUITE #3 EVANSVILLE, IN 47715
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S 0000  Bldg. 00	This visit was for a State licensure survey.  Facility Number: 004274  Dates: 04/30/15 to 05/01/15  QA: cjl 05/19/15	S 0000		
S 0172  Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (L)  Require that the chief executive officer develop and implement policies and programs for the following:  (L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.  Based on document review and interview, the chief executive officer (CEO) failed to ensure post offer and subsequent physicals for 8 of 8 personnel	S 0172	All deficient post offer and subsequent physicals of all employees will be obtained and placed in the personnel records by the Director of Nursing All	07/31/2015

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.

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	<p>(P1, P2, P3, P4, P5, P6, P7, &amp; P8), and immunizations for 6 of 8 personnel (P1, P2, P3, P5, P6, &amp; P8).</p> <p>Findings:</p> <p>1. Review of 8 personnel records (P1, P2, P3, P4, P5, P6, P7, &amp; P8) lacked documentation of a post-offer or subsequent physical examination. The records also indicated the following:</p> <p>a). P1 lacked documentation of complete Rubeola vaccination or titer and indicated a negative (no immunity) Varicella titer.</p> <p>b). P2 lacked documentation of Rubella, Rubeola, or Varicella vaccination, titer, or immunization.</p> <p>c). P3 lacked documentation of Rubella or Rubeola vaccination, titer, or immunization and indicated a negative (no immunity) Varicella titer.</p> <p>d). P5 lacked documentation of Rubella, Rubeola, or Varicella vaccination, titer, or immunization.</p> <p>e). P6 lacked documentation of Rubella, Rubeola, or Varicella vaccination, titer, or immunization and lacked documentation of Hepatitis B vaccination, titer, or declination.</p> <p>f). P8 lacked documentation of Rubella vaccination, titer, or immunization.</p> <p>2. On 5/1/15 at 12:15pm A1, Administrator, and A3, Director of</p>		<p>deficient immunizations records will be corrected by request of records from employees or titers will be obtained for appropriate immunizations as directed by the Director of Nursing. The policy will be amended to include a required post offer physical and subsequent annual physicals by all employees. The required yearly physicals have been added to the Director of Nursing's yearly requirement log and will be monitored by the Director of Nursing and the Administrator for compliance going forward. A policy will be written according to the CDC Advisory Committee for Immunizations Practice Recommendations for which immunizations are required at time of hire and include the procedure for any necessary titers to be obtained prior to employee start date. Immunizations will be added to the Personnel File and Training Checklist used during the hiring process. Policies will be written by July 31, 2015 and approved at the 3rd quarter governing board meeting.</p>		

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S 0176 Bldg. 00	<p>Nursing, confirmed the above and no further documentation or policy &amp; procedure was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (M)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures.</p> <p>Based on document review and interview, the chief executive office (CEO) failed to ensure personnel competency and special procedure in-service(s) for 6 of 6 direct care clinical staff (P2, P3, P4 ,P5, P7, &amp; P8).</p> <p>Findings:</p> <p>1. Review of 6 clinical personnel files, 4 nursing (P3, P4, P7, &amp; P8) and 2 surgical technicians (P2 &amp; P5), lacked evidence of clinical competency checks or special procedure in-services for any procedure or task.</p> <p>2. On 4/30/15 at 2:00pm A3, Director of</p>	S 0176	<p>Competency checklist for registered nurses for intravenous catheter insertion and passing medications included by mouth and eye drops will be created.</p> <p>Competency checklist for surgical technicians for opening and maintaining sterile field and loading lenses will be created.</p> <p>Competency checklist for instrument technician for correct instrument processing and sterilization and correct cleaning of sterilizers per manuals will be created. Competency checklists will be created according to national standards by the Director of Nursing and implemented for all staff immediately. All staff competencies will be completed by July 31, 2015 and placed on a</p>	07/31/2015

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S 0230 Bldg. 00	<p>Nursing, confirmed annual competencies were not performed for any personnel or clinical staff of the center and the facility did not have a policy to do so. A3 also confirmed the nursing staff start intravenous catheters and perform other specialized tasks and the surgical technicians perform specialized surgical tasks.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 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 failed to provide for periodic review of the center's operation by a utilization review or other committee composed of 3 or more duly licensed physicians having no financial interest in the facility.</p>	S 0230	<p>yearly schedule going forward The Director of Nursing will be responsible for completing competency checklist with staff and annual competencies will be added to the Director of Nursing's yearly requirement checklist</p> <p>The Administrator will amend the Governing Board Bylaws to include the duty of establishing a utilization review committee and assuring periodic review is completed. The changes to the Governing Board Bylaws will be presented and approved at the next governing board meeting by July 31, 2015. Once the bylaws amendments are approved, the</p>	08/31/2015

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S 0300 Bldg. 00	<p><b>Findings:</b></p> <p>1. Review of facility documents lacked evidence of periodic review of the center's operation by a utilization review or other committee.</p> <p>2. On 5/1/15 at 1:45pm, A1, Administrator, confirmed periodic review of the center's operations are not being and have not been performed by an utilization review committee or any other committee.</p> <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 a written plan of implementation for quality assessment.</p> <p><b>Findings:</b></p> <p>1. Review of facility documentation lacked evidence of a written quality assessment and performance improvement plan (QAPI).</p>	S 0300	<p>governing board will seek and find 3 physicians without financial interest in the facility to sit on the utilization review committee by August 31, 2015 The governing board will then assure that the committee has met and completed the review by the end of 3rd quarter (September 30, 2015) and is done bi-annually going forward.</p> <p>Written quality assessment and improvement program that meets the states requirements and follows the standards for AAAHC will be further established and written out by the administrator by August 14, 2015 The Administrator and governing board will be responsible for maintaining and updating the</p>	08/14/2015

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S 0320  Bldg. 00	<p>2. On 5/1/15 at 1:30pm, A1, Administrator, confirmed the center did not have a written QAPI plan.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</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>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the center failed to include the function of discharge planning in its quality assessment and performance improvement (QAPI) evaluation .</p> <p>Findings:</p> <p>1. Review of QAPI documentation dated 2/12/15, 12/18/14, 9/18/14 &amp; 5/29/14 lacked evidence of evaluation of discharge planning.</p> <p>2. On 5/1/15 at 1:30pm, A1, Administrator, and A3, Director of Nursing, confirmed the function of</p>			S 0320	<p>QAPI plan going forward</p> <p>The Director of Nursing will add discharge planning to the written quality assessment and improvement program plan. Discharge planning will be added to the quarterly governing board meetings and reviewed quarterly and additionally as the need arises. The first review will be included in the 3rd quarter governing board meeting by July 31, 2015. The Director of Nursing and Administrator will monitor for compliance going forward</p>		07/31/2015

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S 0326 Bldg. 00	<p>discharge planning had not been included in QAPI evaluations.</p> <p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(3)</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>(3) All services performed in the center with regard to appropriateness of diagnoses and treatments related to a standard of care and anticipated or expected outcomes.</p> <p>Based on document review and interview, the center failed to evaluate quality assessment and performance improvement (QAPI) of nursing services.</p> <p>Findings:</p> <p>1. Review of QAPI documentation dated 2/12/15, 12/18/14, 9/18/14 &amp; 5/29/14 lacked evidence of evaluation of nursing services.</p> <p>2. On 5/1/15 at 1:30pm A1, Administrator, and A3, Director of Nursing, confirmed nursing services had not been included in QAPI evaluations.</p>	S 0326	The Director of Nursing will add review of nursing services to the written quality assessment and improvement program plan. Nursing Services will be added to the quarterly governing board meetings and reviewed quarterly and additionally as needed. The first review will be included in the 3rd quarter governing board meeting by July 31, 2015. The Director of Nursing and Administrator will monitor for compliance going forward	07/31/2015
S 0332 Bldg. 00	<p>410 IAC 15-2.4-2.2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2.2(a)(1)</p>			

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	<p>Sec. 2.2. (a) The center's quality assessment and improvement program under section 2 of this rule shall include the following:</p> <p>(1) A process for determining the occurrence of the following reportable events within the center:</p> <p>(A) The following surgical events:</p> <p>(i) Surgery performed on the wrong body part, defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(ii) Surgery performed on the wrong patient, defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>(iii) Wrong surgical procedure performed on a patient, defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excluded are emergent situations: (AA) that occur in the course of surgery; or (BB) whose exigency precludes obtaining informed consent; or both</p> <p>(iv) Retention of a foreign object in a patient after surgery or other invasive procedure. The following are excluded:</p> <p>(AA) Objects intentionally implanted as part of a planned intervention.</p> <p>(BB) Objects present before surgery that were intentionally retained.</p> <p>(CC) Objects not present prior to surgery that are intentionally left in when the risk of removal exceeds the risk of retention, such</p>			

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	<p>as microneedles or broken screws.</p> <p>(v) Intraoperative or immediately postoperative death in an ASA Class I patient. Included are all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>(B) The following product or device events:</p> <p>(i) Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the center. Included are generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination or product.</p> <p>(ii) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. Included are, but not limited to, the following:</p> <p>(AA) Catheters.</p> <p>(BB) Drains and other specialized tubes.</p> <p>(CC) Infusion pumps.</p> <p>(DD) Ventilators.</p> <p>(iii) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in the center. Excluded are deaths or serious disability associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p> <p>(C) The following patient protection events:</p> <p>(i) Infant discharged to the wrong person.</p> <p>(ii) Patient death or serious disability associated with patient elopement.</p> <p>(iii) Patient suicide or attempted suicide resulting in serious disability, while being cared for in the center, defined as events that result from patient actions after admission to the center. Excluded are deaths resulting from self inflicted injuries</p>			

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	<p>that were the reason for admission to the center.</p> <p>(D) The following care management events:</p> <p>(i) Patient death or serious disability associated with a medication error, for example, errors involving the wrong:</p> <p>(AA) drug; (BB) dose; (CC) patient; (DD) time; (EE) rate; (FF) preparation; or (GG) route of administration.</p> <p>Excluded are reasonable differences in clinical judgment on drug selection and dose. Includes administration of a medication to which a patient has a known allergy and drug=drug interactions for which there is known potential for death or serious disability.</p> <p>(ii) Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products.</p> <p>(iii) Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in the center. Included are events that occur within forty-two (42) days postdelivery. Excluded are deaths from any of the following:</p> <p>(AA) Pulmonary or amniotic fluid embolism. (BB) Acute fatty liver of pregnancy. (CC) Cardiomyopathy.</p> <p>(iv) Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in the center.</p> <p>(v) Death or serious disability (kernicterus) associated with the failure to identify and treat hyperbilirubinemia in neonates.</p> <p>(vi) Stage 3 or 4 pressure ulcers acquired after admission to the center. Excluded is</p>			

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	<p>progression from Stage 2 or Stage 3 if the Stage 2 or Stage 3 pressure ulcer was recognized upon admission or unstageable because of the presence of eschar.</p> <p>(vii) Patient death or serious disability resulting from joint movement therapy performed in the center.</p> <p>(viii) Artificial insemination with the wrong donor sperm or wrong egg.</p> <p>(E) The following environmental events:</p> <p>(i) Patient death or serious disability associated with an electric shock while being cared for in the center. Excluded are events involving planned treatment, such as electrical countershock or elective cardioversion.</p> <p>(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient:</p> <p>(AA) contains the wrong gas; or (BB) is contaminated by toxic substances.</p> <p>(iii) Patient death or serious disability associated with a burn incurred from any source while being cared for in the center.</p> <p>(iv) Patient death or serious disability associated with a fall while being cared for in the center.</p> <p>(v) Patient death or serious disability associated with the use of restraints or bedrails while being cared for in the center.</p> <p>(F) The following criminal events:</p> <p>(i) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.</p> <p>(ii) Abduction of a patient of any age.</p> <p>(iii) Sexual assault on a patient within or on the grounds of the center.</p> <p>(iv) Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the center.</p>			

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S 0472 Bldg. 00	<p>Based on document review and interview, the center failed to evaluate quality assessment and performance improvement (QAPI) related to reportable events.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of QAPI documentation dated 2/12/15, 12/18/14, 9/18/14 &amp; 5/29/14 lacked evidence of reportable events being included for evaluation.</li> <li>On 5/1/15 at 1:30pm A1, Administrator, confirmed reportable events were not been included in QAPI evaluations.</li> </ol> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.4-1(2)(h)</p> <p>(h) Environmental surfaces and equipment not requiring sterilization which have been contaminated by blood or other potentially infectious materials shall be cleaned then decontaminated in accordance with acceptable standards of practice and applicable state laws and rules, 410 IAC 1-4.</p> <p>Based on observation, interview, and document review, the center failed to maintain equipment which may be contaminated by blood or infectious materials in accordance with manufacturer recommendation for their point of care glucose monitor testing</p>	S 0332	The Director of Nursing will add reportable events to the written quality assessment and improvement program plan. Reportable events will be added to the quarterly governing board meetings. Monitoring of reportable events will be reviewed after each surgery cary by the Director of Nursing from the daily staffing log and reviewed quarterly and additionally as the need arises during governing board meetings. The first review will be included inn the 3rd quarter governing board meeting by July 31, 2015. The Director of Nursing and Administrator will monitor for compliance going forward	07/31/2015
		S 0472	The Director of Nursing will contact McKesson representative to determine the appropriate model of glucose monitor to order which is appropriate for multi-patient use by July 31, 2015. The unit will be purchased by 7/31/15 and in use as soon as	07/31/2015

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S 0526  Bldg. 00	<p>device.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 4/30/15 at 3:45pm during facility tour in the presence of A1, Administrator, and A3, Director of Nursing, a McKesson TRUEtrack Blood Glucose monitor was observed in the patient care area.</li> <li>Review of the glucose monitor manufacturer manual indicated the following: The TRUEtrack Blood Glucose Monitoring System is for one person use ONLY. DO NOT share your Meter...with anyone. DO NOT use on more than one person. ALL parts of your Blood Glucose Monitoring System could carry blood-borne diseases after use, even after cleaning and disinfection.</li> <li>On 4/30/15 at 3:45pm, A3 indicated this was the monitor used to test the blood sugar of any/all patients requiring a glucose check. A3 further indicated this device as the only device used for testing of all patients and that it was cleaned with alcohol between patient use.</li> </ol> <p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p>		it is received. The previously used unit will be removed from the facility		

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S 0704	<p>(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.</p> <p>Based on document review and interview, the center failed to annually assess competency of personnel performing laboratory testing for 4 of 4 nursing staff personnel files reviewed (P3, P4, P7, &amp; P8).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of 4 nursing staff personnel files (P3, P4, P7, &amp; P8) lacked documentation of competency evaluations of laboratory glucose and/or pregnancy testing.</li> <li>2. On 4/30/15 at 2:00pm, A3 indicated annual competencies were not documented/conducted for any clinical staff. No further documentation was provided prior to exit.</li> <li>3. On 4/30/15 at 3:45pm, A3, Director of Nursing, indicated the nurses of the center perform blood glucose tests and pregnancy tests in the center.</li> </ol> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND</p>	S 0526	Competency checklist for the registered nurses for all laboratory testing (capillary glucose monitor and pregnancy test) will be created by the Director of Nursing based on the manufacturers recommendations and national standards. The competencies will be completed by the Director of Nursing with all appropriate staff members by July 31, 2015 and placed on the yearly schedule going forward. The Director of Nursing will be responsible for completing competency checklist with staff and competencies will be added to the Director of Nursing's yearly requirement checklist	07/31/2015

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Bldg. 00	<p><b>SURGICAL</b> 410 IAC 15-2.5-4(a)(1)</p> <p>The medical staff shall do the following:</p> <p>(1) Conduct outcome-oriented performance evaluations of its member at least biennially. Based on document review and interview, the medical staff (MS) of the center failed to conduct outcome-oriented performance evaluations of its members at least biennially for 2 MS members (MD#1 and AH#1).</p> <p>Findings:</p> <p>1. Review of credential files for 2 MS members, MD#1 and AH#1, lacked documentation of a biennial performance review for either of the 2 MS members.</p> <p>2. On 5/1/15 at 12:00pm, A1, Administrator, confirmed performance evaluations were not being conducted for either of the MS members, MD#1 or AH#1.</p>	S 0704	The Administrator will ensure Medical Staff Bylaws specify biennial performance reviews for all medical staff and allied health professionals. The Administrator will perform performance reviews on current medical staff to correct any deficiencies by July 31, 2015 and then add reviews to yearly requirement log to insure completion going forward on an appropriate time table	07/31/2015
S 0710 Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p>			

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

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	<p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff. Based on document review and interview, the medical staff (MS) of the center failed to include documentation of current health status for 2 MS members (MD#1 &amp; AH#1).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of 2 MS credential files (MD#1 &amp; AH#1) lacked documentation of a current health status statement.</li> <li>2. On 5/1/15 at 12:00pm, A1, Administrator, confirmed the credential files for MD#1 and AH#1 lacked documentation of current health status. No further documentation was provided prior to exit.</li> </ol>	S 0710	The Administrator will obtain current health status records for all physicians and allied health professionals and place in files by July 31, 2015 to correct any deficiencies. The Administrator will establish a policy to obtain updated health status records on all physicians and allied health professionals on an annual basis. The policy will be presented and approved at the 3rd quarter governing board meeting in July, 2015. The Administrator will add health status reports tot the yearly requirements log to insure completion going forth on the appropriate time table	07/31/2015

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S 1198 Bldg. 00	<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 safety management program of the center failed to coordinate emergency and disaster preparedness with an appropriate community, state, or federal agency.</p> <p>Findings:</p> <p>1. Review of facility documents lacked evidence of coordination of emergency and disaster preparedness with an appropriate agency at any time.</p> <p>2. On 5/1/15 at 12:20pm, A1, Administrator, and A3, Director of Nursing, confirmed the center had not coordinated emergency and disaster preparedness with any outside agency: local, state, or federal.</p>	S 1198	<p>The Administrator will search out emergency disaster training and enroll in an appropriate class prior to July 31, 201 and complete class prior to August 31, 2015. The Administrator will make contact with the local red cross and hospitals to determine the center's available resources in event of a disaster by July 31, 2015. The Administrator will draft an emergency disaster policy after obtaining information from local agencies and will present tot the governing board during the 3rd quarter meeting in July, 2015 for approval</p>	08/31/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2015

FORM APPROVED

OMB NO. 0938-0391

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