

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001017		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/11/2012	
NAME OF PROVIDER OR SUPPLIER  MUNCIE EYE SPECIALISTS SURGERY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 200 N TILLOTSON AVE MUNCIE, IN 47304			
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S0000	<p>The visit was for a licensure survey.</p> <p>Facility Number: 005398</p> <p>Survey Dates: 07-09-12 to 07-11-12</p> <p>Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Karilyn Tretter, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 07/19/12</p> <p>10/24/12 revised due to IDR</p>	S0000	Correct.				

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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S0153	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(c) (5) (C)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies.</p> <p>Based on policy/procedure review, personnel file review and interview, the Chief Executive Officer failed to ensure that employee orientation checklists were included in personnel files for 8 of 13 (E#2, E#3, E#4, E#5, E#6, E#8, E#9, E#10) nursing personnel.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. During policy/procedure review on 7-10-12 at 0930, it was found that Eye Specialists Surgery Center, LLC Policy No. 3.12 "Employee Orientation" states, under Practices &amp; Procedures "The orientation of new employees shall take place within the first week of employment beginning with the first day. The orientation checklists that are a part of this policy ...are to be included in the personnel file of the employee."</li> <li>2. During personnel file review on 7-9-12 at 1415, it was found that the personnel files of E#2, E#3, E#4, E#5, E#6, E#8, E#9, and E#10 lacked orientation checklists.</li> <li>3. During interview with E#10 (Patient Care Manager/Administrator) on 7-10-12 at 1310, he/she stated that when American Health</li> </ol>	S0153	Each employee file will have an employee orientation check off list. There will be a letter with each one stating this was updated due to prior company confiscation of employee files. Each employee file will display a record checklist of contents. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	10/15/2012			

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	<p>Network (AHN) took over management of the ASC in January 2010, they set up all new personnel files. The nursing personnel who were hired to work at the ASC prior to January 2010 had their orientation checklists and some other paperwork from their personnel files taken by the previous company that managed/ran the facility. E#10 stated unknown what was done with the paperwork by the previous company.</p>			

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S0442	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on policy/procedure review, personnel file review, and interview, the ASC Infection Control Committee failed to monitor the communicable disease history of new personnel and current personnel through their employee health program for 5 of 13 (E#4, E#7, E#8, E#10, E#11) nursing personnel.</p> <p>Findings included:</p> <p>1. During policy/procedure review on 7-10-12 at 1100, Policy No. 3.111 "Employee Physical Examination" states, under Practice &amp; Procedure "1. Initial examination shall include the following: g. Immunization history obtained for Rubeola, Rubella and Varicella."</p> <p>2. During personnel file review on 7-9-12 at 1515, there was no documentation of</p>	S0442	Employee files will be updated to reflect vaccination history of employees. Each file will display a Health File Checklist for each employee. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	10/15/2012			

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	<p>varicella immunity or immunizations for E#4 (self-attestation of having had the disease, not confirmed by a physician), E#7, E#8, E#10, and E#11.</p> <p>3. During interview with E#10 (Patient Care Manager/Administrator) on 7-11-12 at 1000, he/she reviewed the personnel files and confirmed that the files lacked documentation regarding varicella.</p>				

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S0472	<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 policy/procedure review and interview, the ASC failed to maintain a list of cleaning products approved by the Infection Control Committee.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. During policy/procedure review on 7-10-12 at 1330, there was a list found "Cleaning Supplies For Surgery Center." Five cleaning products listed. No information that products approved by Governing Body or Infection Control Committee.</li> <li>2. During interview with E#10 (Patient Care Manager/Administrator) on 7-10-12 at 1410, he/she confirmed that the facility lacked a list of cleaning products approved by the Infection Control Committee of the ASC. He/she also confirmed that the agreement with the contracted housekeeping services failed to ensure that the housekeeping staff would use facility-approved disinfectant products when cleaning.</li> </ol>	S0472	The cleaning supplies for surgery center list was presented by the Infection Control Committee to the board 8-6-12; awaiting approval by the Governing Body. The cleaning services contract will reflect the approved products to be used for cleaning in the ASC. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	10/15/2012			

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S0526	<p>410 IAC 15-2.5-2 LABORATORY SERVICES 410 IAC 15-2.5-2 (h)</p> <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 policy/procedure review, personnel file review, and interview, it was found that 7 of 7 (E#1, E#2, E#3, E#4, E#5, E#8, E#9) nursing personnel of the ASC failed to have their glucometer competency assessed annually.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>During policy/procedure review on 7-10-12 at 1000, Eye Specialists Surgery Center, LLC Policy No. 9.02 "Blood Glucose Testing" states "Nursing personnel in Pre/Post-operative area is responsible for ensuring glucometer testing is performed consistent with policy." Also, AHN provides mandatory inservices (Compliance Training) that all nursing personnel at the ASC must do annually. One is "glucometer inservice", but it consists of a series of questions.</li> <li>During personnel file review on 7-9-12 at 1415, no documentation of glucometer competency was found in any of the files of the nurses who work pre-op and /or post-op (E#1, E#2, E#3, E#4, E#5, E#8, E#9).</li> <li>During interview with E#10 (Patient Care Manager/Administrator) on 7-10-12 at 1030, he/she acknowledged that they had not been doing glucometer competencies, just the</li> </ol>	S0526	Glucometer competency with check offs will be kept in each employee file. Inservice will be provided with proper check off skills per manufacture. This will be done annually. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	10/15/2012			

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	written tests. E#4 had done special training on the Internet to be a glucometer trainer, so he/she will be "checking off" the nursing staff annually on proper use of the glucometer.				

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S0676	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(g)</p> <p>(g) All original medical records or legally reproduced medical records must be maintained by the center for a period of seven (7) years in accordance with subsection (c)(6) and (c)(7), must be readily accessible, in accordance with the center policy and must be kept in a fire resistive structure.</p> <p>Based on document review, observation and interview, the center lacked a policy/procedure and departmental waiver for off-site storage of medical records (MR).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 7-09-12 at 1230 hours, staff A1 was requested to provide documentation including a waiver from the Indiana State Department of Health (ISDH) for off-site MR storage and none was provided prior to exit.</li> <li>The policy/procedure Medical Records - General (approved 12-10) failed to ensure that an approved waiver from the Indiana State Department of Health was obtained prior to relocating MR from the center to an off-site facility or location.</li> <li>During a center tour on 7-09-12 at</li> </ol>	S0676	Waiver obtained from the ISDH on August 28, 2012 which allows for off-site storage of the Centers medical records. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	08/28/2012			

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	<p>1530 hours, surgery center medical records were observed in storage in an office located in the basement of the building away from the surgery center area of the building.</p> <p>4. During an interview on 7-09-12 at 1610 hours, staff A1 confirmed that center MR were being stored in a common area location away from the surgery center and no waiver had been obtained from ISDH.</p>				

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S0862	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(C)</p> <p>Requirement for surgical services include:</p> <p>(2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows:</p> <p>(C) A provision for the following equipment and supplies to be available to the surgical and recovery areas:</p> <p>(i) Emergency call system. (ii) Oxygen. (iii) Resuscitation equipment. (iv) Defibrillator. (v) Cardiac monitors. (vi) Tracheostomy set. (vii) Oximeter. (viii) Suction equipment. (ix) Other supplies and equipment specified by the medical staff.</p> <p>Based on document review, observation and interview, the center failed to ensure that an emergency call system or response was available for 1 of 9 required emergency equipment.</p> <p>Findings:</p> <p>1. The policy/procedure Code Blue Condition and Response (approved 12-10) lacked a specific and clear</p>	S0862	On July 13, 2012 our Maintenance staff repaired the call light system. The system will be recorded on the preventive maintenance log for inspection. Policy 5.39 Code Blue Condition and Response updated to reflect a uniform method of alerting center staff in the event of a patient, visitor, or public emergency. The ASC Patient Care Manager will be responsible for completion, implementation &	07/13/2012			

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	<p>provision that ensured a uniform method of alerting center staff in the event of a patient, visitor, or public emergency.</p> <p>2. During a tour of the center on 07-09-12 at 1440 hours, the Dukane nurse call system switches located in the patient bathroom and at each patient care bay failed to signal an alert when tested for signal continuity.</p> <p>3. During an interview on 7-10-12 at 1150 hours, staff A1 indicated that the Dukane control panel was removed in 2010 due to obsolescence and confirmed that the available nurse call system switches were inoperative. Staff A1 confirmed that the Code Blue policy/procedure lacked a standard response for alerting center staff in the event of a patient or public emergency.</p>		<p>monitoring for compliance, policy pending approval per Governing Board.</p>				

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S1040	<p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAc 15-2.5-6(3)(F)</p> <p>Pharmaceutical service must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(F) Instructions to the patient on the use of take home medication is the responsibility of the prescribing practitioner.</p> <p>Based upon document review and interview, the center failed to have a policy/procedure regarding the physician responsibility of instructing the patient on the use of take home medication when dispensed by the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The policy/procedure Pharmaceutical Services (revised 1-12) failed to indicate the responsibility for the prescribing practitioner to instruct the patient on the use of take home medication if dispensed by the center.</li> <li>2. During an interview on 7-11-12 at 1015 hours, staff A1 confirmed that the policy/procedure failed to indicate the physician responsibility for instructing the patient on the use of take home medication.</li> </ol>	S1040	<p>Policy 8.01 Pharmaceutical Services updated to indicate the responsibility to the prescribing practitioner to instruct the patient on the use of take home medication. The ASC Patient Care Manager will be responsible for completion, implementation &amp; monitoring for compliance, policy pending approval per Governing Board.</p>	10/15/2012	

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S1162	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)</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: Based on document review, observation, and interview, the center failed to ensure that the facility defibrillator was maintained in good working order as recommended by the manufacturer.</p> <p>Findings:</p> <p>1. The Medtronic Physiocontrol Lifepak 500 Automated External Defibrillator (AED) service manual (1999) indicated the following: " Keep the following supplies readily accessible ...spare defibrillation electrodes ...[and] ...check the expiration date on batteries and therapy electrodes ...replace if expired. "</p> <p>2. During a tour on 7-09-12 at 1445 hours, the following condition was</p>	S1162	The expired pads used for teaching purposes were moved to another location. The ASC has already obtain a spare set of pads so that the AED is equipped with two sets of pads. Check list updated to reflect maintaining two sets of pads at all times. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	07/27/2012			

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	<p>observed: a Lifepak 500 AED with 2 expired defibrillation electrode packs (expired 7-28-09 and 9-28-08).</p> <p>3. During an interview on 7-09-12 at 1445 hours, staff A1 confirmed that the emergency equipment was expired.</p>			

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S1168	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(iii)</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>(iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially.</p> <p>Based on document review and interview, the preventive maintenance (PM) records for patient care equipment lacked documentation of electrical current leakage testing for 4 PM records reviewed.</p> <p>Findings:</p> <p>1. PM documentation dated 2-07-12 for 2 anesthesia machines and 2 operating room lights failed to indicate that ground current leakage testing was performed and recorded as either pass/fail or otherwise indicate the test measurements on the</p>	S1168	The Centers Preventive Maintenance personnel completed the leakage testing for the equipment in question on 8-14-2012. Discussion took place with personnel to further properly document the results in the future. The ASC Patient Care Manager will be responsible for completion, implementation & monitoring for compliance.	08/14/2012			

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	documentation.  2. During an interview on 7-10-12 at 1145 hours, staff A1 confirmed that the indicated equipment PM records lacked documentation of electrical current leakage testing.				

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S1180	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(1)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(1) A review of safety functions by a committee appointed by the chief executive officer that includes representatives from administration and patient care services.</p> <p>Based on document review and interview, the center failed to establish a safety management program that included a review of safety functions by a committee appointed by the chief executive officer and included representatives from administration and patient care services.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 7-09-12 at 1210 hours, staff A1 was requested to provide documentation of a safety management program including committee minutes and a designated safety officer and none was provided prior to exit.</li> <li>During an interview on 7-09-12 at 1330 hours, staff A1 indicated that the safety management functions were integrated in the Quality Assurance Program at the center.</li> <li>The Quality Assessment and Risk Management Plan (approved 12-10) failed to indicate that the safety management committee was integrated in the QA committee functions and failed to ensure that a representative from patient care services was present and included in the committee.</li> <li>The policy/procedure Safety Management (approved 12-10) failed to indicate the scope of safety program responsibilities to be reported through the QA program and failed to indicate a process or center-wide plan for safety management.</li> </ol>	S1180	<p>Policy 1.05 Quality Assessment and Risk Management Plan updated to include the integration of safety management into the QA committee functions. Facility will make arrangements to have patient care service representation included in the safety committee. Policy 14.00 Safety Management updated to reflect scope of safety program plan and to be reported through the QA program. The ASC Patient Care Manager will be responsible for completion, implementation &amp; monitoring for compliance to make sure that the correct people attend meeting &amp; review of minutes; policy pending approval per Governing Board.</p>	10/15/2012			

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	<p>5. The documents Committee Meeting Minutes as a Whole dated 2-06-12 and Committee Meeting dated 5-01-12 failed to indicate that a representative from patient care services was present for the safety committee portion of the meetings and failed to indicate participation or discussion by a committee.</p> <p>6. During an interview on 7-11-12 at 1315 hours, staff A1 confirmed that the center failed to develop a written safety management plan, that the safety committee minutes failed to indicate participation by a representative of patient care services and that the safety meeting minutes failed to document a committee process for reviewing safety functions to comply with state requirements.</p>			

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S1188	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(4)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(4) A written fire control plan that contains provisions for the following:</p> <p>(A) Prompt reporting of fires. (B) Extinguishing of fires. (C) Protection of patients, personnel, and guests. (D) Evacuation. (E) Cooperation with firefighting authorities. (F) Fire drills.</p> <p>Based on document review and interview, the center failed to maintain and follow its policy/procedure for conducting quarterly fire drills for 3 of 5 required drills.</p> <p>Findings:</p> <p>1. The policy/procedure Emergency Operations (approved 12-10) lacked a provision for notifying the alarm monitoring service prior to conducting the fire drill and lacked a provision ensuring that an audible fire alarm signal will sound when conducting a fire drill per NFPA 101, 2000 Edition Chapter 21.7.1.2</p> <p>NFPA 101, 2000 Edition Chapter 21.7.1.2</p>	S1188	<p>Fire Drill Checklist in Policy 14.01 Emergency Operations updated to reflect "audible" alarm activated with notification to Alarm Company. Fire Drill documentation log in Policy used to reflect fire drill performed (no use of word "simulation" of fire to be used). The ASC Patient Care Manager will be responsible for completion, implementation &amp; monitoring for compliance.</p>	10/15/2012			

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	<p>indicates the following:</p> <p>[Fire exit drills in ambulatory health care facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.]</p> <p>2. Fire drill documentation dated 5-29-11, 3-28-12 and 6-25-12 failed to indicate that the fire alarm system was activated as part of the fire drill for the indicated dates.</p> <p>3. During an interview on 7-10-12 at 1605 hours, staff A1 indicated that the alarm monitoring company had requested that the center not activate the fire alarm when contacted by the surgery director/safety officer prior to the 5-11, 3-12 and 6-12 fire drills. Staff A1 confirmed that the Education Report documentation dated 3-30-11, 7-20-11 and 3-28-12 indicating " simulated fire drill " failed to clearly indicate that a fire drill was performed and confirmed that</p>			
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	the policy/procedure lacked the indicated provisions.			

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S1198	<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 upon document review and interview, the center lacked documentation of a disaster preparedness and participation with community, state and federal emergency and disaster preparedness agencies.</p> <p>Findings:</p> <p>1. On 7-09-12 at 1210 hours, staff A1 was requested to provide documentation of participation with appropriate local, state, and federal disaster management agencies and none was provided prior to exit.</p> <p>2. The policy/procedure Emergency Operations (approved 12-10) external disaster plan failed to ensure participation on a regular basis with State district 6 disaster management activities, county emergency preparedness providers or the local hospital and failed to ensure</p>	S1198	<p>Policy 3.14 Continuing Education / In-Service Training updated to reflect annual in-service training of a disaster drill. Policy 14.01 Emergency Operations updated to reflect the safe location to move to in the event of a tornado warning. Signed copy of Memorandum of Understanding with the Delaware County Emergency Management Agency was presented to surveyors on 7-10-12. Talks are occurring between the Delaware County Emergency Management Agency and IU Health Ball Memorial Hospital discussing our surgery centers participation in county emergency preparedness. Education documentation log will reflect the annual drill performed. The ASC Patient Care Manager will be responsible for completion, implementation &amp; monitoring for compliance, policies pending approval per Governing Board.</p>	10/15/2012			

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	<p>that disaster drills were performed on a regular basis at the center. The Tornado Plan failed to indicate a specific location for center staff, patients and visitors to shelter in place in the event of a tornado warning.</p> <p>3. The documentation Education Report dated 3-30-11 and 3-28-12 indicated the following: " Policy 14.01 Reviewed Emergency Operations: Fire, Power Failure, Evacuation, Tornado, Bomb Threat, Terrorist Attack. " The documentation failed to indicate that a drill of any of the indicated disasters (except for a fire drill performed on each date) was performed.</p> <p>4. During an interview on 7-10-12 at 1605 hours, staff A1 confirmed that the documentation dated 3-30-11 and 3-28-12 failed to indicate that center staff performed an emergency drill except for a fire drill and confirmed that the policy/procedure lacked the indicated provisions.</p>				