

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001180	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERVIEW SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1276 NORTH PLAZA DRIVE ROCKPORT, IN 47635
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S000000	This visit was for a standard licensure survey.  Facility Number: 012742  Survey Dates: 9/15/14 to 9/17/14  Surveyor: Trisha Goodwin, RN Public Health Nurse Surveyor  QA: cloughlin 09/30/14	S000000		
S000024	410 IAC 15-2.2-2 SURVEY PROCEDURES 410 IAC 15-2.2-2 (a)  Sec.2.(a) The center shall fully cooperate with licensure and complaint investigation inspections conducted by representatives of the department. Based on requests and interview, the facility failed to cooperate with licensure inspection conducted by the state agency representative in two (2) instances.  Findings:  1. In opening survey on 9/15/14 at 2:30pm with A1 and A2, requests were made for review of facility administrative	S000024	<b>1.To correct the deficiency, the policy for the Administrator's coverage was updated to include allowing the Business office manager to access all credential and personnel files during the Administrator's absence.</b> <b>2.By allowing the designated staff the authorization and responsibility of the credential and personnel files in the</b>	10/17/2014

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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S000106	<p>and clinical documents to include credential and personnel files.</p> <p>2. In interview on 9/17/14 at 12:00pm, a second request was made to review credential and personnel files at which time employee A1, the business office manager, indicated communication from A3, the facility administrator, refusing to allow access to either credential or personnel documents by anyone in the facility.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(3)</p> <p>The governing body shall do the following:</p> <p>(3) Review the bylaws at least triennially.</p> <p>Based on document review and interview, the facility failed to show evidence of reviewing governing body bylaws triennially.</p> <p>Findings:</p>	S000106	<p><b>Administrator's absence, this deficiency will be prevented from recurring. An all staff inservice was held on October 7, 2014 to review the State form 2567, and discuss the Plan of Corrections implemented. On October 16, 2014, the Medical Executive Committee approved the changes and corrections. On October 17, 2014 the Board of Managers approved the changes and corrections.</b></p> <p><b>3.The Administrator or designee is responsible for ensuring the security of all credential and personnel files daily, and allowing access to regulatory agencies as needed.</b></p> <p><b>4.Date of Correction: 10/17/14</b></p> <p><b>1.The facility disputes the violation of the rule "The governing body shall do the following: (3) Review the bylaws at least triennially." Specifically, the citation is "Board of Managers bylaws indicated the most recent review date as 7/21/11" and "A1</b></p>	11/26/2014			

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	<p>1. Review of facility Board of Managers bylaws indicated the most recent review date as 7/21/11.</p> <p>2. In interview on 9/17/14 at 3:30pm, A1 indicated no more recent review could be determined and no further documentation was provided prior to exit.</p>		<p><b>indicated no more recent review could be determined and no further documentation was provided prior to exit.” Reason: The surveyor was reviewing the facility “Development manual” which includes the Operating Agreement and Medical Staff Bylaws. The date cited by the surveyor was the date the members signed the Operating Agreement indicating their partnership, see attached. The Medical Staff Bylaws document was signed at the member’s meeting on June 25, 2012 immediately prior to the opening of our center on July 16, 2012. The Business office manager provided the surveyor with the board meeting minutes for June 25, 2012, which documents the re-election of the Board of Managers (BOM), and Medical Executive Committee (MEC) and the review &amp; approval of the Medical Staff bylaws at that time, which included the attendance by all members of both Committees. The Triennial rule has not been violated as evidenced by the approval of the bylaws on June 25, 2012, signed by the Medical Director on said date, immediately after approval by the members. The bylaws document is referenced and the date quoted in the</b></p>	

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S000172	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND		<p><b>citation S 728 by the surveyor, which contradicts the date cited in S 106 tag.</b></p> <p><b>2. Please delete this tag S 106 If IDR denied, please see below POC</b></p> <p><b>1.To correct the deficiency, on 11/17/14 the BOM was provided a copy of the operating agreement which is inclusive of the BOM bylaws for review and approval. Signatures of approval from the BOM will be obtained upon the surgeons next visit to the center or via email/scanned document see attached "supporting document re-approval of BOM bylaws</b></p> <p><b>2.To prevent this deficiency from recurring, the Administrator will ensure the BOM bylaws are approved by the BOM at least triennially. All surgeon owner/members were notified of the triennial requirement on 11/14/14 via the weekly report.</b></p> <p><b>3.The Administrator will be responsible for ensuring triennial approval of the BOM bylaws. The Administrator will report changes to the Quality Assurance (QA) Committee quarterly.</b></p> <p><b>4.Date of Correction: 11/26/14</b></p>		

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	<p><b>DUTIES</b> 410 IAC 15-2.4-1 (c)(5) (L)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(L) Maintaining personnel records for each employee of the center which include personal data, education and experience, evidence of participation in job related educational activities, and records of employees which relate to post offer and subsequent physical examinations, immunizations, and tuberculin tests or chest x-rays, as applicable.</p> <p>Based on interview, it could not be determined that the facility maintained personnel records for each employee of the center.</p> <p>Findings:</p> <p>1. In opening survey on 9/15/14 at 2:30pm with A1 and A2, requests were made for review of facility administrative and clinical documents to include credential and personnel files.</p> <p>2. In interview on 9/17/14 at 12:00pm, a second request was made to review credential and personnel files at which time employee A1, the business office manager, indicated communication from A3, the facility administrator, refusing to allow access to either credential or personnel documents by anyone in the</p>	S000172	<p><b>1.To correct the deficiency, the policy for the Administrator's coverage was updated to include allowing the Business office manager to access all personnel files during the Administrator's absence.</b></p> <p><b>2.By allowing the designated staff the authorization and responsibility of the personnel files in the Administrator's absence, this deficiency will be prevented from recurring. An all staff inservice was held on October 7, 2014 to review the State form 2567, and discuss the Plan of Corrections implemented. On October 16, 2014, the Medical Executive Committee approved the changes and corrections. On October 17, 2014 the Board of Managers approved the</b></p>	10/17/2014			

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S000230	<p>facility.</p> <p>3. No further information or documentation was provided prior to exit.</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 facility failed to provide utilization review by a committee composed of three (3) physicians having no financial interest in the facility in the past 12 months.</p> <p>Findings:</p> <p>1. Review of facility Utilization Review documentation for the past 12 months indicated the committee and attendees to</p>	S000230	<p><b>changes and corrections.</b></p> <p><b>3.The Administrator or designee is responsible for ensuring the security of all personnel files, daily, and allowing access to regulatory agencies as needed.</b></p> <p><b>4.Date of Correction: 10/17/14</b></p> <p><b>1.To correct the deficiency, the Administrator recommended the addition of the following to the Utilization Review Committee/Medical Executive Committee (UR/MEC): the anesthesiologist and two non-owner surgeons. On October 16, 2014, the Medical Executive Committee approved the changes and corrections. On October 17, 2014 the Board of Managers approved the changes and corrections.</b></p>	10/17/2014	

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S000432	<p>be comprised of physician owners.</p> <p>2. Review of the document titled Utilization Review (UR) Committee (MEC) indicated four (4) members on the committee: MD 2, MD 3, MD 21 and MD 19.</p> <p>3. In interview on 9/17/14 at 3:30pm, A1 indicated each of the above MDs to be on the UR committee and each to have some financial interest in the facility.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iii)</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>(iii) Cleaning, disinfection, and sterilization.</p> <p>Based on observation, document review</p>	S000432	<p><b>2.To prevent this deficiency from recurring, the Administrator will monitor the committee members for any changes of ownership, and request replacements with other non-owner members as needed. Upon re-election of members, the Administrator will ensure that there is a minimum of three non-owner members on the UR/MEC committee.</b></p> <p><b>3.The Administrator or designee is responsible for monitoring the committee membership, quarterly, with each meeting and as needed with ownership changes. The Administrator will report changes to the QA Committee quarterly.</b></p> <p><b>4.Date of Correction: 10/17/14</b></p> <p><b>1.To correct this deficiency,</b></p>	10/17/2014			

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	<p>and interview, the facility failed to follow manufacturer instructions for quality control testing of the disinfectant Rapicide ortho-Phthaladehyde (OPA).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During tour of the facility on 9/16/14 beginning at 12:30pm in the presence of A2 in the dirty instrument cleaning area, the OPA cleaning agent Rapicide was indicated by A2 to be the agent used as high-level disinfectant. A2 indicated the solution to be tested one time per day prior to use with Rapicide OPA/28 test strips for pass/fail results.</li> <li>2. Review of the test strip package insert indicated: Perform quality control testing by following DIRECTIONS FOR USE and testing a positive and a negative control solution.</li> <li>3. Review of the facility document titled Cidex OPA Log indicated only a +/- before use result and no documentation of control testing with both a positive and negative solution.</li> <li>4. In interview on 9/16/14 at 3:45pm, A2 indicated the facility does not perform a quality control test as indicated by Rapicide manufacturer instructions and no further documentation was provided prior to exit.</li> </ol>		<p><b>the Rapicide OPA/28 negative controls were performed immediately, and daily when in use thereafter, along with the positive controls which were already being performed. The "Rapicide OPA/28 solution log" was updated to include the documentation of negative and positive controls.</b></p> <p><b>2.To prevent this deficiency from recurring, the policy was updated to be inclusive of the negative and positive control checks. Additionally, the OR staff were trained on the policy &amp; proper procedures for control checks of Rapicide OPA/28. An all staff inservice was held on October 7, 2014 to review the State form 2567, and discuss the Plan of Corrections implemented. On October 16,2014, the Medical Executive Committee approved the changes and corrections. On October 17, 2014 the Board of Managers approved the changes and corrections.</b></p> <p><b>3.The Administrator, Infection Control (IC) nurse or designee is responsible for the monitoring of the Rapicide OPA/28 log documentation, daily, for compliance and performance of control checks. The IC nurse will report compliance to the IC Committee quarterly. The Administrator will report to the</b></p>		

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S000710	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p>		<p><b>QA Committee quarterly.</b> <b>4.Date of Completion:</b> <b>10/17/14</b></p>	

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	<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> <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 interview, it could not be determined that the facility maintained a file for each member of the medical staff (MS).</p> <p>Findings:</p> <p>1. On 9/15/14 at 2:30pm during opening comments with A1 and A2, request was made for a list of credentialed personnel of which to select credential files for</p>	S000710	<p><b>1.To correct the deficiency, the policy for the Administrator's coverage was updated to include allowing the Business office manager to access all medical staff files during the Administrator's absence.</b></p> <p><b>2.By allowing the designated staff the authorization and responsibility of the medical staff files in the Administrator's absence, this deficiency will be</b></p>	10/17/2014			

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S000728	<p>review.</p> <p>2. Review of the document labeled Providers and indicated by A1 to be a list of current providers for the facility indicated five (5) DPM (podiatrists), eight (8) Orthopaedic MDs, one (1) pain MD, two (2) Ophthalmic MDs, three (3) MD Anesthesiologists, one (1) General Surgeon, two (2) Ears, Nose and Throat (ENT) MDs, four (4) Certified Registered Nurse Anesthetists (CRNA), two (2) Physician Assistants (PA), one (1) Certified Surgery Tech, and one (1) RN First Assist.</p> <p>3. In interview on 9/17/14 at 12:00pm, after a second request to review selected files, employee A1 indicated that the administrator, A3, refused to allow access to credential files at this time and no further documentation or information was provided prior to exit.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)</p> <p>(b) The medical staff shall adopt and enforce bylaws to carry out its responsibilities. These bylaws and rules must be as follows: Based on document review and interview, it could not be determined that the medical staff (MS) of the facility approved bylaws or adopted rules.</p>	S000728	<p><b>prevented from recurring. An all staff inservice was held on October 7, 2014 to review the State form 2567, and discuss the Plan of Corrections implemented. On October 16, 2014, the Medical Executive Committee approved the changes and corrections. On October 17, 2014 the Board of Managers approved the changes and corrections.</b></p> <p><b>3.The Administrator or designee is responsible for ensuring the security of all medical staff files, and allowing access to regulatory agencies as required.</b></p> <p><b>4.Date of Correction: 10/17/14</b></p> <p><b>1.The facility disputes the example "This RULEis not met as evidenced by: Based on document review and</b></p>	10/17/2014			

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of facility documents failed to include documentation of medical staff rules.</li> <li>2. Review of the document titled Medical Staff Bylaws signed on 6/25/12 by MD2 indicated on page 20 in ARTICLE IX - ADOPTION A. These Bylaws, together with existing Rules and Regulations, have been adopted by...</li> <li>3. Review of Medical Executive Committee (MEC) meeting minutes included meeting dates 1/8/14 and 5/8/14 and indicated no review or adoption of MS bylaws or rules.</li> <li>4. In interview on 9/17/14 at 3:30pm, A1 indicated medical staff rules nor other MEC minutes could be produced at that time and no further documentation was provided prior to exit.</li> </ol>		<p><b>interview, it could not be determined that the medical staff (MS) of the facility approved bylaws..." Reason: The IDR for S 0106 proves that the Medical Staff Bylaws were in fact approved by the newly elected MEC and BOM's, and signed by the Medical Director on the same date of 6/25/12, which is quoted by the surveyor later in her statements on citation S 0728.</b></p> <p><b>2.Please delete examples including the lack of approval of bylaws.</b></p> <p>POC for remaining S 0728</p> <p><b>1.To correct the deficiency regarding the lack of approval for Medical Staff Rules,the MEC was provided a copy of the rules on October 16, 2014 for approval. The BOM was provided a copy of the rules on October 17, 2014 for approval.</b></p> <p><b>2.To prevent this deficiency from recurring, the triennial approval of the Medical Staff Bylaws will be inclusive of the Medical Staff Rules for approval by the MEC and BOM. An all staff inservice washeld on October 7, 2014 to review the State form 2567, and discuss the Plan of Corrections implemented. On October 16,2014, the Medical Executive Committee approved the changes and corrections. On October 17, 2014 the Board of</b></p>		

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S001010	<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, document review, and interview, the facility failed to follow policy for drug handling, storing, and labeling in three (3) instances.</p> <p>Findings:</p> <p>1. During facility tour on 9/16/14 between 12:30pm and 1:30pm in the presence of A2, inside the anesthesia</p>	S001010	<p><b>Managers approved the changes and corrections.</b></p> <p><b>3.The Administrator or designee is responsible for triennial renewal of the approval of the Medical Staff bylaws which includes the Medical Staff Rules. The Administrator will report compliance to the QA Committee quarterly.</b></p> <p><b>4.Date of Correction: 10/17/14</b></p> <p><b>1.To correct the immediate deficiency, all identified improperly labeled vials &amp; single use vials were disposed of at the time of discovery during the survey on 9/16/14. All anesthesia carts were checked for any remaining improperly labeled medication vials. The IC nurse discussed the deficiency with the</b></p>	10/17/2014

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NAME OF PROVIDER OR SUPPLIER  RIVERVIEW SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1276 NORTH PLAZA DRIVE ROCKPORT, IN 47635			
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	<p>block cart located outside the patient pre-op area, the following were observed:</p> <p>1 opened - 20ml vial Lidocaine 2% 20mg/ml MDV (multi-dose vial) without opened add-on label; approximately 15ml remained. 1 opened - 30ml single dose vial (SDV) Sensorcaine 0.5% without add-on label; approximately 5ml remained.</p> <p>2. During facility tour on 9/16/14 between 12:30pm and 1:30pm in the presence of A2, inside surgery suite 2 inside the anesthesia cart, the following was observed: Neostigimine 1:1000 (10mg/10ml) with a hand written add-on label dated 10/11/14, no initials were noted. The vial was approximately 3/4 full.</p> <p>3. Review of facility policy and procedure (P&amp;P) titled Multi-dose Vials, effective 6/25/12, indicated under Procedure in number 2. Multi-dose vials are to be dated for 28 days when expired and initialed when opened. 3. Single use vials are opened and discarded after one time use.</p> <p>4. Review of the facility P&amp;P titled Medication administration, effective date 6/25/12, indicated in the section subtitled Procedure under number 3. f. Any multi-dose vial or ophthalmic drops shall be dated and initialed for expiration within 28 days of initial puncture of vial...</p>		<p><b>anesthesia team and reviewed the policy for proper medication labeling on 9/16/14.</b></p> <p><b>2.To prevent the recurrence, the Administrator discussed the current and past anesthesia deficiencies with the consultant anesthesia group on 9/18/14 and arranged a consultant visit to audit the Anesthesia team's performance. The consultant met with the Administrator on 10/1/14 to review the state survey findings prior to auditing the Anesthesia team. The Administrator met with the Anesthesiologist, CRNA and IC nurse on 10/7/14 to review the State form 2567. All noncompliance issues/hindrances were discussed. It was agreed that a push lock anesthesia block cart would be beneficial to the anesthesiologist, so the order was placed on 10/8/14. Medication expiration labels were placed on all anesthesia carts on 10/8/14 for ease of compliance with proper labeling of multi-dose vials. Anesthesia was instructed that all single dose vials are to be immediately thrown away after use</b></p> <p><b>3.The Anesthesiologist and CRNA is responsible for ensuring the proper labeling of</b></p>				

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S001170	<p>5. In interview on 9/16/14 at 1:10pm, A2 indicated opened medication vials should be labeled with date to show expiration 28 days from date opened, time opened and initials of person accessing vial. A2 further indicated SDV are to be discarded after one time use.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iv)</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>(4) The patient care equipment requirements are as follows:</p> <p>(B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:</p> <p>(iv) Defibrillators must be discharged at least in accordance with manufacturers' recommendations, and a discharge log with initialed entries must be maintained.</p> <p>Based on document review and interview, the facility failed to follow</p>	S001170	<p><b>all medication vials in their anesthesia carts, daily. The IC nurse or designee is responsible for monitoring the appropriate labeling of medication vials when doing monthly medication outdate audits. The IC nurse will report noncompliance to the IC Committee. The Administrator will report findings to the QA Committee.</b></p> <p><b>4.Date of Completion: 10/17/14</b></p> <p><b>1.To correct this deficiency, the Zoll Operator's shift</b></p>	10/17/2014			

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S001198	<p>recommended defibrillator discharge according to manufacturer recommendations.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of facility documentation titled Emergency Crash Cart &amp; Defibrillator Checklist indicated defibrillator checks as follows: ...2. Defibrillator pads (current) or gel present...5. Defibrillator test "OK" (on battery)</li> <li>Review of the manufacturer's manual, section 9-6, document titled Operator's Shift Checklist for M Series indicated eight (8) checks, each with subcategories, to be checked each shift.</li> <li>In interview on 9/17/14 at 2:55pm, A2 indicated the facility does not include all checks as recommended by manufacturer and no further documentation was provided prior to exit.</li> </ol> <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</p>				<p><b>checklist from the defibrillator operator's manual was implemented immediately for the daily defibrillator check by the recovery nurses.</b></p> <p><b>2.To prevent this deficiency from recurring, the Zoll customer service department was contacted on 9/19/14 for training purposes. An all staff inservice was held on October 7, 2014 to review the State form 2567, and discuss the Plan of Corrections implemented. A Zoll Training module kit was ordered and received on 10/10/14. All nurses were inserviced on the proper daily check of the Zoll Defibrillator.</b></p> <p><b>3.The Recovery nurse is responsible for performing the daily checklist on the Zoll defibrillator. The Administrator or designee is responsible for monitoring the completion of the documentation of the daily defibrillator check during monthly facility audits. The Administrator will report compliance to the QA Committee quarterly</b></p> <p><b>4.Date of Completion: 10/17/14</b></p>		

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	<p>following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based on document review and interview, it could not be determined that the facility participated in emergency and disaster preparedness with appropriate community, state, and federal agencies in any instance.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of facility documents failed to include documentation of regular participation with an appropriate agency for disaster and emergency preparedness in any instance.</li> <li>In interview on 9/17/14 at 3:00pm A1 indicated the facility had contacted a local agency about emergencies and hazards and provided a copy of an email as documentation.</li> <li>Review of a facility email document dated 8/12/14 indicated contact from the local county emergency management agency in regards to "vulnerability" of hazards in the area.</li> <li>No further documentation was provided prior to exit.</li> </ol>	S001198	<p><b>1.The facility disputes the violation of the rule "(c) A safety management program must include, but not be limited to,the following: (6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies."</b></p> <p><b>Reason: The facility has been coordinating disaster preparedness with the Spencer County EMA since the August 2012 state survey citation. The Spencer County EMA provided the emergency weather radio in 2012, and has toured the center to review the safest storm shelter locations. The Administrator had contacted the Spencer County EMA on May 1, 2013, regarding fire training, and had emailed the Spencer County EMA on August 12,2014 to provide a recently obtained "vulnerability" spreadsheet with the request to obtain their expert opinion of our threats. The email chain was provided to the surveyor, as she stated in this citation. The Spencer County EMA Director was in training at that time, and was</b></p>	11/14/2014			

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			<p><b>coordinating an available date to come to the facility to meet with the Administrator to review the vulnerability spreadsheet.</b></p> <p><b>2.Please delete this tag</b> If IDR denied</p> <p><b>1.To correct this deficiency, the Administrator and Spencer County EMA Director met on September 23, 2014 and reviewed the facility risk level and completed the vulnerability spreadsheet. The Director and Administrator met again on 11/14/14 to discuss the center's ability to serve as a triage center, staging center or Point of Distribution site for emergency response. See attached supporting document disaster planning with Spencer County</b></p> <p><b>2.To prevent the deficiency from recurring, the Administrator will continue to communicate at least annually with the Spencer County EMA to coordinate and update emergency and disaster preparedness.</b></p> <p><b>3.The Administrator or designee will be responsible for coordinating with the Spencer County EMA at least annually. The Administrator will report compliance to the QA Committee.</b></p> <p><b>4.Date of Completion:</b> 11/14/14</p>		

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

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