

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001003	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/29/2014
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NAME OF PROVIDER OR SUPPLIER  PREMIER SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 11141 PARKVIEW PLAZA DRIVE, SUITE 200 FORT WAYNE, IN 46845
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S000000	The visit was for a licensure survey.  Facility Number: 005385  Survey Date: 10-27/29-14  Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor  Linda Plummer, RN Public Health Nurse Surveyor  QA: claughlin 11/12/14	S000000		
S000110	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)  The governing body shall do the following:  (5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up. Based on document review and interview, the governing body failed to follow its bylaws and document at least a	S000110	<b>WHO</b> Identify the title of the person responsible for the corrective action and ongoing compliance.	01/02/2015

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>quarterly review of quality assessment and performance improvement (QAPI) program for 3 of 4 quarters in 2013 and 2014.</p> <p>Findings:</p> <p>1. The Governing Body Bylaws (approved 11-12) indicated the following: "At all quarterly meetings, the Governing Body shall review information on ...the following topics: ...Quality Improvement ...Safety/Risk Management ..."</p> <p>2. The governing body meeting minutes for the 3rd Quarter 2013 (11-21-13), 12-19-13, 1-16-14, 4th Quarter 2013 (2-27-14), 3-20-14, 4-17-14, 1st Quarter 2014 (5-14-14), 6-19-14 and 7-17-14 failed to indicate that QAPI documentation was presented and reviewed by the governing body.</p> <p>3. On 10-28-14 at 1655 hours, quality manager A3 confirmed that the governing body meeting documentation failed to indicate that any QAPI reports were presented or reviewed by the governing body.</p>		<p>Clinical Director is responsible for corrective action and ongoing compliance.</p> <p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b> Clinical Director will ensure that the elements of the QAPI program are presented to the governing body at least quarterly for review, feedback, and approval, when required. A standard meeting agenda template was designed and will be used for Governing Body meetings to ensure ongoing compliance with this standard.</p> <p><b>WHEN Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</b> Clinical Director presented the concept of this plan of correction to the governing body on 12/18/14. Governing body approved. The standard Governing Body Agenda template was completed January 2, 2015.</p> <p><b>HOW Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance. Describe how staff was trained.</b> The Clinical Director will use the new standard template for Governing Body agenda items will be used to ensure compliance with providing elements of QAPI. The Clinical Director will review</p>				

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S000116	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(2)(A-D)</p> <p>The governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff.</p> <p>(B) Reappointments are acted upon at least biennially.</p> <p>(C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications.</p> <p>(D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.</p> <p>Based on document review and interview, the center failed to follow its governing board bylaws regarding medical staff reappointment for 8 of 8 (MD11, MD12, MD14, MD15, MD16, MD17, MD18 and MD19) credential files reviewed.</p> <p>Findings:</p> <p>1. The Governing Body Bylaws</p>	S000116	<p>meeting minutes to ensure that they accurately reflect actions involving the QAPI program.</p> <p><b>WHO</b>Identify the title of the person responsible for the corrective action and ongoing compliance. The Medical Director is responsible for presenting credentialing and privileging requests to the governing body and ongoing compliance with this measure.</p> <p><b>WHAT</b>Describe the action(s) taken and how the standard</p>	01/02/2015

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	<p>(approved 11-12)) indicated the following: "The Governing Body shall review all recommendations from the Medical Executive Committee regarding the appointment and/or reappointment of practitioners applying for medical staff membership ...All appointment, reappointment, and decisions to deny privileges, terminate privileges or to revise a member ' s privileges, are not final until reviewed by the Medical Executive Committee, approved by the Governing Body and signed by the Governing Body Chairman and the Medical Director. The Governing Body will make decisions in the areas described above including those that may differ from the Medical Executive Committee recommendation its quarterly meeting or at a special meeting ..."</p> <p>2. The Governing Body meeting minutes dated 1-16-14, 2-27-14, 3-20-14 and 4-17-14 failed to indicate that the reappointment recommendations for MD11, MD12, MD14, MD15, MD16, MD17, MD18 and MD19 were presented and approved by the governing body.</p> <p>3. The credential file for medical staff members MD14, MD15, MD17, MD18 and MD19 indicated a medical director MD11 recommendation for reappointment on 2-26-14 and no</p>		<p><b>was addressed.</b></p> <p>1. Credentialing files for Medical Staff appointments / reappointments which were identified during survey as approved by the Medical Executive Committee but lacking documentation of approval by the Governing Body, were presented to the Governing Body (including supportive material) on 11-20-14 for approval. 2. The Medical Staff appointment/ reappointment worksheet has been revised to include the following: * A signature line, date, time for the Medical Director to indicate a review of the credentialing documents * A Signature line, date, time for the Medical Director as representative of the Medical Executive Committee to document approval by the MEC and the date of the meeting when this action took place. * A Signature line, date, time for the Chairman of the Governing Body to document approval by the Governing Body and the date of the meeting when this action took place.3. The Clinical Director added Medical Staff Appointment / Reappointment as a standard agenda item for the Governing Body. * Once completed, the revised Medical Staff appointment / reappointment worksheet will be part of each medical staff member's credentialing file. 3. The templates for the Governing Body meeting agenda and meeting minutes have been</p>		

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	<p>documentation indicated a date of approval by the governing body.</p> <p>4. The credential file for medical staff member MD12 indicated a medical director MD11 recommendation for reappointment on 3-14-14 and no documentation indicated a date of approval by the governing body.</p> <p>5. The credential file for medical director and governing body chairman MD11 indicated a medical director MD11 recommendation for reappointment on 3-25-14 and no documentation indicated a date of approval by the governing body.</p> <p>6. The credential file for medical staff member MD16 indicated a medical director MD11 recommendation for reappointment on 3-12-14 and no documentation indicated a date of approval by the governing body.</p> <p>7. During an interview on 10-29-14 at 1405 hours, clinical director A2 and QA manager A3 confirmed that no credential file or governing body meeting documentation indicated that the governing body had reviewed and approved the reappointment recommendations for the 8 physicians.</p>		<p>revised to record and reflect governing body decisions regarding medical staff appointment and reappointments. Agenda and meeting minutes template includes all medical executive committee recommendations including appointment / reappointment.</p> <p><b>WHEN</b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</p> <p>1. Credentialing files were presented to the Governing Body on 11-20-14 and approved. This was reflected in the Governing Body meeting minutes.. 2. The Medical Staff appointment / reappointment worksheet was modified on January 2, 2015. 3. The concept for the revisions to the Governing Body Agenda and Meeting Minutes template was presented to the Governing Body on 12-18-14 and approved. The standard Governing Body Agenda template Governing Body Meeting Minutes template revisions were completed on January 2, 2015.</p> <p><b>HOW</b>Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</p> <p>The Clinical Director will work with Medical Director to ensure that all Medical Executive Committee's recommendations for Medical Staff appointments / reappointments, as well as</p>	

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S000150	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c) (5) (A)</p> <p>(c) The governing body shall do the following:</p> <p>(5) Require that the chief executive officer develop and implement policies and programs for the following:</p>		<p>supportive materials, are presented to the Governing Body and documented in the minutes. The standard Governing Body Agenday template will help to ensure that compliance is sustained. The Clinical Director will ensure that the Chairman of the Governing Body signs the Medical Staff appointment / reappointment letter as a representative of the Governing Body. To ensure complainace the Quality Accredidaton specialist will audit the medical executive committee and governing body meeting minutes to verify that medical staff appointment and reappointment cadidates are documented and correlates with the completed appointment and reappointment letters. Audit will verify corralating dates of appointment and reappointment with the medical director and chairman of the board signatures. Quality Accrediation specialist will complete audits for three consecutive months with a goal of 100%.</p>	

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	<p>(A) Ensuring the employment of personnel, in accordance with state and federal rules, whose qualifications are commensurate with anticipated job responsibilities.</p> <p>Based on personnel file review and interview, the governing board failed to ensure that 1 of 2 surgical technologists hired in 2014 provided proof of graduation from a surgical tech school, as required per their job description.</p> <p>Findings:</p> <p>1. Review of the Surgical Technician job description, in the personnel file for staff member N9, hired 1/23/14, indicated:</p> <p>a. Under "Position Requirements", in the area of: "Total Education, Vocation Training and Experience:", it reads: "Graduate of a Surgical Technologist Program."</p> <p>2. At 2:00 PM on 10/29/14, interview with staff member #50, the Clinical Director, indicated:</p> <p>a. Attempts at contacting staff member N9 have not been productive and there is still no documentation of graduation form a surgical technology program for this staff member at this time.</p> <p>b. A copy of surgical technology program graduation should have been provided at the time of hire in January of 2014.</p>	S000150	<p><b>WHO</b>Identify the title of the person responsible for the corrective action and ongoing compliance.</p> <p>The Clinical Director is responsible for the corrective action and ongoing compliance for this measure.</p> <p><b>WHAT</b>Describe the action(s) taken and how the standard was addressed.</p> <p>The Pre-Employment Checklist template was revised to require evidence of surgical technician program completion prior to the start of employment. For the employee identified during the survey, multiple attempts to contact the employee to obtain documentation for completion of a surgical technician program were unsuccessful. As of 12/29/2014, the employee has been terminated from Premier Surgery Center.</p> <p><b>WHEN</b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</p> <p>The revision of the Pre-Employment Checklist template was completed on January 2, 2015. A certified letter of separation of employment was sent to identified employee on</p>	01/02/2015

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S000172	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 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</p>		<p>12/29/2014.</p> <p><b>HOW Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</b></p> <p>The revised Pre-employment checklist template will help to ensure all new hires have all of the required elements documented prior to the start of employment or an appropriate identified time frame. To ensure complainace the Quality Accredidaton specialist will audit new hire pre-employment records to verify all the required elements are documented and corralate to the completed pre-employment checklist. Quality Accreditation specialist will complete audit of all new hires for three consecutive months with a goal of 100%.</p>		

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	<p>tuberculin tests or chest x-rays, as applicable.</p> <p>Based on document review, employee file review, and staff interview, the governing board failed to ensure that tuberculin testing was per facility policy for 3 of 3 contracted housekeeping staff (N20, N21, and N22), for 6 of 7 staff hired in 2014 (N3, N5, N6, N7, N9, and N10), and for 1 staff member hired prior to 2014 (N4).</p> <p>Findings:</p> <p>1. Review of the "Tuberculosis Exposure Control Plan" indicated:</p> <p>a. The plan was last approved on 5/12/13.</p> <p>b. In section II., it reads: "...Part-time, temporary, contract and full-time health care workers will be included in the TB (tuberculosis) screening program. This includes physicians, nurses,...(e.g., clerical, housekeeping, maintenance, volunteers and janitorial staff)."</p> <p>c. On page 3, in section B. Low Risk...3., it reads: "Screening Frequency All newly hired health care workers will have a baseline two-step tuberculin skin test (TST) or one blood assay for M tuberculosis (BAMT) result. If employee has had a negative tuberculin skin test (TST) within the past year, the employee will need to supply documentation of test and then will only need to complete one</p>	S000172	<p><b>WHO</b>Identify the title of the person responsible for the corrective action and ongoing compliance.</p> <p>The Clinical Director is responsible for the corrective action and ongoing compliance for this measure.</p> <p><b>WHAT</b>Describe the action(s) taken and how the standard was addressed.</p> <p>1. Policy TM02 Employee Laboratory Screening was revised with the addition of the following as an acceptable method of TB Screening Tests for employees: "Pre-employment Interferon-gamma release assays or IGRAs; a QuantiFeron-TB Gold in-tube test (QFT-GIT) or a T-SPOT TB are the accepted IGRAs screens" Staff members identified as deficient during the survey have meet the TB Screening testing requirements with the above policy revision. 2. Housekeeping staff identified as deficient during the survey are required to submit evidence of TB screening testing by January 5, 2015 according to acceptable measures outlined in the revised policy TM02 Employee Laboratory Screening. 3. (a) Employee N3 received the QFT screening test on October 28, 2014. 3 (b) Employee N4 TB Symptom Screening form was completed by January 5, 2015. 3. (c-g) All employees are compliant</p>	01/05/2015

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	<p>TST. Each employee will be required to complete an Annual Tuberculosis Symptom Screen...".</p> <p>d. On page 4, in section V., TB Risk Assessment, it reads: "A. An evaluation of the risk for transmission of M. tuberculosis will be conducted on an annual basis, or more frequently if necessary...".</p> <p>2. Review of three contracted housekeeping staff files, N20, N21, and N22, indicated that TST information was lacking in the three files.</p> <p>3. Review of employee files indicated:</p> <p>a. N3 had a TST on 8/4/14 that was to be read between 9:40 AM on 8/6/14 and 9:40 AM on 8/7/14, but had a note that "PT DIDT (sic) HAVE IT READ".</p> <p>b. N4, hired 12/7/07, had a form "Annual Tuberculosis Symptom Screen" that was dated 5/29/13.</p> <p>c. N5 had a TST in March 2014, but lacked a second TST for a two-step procedure, or documentation of a negative TST in the previous 12 months.</p> <p>d. N6 had a TST in May 2014, but lacked a second TST for a two-step procedure, or documentation of a negative TST in the previous 12 months.</p> <p>e. N7 had a TST in August of 2014, but lacked a second TST for a two-step procedure, or documentation of a</p>		<p>with the revisions made to Policy TM02 Employee Laboratory Screening. 4. (a-c) 2014 TB Risk Assessment and TB Exposure Control Plan were updated / completed and approved by Medical Executive Committee on 11-11-14 and Governing Body on 12-18-14.</p> <p><b>WHEN</b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</p> <p>1. Policy TM02 Employee Laboratory Screening revision was completed, presented to and approved by the Infection Control Committee on 11-5-14. Presented to and approved by the Medical Executive Committee on 11-11-14. Presented to and approved by the Governing Body on 12-18-14. 2. Housekeeping staff compliant with appropriate TB Screening Testing by 01-05-14. 3. (a) N3 compliant on October 28, 2014. 3. (b) - N4 compliant on 01-05-14. 3. (c-g) - Remaining identified employees were compliant with the final approval of the revised policy on 12-18-14. 4. (a-c) - 2014 TB Risk Assessment and TB Exposure Control Plan were updated / completed and approved by Medical Executive Committee on 11-11-14 and Governing Body on 12-18-14.</p> <p><b>HOW</b>Describe how the actions described in the 'What' section were implemented and the</p>				

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S000404	<p>negative TST in the previous 12 months.</p> <p>f. N8 and N9 had a TST in January of 2014, but lacked a second TST for a two-step procedure, or documentation of a negative TST in the previous 12 months.</p> <p>g. N10, hired 6/2014, had an "Annual Tuberculosis Symptom Screen" form dated 6/16/14, but lacked a BAMT or two step TST upon hire.</p> <p>4. At 3:07 PM on 10/27/14 and 9:50 AM on 10/28/14, interview with staff member #51, the quality and PI (performance improvement) staff member, indicated:</p> <p>a. The last TB risk assessment for the facility was done 7/2013.</p> <p>b. A TB risk assessment for 2014 has not been done.</p> <p>c. A 2014 TB Exposure Control Plan has not been approved by the Governing Board and Medical Executive Committee.</p> <p>d. Staff hired in 2014 did not have two-step TB tests done, or documentation of a negative TB test within 12 months of hire and one TST done, as required by the previous TB Exposure Control Plan.</p> <p>e. Staff member N3 had no follow up done when they failed to present for the reading of the TST done on 8/4/14.</p> <p>410 IAC 15-2.5-1</p>		<p><b>process for sustaining compliance.</b></p> <p>With revisions to the policy TM02 Employee Laboratory Screening, in addition to the revised Pre-Employment Checklist, the Clinical Director will maintain compliance and ensure all newly hired employees have required documentation. Additionally, an annual review of housekeeping staff files to ensure evidence of required documentation is complete will ensure compliance is sustained. To ensure complainace the Quality Accredidaton specialist will audit new hire pre-employment records to verify all the appropriate TBscreening was completed according to policy . Quality Accreditation specialist will complete audit of all new hires for three consecutive months with a goal of 100%.</p>		

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	<p><b>INFECTION CONTROL PROGRAM</b> 410 IAC 15-2.5-1(b)</p> <p>(b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers.</p> <p>Based on document review, and interview, the infection control committee failed to maintain a written, active, and effective infection control program.</p> <p>Findings:</p> <p>1. Review of the 2013 - 2014 Infection Control Plan indicated:</p> <p>a. The signature page was signed by the Medical Director (on behalf of the governing board) and Clinical Director (on behalf of the Medical Executive Committee) on 5/14/13.</p> <p>b. There was a signature page for a 2014 - 2015 Infection Control Plan that was signed 5/12/13 by the Medical Director.</p> <p>c. On page one of the Plan, it read under "Purpose", "...the center will develop, maintain, and annually review an Infection Control plan...The plan will be approved by the Medical Executive</p>	S000404	<p><b>WHO</b>Identify the title of the person responsible for the corrective action and ongoing compliance.</p> <p>The Clinical Director with the assistance of the Quality Accreditation Specialist and the Infection Control Committee Chair are responsible for the corrective action and ongoing compliance of this measure.</p> <p><b>WHAT</b>Describe the action(s) taken and how the standard was addressed.</p> <p>1. The Facility Plans Approval Signature Page was revised to include the dates of approval by each appropriate committee, i.e. Safety Committee, Infection Control Committee, Quality Improvement Committee, Medical Executive Committee, and Governing Body. It also has a signature line for the Clinical Director, the Medical Director (as representation for the Medical Executive Committee), and the Chairmas of the Governing Body</p>	12/18/2014

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	<p>Committee as well as the Governing Body."</p> <p>d. An attachment was titled "Analysis of Infection Control Risk Assessment 2013".</p> <p>2. At 3:07 PM on 10/27/14 interview with staff member #50, the quality and PI (performance improvement) staff member, indicated:</p> <p>a. The Infection Control Plan for 2014 has not been developed and approved, only the one signed in 2013 for May of 2013 to May of 2014 has been completed and approved by the Governing Board and Medical Executive Committee.</p> <p>b. A risk assessment for a 2014 to 2015 Infection Control Plan (ICP) has not been done to be able to develop a current ICP.</p> <p>c. Currently, the facility has no ICP.</p>		<p>(as representation from the Governing Body). 2. The Infection Control Plan was revised based on the revised Infection Control Risk Assessment &amp; Analysis. It was approved to serve as the 2014 / 2015 Infection Control Plan by the Infection Control Committee on 11-5-14, the Medical Executive Committee on 11-13-14 and the Governing Body on 12-18-14.</p> <p><b>WHEN</b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</p> <p>1. The Facility Plans Approval Signature Page revision was completed on 11-12-14. 2. The Infection Control Plan, Infection Control Risk Assessment &amp; Analysis revisions were approved by the Infection Control Committee on 11-5-14, the Medical Executive Committee on 11-13-14 and the Governing Body on 12-18-14.</p> <p><b>HOW</b>Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</p> <p>The Clinical Director with the assistance of the Quality Accreditation Specialist and the Infection Control Committee Chair will ensure that an annual review of the Infection Control Risk Assessment &amp; Analysis is performed and the Infection</p>	

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S000414	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(1)</p> <p>(f) The center shall establish a committee to monitor and guide the infection control program in the center as follows:</p> <p>(1) The infection control committee shall be a center or medical staff committee, that meets at least quarterly, with membership that includes, but is not limited to, the following:</p> <p>(A) The person directly responsible for management of the infection surveillance, prevention, and control program as established in subsection (d).</p> <p>(B) A representative from the medical staff.</p> <p>(C) A representative from the nursing staff.</p> <p>(D) Consultants from other appropriate services within the center as needed.</p> <p>Based on document review and interview, the infection control committee failed to ensure that an</p>	S000414	<p>Control Plan is revised annually based on the results of the Infection Control Risk Assessment as well as other pertinent contributing factors. This review will take place during the months of December and January. This consistency will ensure sustained compliance with this measure.</p> <p><b>WHO identify the title of the person responsible for the corrective action and ongoing</b></p>	11/05/2014

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	<p>infection control committee met quarterly, as required by the 2013 - 2014 infection control plan, and Indiana licensure rules.</p> <p>Findings:</p> <p>1. Review of the May 2013 to May 2014 Infection Control Plan (ICP) indicated:</p> <p>a. On page one under "Plan Leadership and Reporting Structure", it read: "...The Infection Preventionist will oversee of the infection control program while chairing and working with the ICC (infection control committee), which will meet no less than quarterly...".</p> <p>b. On page two under "Infection Control Committee", it reads: "...The IC (infection control) Committee will meet at least quarterly...".</p> <p>2. Review of the binder of ICC meeting minutes indicated that there were none for 2014 and those for 2013 read 1st quarter, 2nd quarter, etc., but had no actual dates of the meetings listed.</p> <p>3. At 10:55 AM on 10/27/14, interview with staff member #50, the clinical director, indicated:</p> <p>a. The previous clinical director left in February 2014.</p> <p>b. This staff member was interim clinical director and was here one to two days/week from February to June of</p>		<p><b>compliance.</b></p> <p>The Clinical Director with the assistance of the Quality Accreditation Specialist and the Infection Control Committee Chair are responsible for the corrective action and ongoing compliance of this measure.</p> <p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b></p> <p>1. &amp; 2 &amp; 3 (c, e) - The Infection Control Committee will meet at least quarterly. The group has begun to use a new meeting minutes template which includes a date (mm/dd/yy), a roster of committee members present and those absent, agenda topics with subsequent points of discussion, action items, time frames, and members responsible for action items as appropriate. 3. (d) - The Medical Director has agreed to represent the medical staff on the Infection Control Committee by attending Infection Control Committee meetings, which occur at least quarterly.</p> <p><b>WHEN Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</b></p> <p>1. &amp; 2 &amp; 3 (c, e) - The Infection Control Committee met on 11-05-14 utilizing the new meeting minutes template. 3 (d) - The Medical Director attended the Infection Control Committee meeting on 11-05-14.</p>		

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S000434	<p>2014, when they became full time clinical director.</p> <p>c. The 2013 meetings are not dated to know when they occurred.</p> <p>d. A meeting was held on 10/21/14 where infection control issues were discussed, but a physician was not present so it cannot be considered to be an ICC meeting.</p> <p>e. The facility has not conducted quarterly ICC meetings in 2014, as required by the 2013 - 2014 infection control plan, and Indiana licensure rules.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(iv)</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>(iv) Aseptic technique, invasive procedures, and equipment usage.</p> <p>Based on policy and procedure review, observation, and interview, the infection</p>	S000434	<p><b>HOW</b> Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</p> <p>The Clinical Director with the assistance of the Quality Accreditation Specialist, Infection Control Committee Chair, and Medical Director will ensure compliance with this measure is sustained through a set schedule of quarterly meetings and utilizing the new meeting minutes template. In the event that the Medical Director or other committee members are unable to attend the meeting, it will be rescheduled to a date as close to the originally schedule date as possible to ensure adequate representation for the meeting.</p> <p><b>WHO</b> Identify the title of the person responsible for the corrective action and ongoing</p>	01/22/2015			

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	<p>control practitioner failed to ensure that nursing staff did not wear their surgical mask down about the neck for one private scrub nurse.</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Center Personnel Attire", PC 204, last reviewed/revised 5/2012, indicated:</p> <p>a. On page 5, under "7. Masks", it read: "1. All personnel will wear a mask, completely secured...2. A new mask must be worn for each operative procedure. 3. The mask will be changed when it becomes wet or soiled, if appropriate."</p> <p>2. At 9:00 AM on 10/28/14, it was observed that a private scrub person was sitting around the break room table with their surgical mask dangling about the neck.</p> <p>3. Interview with staff member #50, the clinical director, at 9:00 AM on 10/28/14 indicated that:</p> <p>a. Per AORN (Association of Peri Operative Nurses) standards, surgical masks should be removed at the end of a surgical procedure, and not left dangling about the neck.</p> <p>b. The private surgical scrub person should have removed their surgical mask after the operative procedure they were</p>		<p><b>compliance.</b></p> <p>The Clinical Director is responsible for the corrective action and ongoing compliance for this measure.</p> <p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b></p> <p>Policy PC 204 "Center Personnel Attire" was revised by adding the following verbiage under II.C.1.d: "d. "Masks are to be removed and not dangling around the neck, per AORN standards." Staff will be advised of the updated policy at a unit meeting on 1-22-15. An informational poster was posted in the physicians lounge and dressing rooms for additional communication to all affected personnel.</p> <p><b>WHEN Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</b></p> <p>Policy PC 204 "Center Personnel Attire" revision was completed on 12-31-14. The revised policy will be presented to the Medical Executive Committee 01-13-15 and the Governing Body on 01-15-15 for approval. Staff were advised of the updated policy at a unit meeting on 01-22-15. Information Posters were posted on 01-22-15.</p> <p><b>HOW Describe how the actions described in the 'What' section were implemented and the process for sustaining</b></p>		

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S000612	<p>involved in, and prior to entering the break room.</p> <p>c. The current policy (PC204) should have the statement that masks are not to be dangling about the neck, to be in line with AORN standards.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(1)</p> <p>(c) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows:</p> <p>(1) Medical records are documented accurately and in a timely manner, are readily accessible, and permit prompt retrieval of information.</p> <p>Based on policy and procedure review, medical record review, and interview, the facility failed to ensure the accuracy of 1 of 1 medical record for physician #60 (Pt. medical record #6).</p> <p>Findings: 1. Review of the policy and procedure "Guidelines for Maintaining the Medical Record as a Medical-legal Document", MR 04, with a last review/revision date of 6/2012, indicated: a. Under "Purpose", it reads: "The Center is committed to providing medical records that are documented in a timely,</p>	S000612	<p><b>compliance.</b> The Clinical Director will address any observations of non-compliance immediately. Compliance will be monitored and reported to the Infection Control Committee, Medical Executive Committee, and Governing Body to help ensure compliance.</p> <p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b> A universal Medication Administration Record (MAR) form is being developed to provide a single, consistent area for nurses to document medication administration. Currently medications can be documented on a number of chart forms and can lead to confusion. By moving to a single MAR form, the patient's story of medication administration is better recorded and provides clinical staff with a single reference point. The form will be completed by 01-12-15 so</p>	01/15/2015

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	<p>accurate manner...".</p> <p>2. Review of patient medical records indicated that patient #6 had documentation:</p> <p>a. On the "Pre-Op Record" form indicating that Versed 2 mg was given IV (intravenously) at 6:45 AM on 6/23/14.</p> <p>b. In the "Nurse's Notes" form that Versed 1 mg was given IV at 6:40 AM and Versed 1 mg was given IV at 7:01 AM.</p> <p>3. Interview with staff member #51, the quality/PI (performance improvement) manager, at 9:30 AM on 10/29/14, indicated:</p> <p>a. Review of the pre op record document, and nurses notes page, for patient #6 indicates that the patient received 4 mg total of Versed.</p> <p>b. Upon review of the Versed sign out sheet, the indication is that pt. #6 received a total of 2 mg Versed on 6/23/14.</p> <p>c. Documentation is not accurate in the medical record for pt. #6 as documentation makes it appear that Versed was given at 6:40 AM, 6:45 AM, and again at 7:01 AM for a total of 4 mg, when, in fact, the patient only received 2 mg total.</p>		<p>it can be presented to the Medical Executive Committee for review / approval on 01-13-15 and the Governing Body on 01-15-15.</p> <p><b>WHEN</b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</p> <p>The new Medication Administration Record (MAR) form will be completed by 01-12-15 for presentation to the Medical Executive Committee on 01-13-15 and the Governing Body on 01-15-15.</p> <p><b>HOW</b>Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</p> <p>Staff will be educated on the new form during a staff meeting on 01-22-15. Any clinical staff member not in attendance will receive individual training and documentation of training will be kept in their personnel files. Compliance with the new form will become part of the regular monthly documentation audits.</p>		

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S000630	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(d)</p> <p>(d) The medical record must contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of the patient's stay in the center and the results.</p> <p>Based on document review, observation, and interview, the center failed to ensure that the medical record (MR) accurately documented the medical and nursing care provided for 2 of 7 (PT21 and PT27) MR reviewed.</p> <p>Findings:</p> <p>1. The medical staff Rules and Regulations (approved 11-13) indicated the following: "The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient he/she admits ..." The medical staff Rules and Regulations failed to indicate a requirement for medical staff documentation to accurately describe the medical care provided at the center.</p> <p>2. The policy/procedure Guidelines for</p>	S000630	<p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b></p> <p>1. A revision to the Medical Staff Rules and Regulations included the addition of the following verbiage, which is found underlined in Section VIII: "The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient he/she admits <u>in order to provide documentation which accurately describes the medical care provided to the patient.</u> The record shall include....." 2. The policy MR04 "Guidelines for Maintaining the Medical Record as a Medical-legal Document" was revised to include the following verbiage which is found underlined in the section "PURPOSE": "The Center is committed to providing medical records that are documented in a timely manner <u>which accurately</u></p>	01/22/2015

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	<p>Maintaining the Medical record as a Medical-legal Document (approved 2-14) indicated the following: "It is the expectation of the center that practitioners and individuals documenting in the records provide accurate and legible documentation in a timely manner."</p> <p>3. MR documentation dated 9-15-14 for PT27 indicated that the patient consented for a left-sided procedure and indicated that PT27 was initially transported to the recovery area after a procedure where a nursing staff identified that bandaids observed on the right side of the spine were not consistent with the surgical consent or discharge instructions. Nursing documentation indicated that PT27 was examined by MD14 in the recovery area and indicated that MD14 discussed the procedure with PT27 before the patient returned to the OR. The Operative Report by MD14 failed to indicate that MD14 performed a right-sided procedure on PT27 and released the patient to the recovery area prior to the patient return to OR for a left-sided procedure as indicated on the surgical consent, OR record and recovery area entries by nursing staff.</p> <p>4. During an interview on 10-28-14 at 1145 hours, medical staff and governing</p>		<p><u>describes the medical care provided to the patient.</u> This policy is to facilitate the assurance of consistency in maintaining the medical record while providing confidentiality to the patient". 3 &amp; 4. Policy ADM18 "Informed Consent" was updated to include the following verbiage under V. "The surgical/procedural consent needs to clearly define the intended procedure to be performed, including site and laterality, iff applicable." A policy "Surgical Time Out" was developed to clearly separate the expectations of each team member. The policy verbiage includes the following: "The time out is to be initiated by the physician" and the circulating nurse "directly confirms from the consent" to ensure the correct procedure is performed on the correct patient. 5 &amp; 6. The Safe Surgical Checklist is being revised so that all documentation will be authenticated with the time that it was performed. Additional education will be provided to staff members on the revised form as well as the importance of the Safe Surgical Checklist and the purpose of each phase. Staff are to document on the form during the phase of care as intended.</p> <p><b>WHEN Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</b></p>				

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	<p>body member MD12 confirmed that the Informed Consent for PT27 failed to indicate the procedure performed and confirmed that the Operative Report by MD14 failed to accurately describe the course of treatment for PT27.</p> <p>5. During an observation on 10-28-14 at 0930 hours, the MR for PT21 indicated that the document titled Operating Room Safety Checklist was completed by nurse N14 including the surgical time out to be performed in the OR and PT21 was observed to be in the pre-op area prior to surgery.</p> <p>6. During an interview on 10-28-14 at 0930 hours, physician MD12 confirmed that the Operating Room Safety Checklist for PT21 was already completed by the nurse and confirmed that the patient was waiting to be seen by the MD12 in the pre-op area prior to surgery.</p>		<p>1. The Medical Staff Rules and Regulations revision will be presented to the Medical Executive Committee for approval on 01-13-15. It will be presented to the Governing Body on 01-15-15. Once approved by the Governing Body, the Medical Staff Rules and Regulations with outlined revisions will be sent electronically (within 2 weeks) to the Medical Staff for vote of approval. Medical Staff will have 14 days to respond. 2. The revision to policy MR04 was completed on 12-30-14. It will be presented to the Medical Executive Committee on 01-13-15 and the Governing Body on 01-15-15. 3 &amp; 4. Informed Consent policy revision was completed on 11-03-14. It was presented to Medical Executive Committee and approved on 11-13-14 and Governing Body on 11-18-14. 5 &amp; 6. The Safe Surgical Checklist revision will be presented to the Medical Executive Committee for approval on 01-13-15 and the Governing Body on 01-15-15. Staff education will occur at a staff meeting on 01-22-15. Staff education will occur during a staff meeting on 01-22-15.</p> <p><b>HOW Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</b></p> <p>1 - 4. In order to sustain compliance, Staff will complete</p>		

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S000640	<p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(e)(1)</p> <p>(e) All entries in the medical record must be as follows:</p> <p>(1) Legible and complete. Based on policy and procedure review, medical record review, and interview, the facility failed to ensure that 1 of 1 anesthesiologist completed their</p>	S000640	<p>an incident report to document episodes where inaccurate documentation is noted in the medical record. This will include details of the inaccuracy. This data will be tracked by the Clinical Director and reported to the Medical Director and Medical Executive Committee. Any trends of non-compliance will be handled by the Medical Director and reported to the Governing Body. 5 &amp; 6. The Clinical Director will perform random observations of staff during each phase of care to ensure compliance of proper use and documentation on the Safe Surgical Checklist form. Any observations of non-compliance will be discussed with the staff member involved immediately. These incidents will be tracked by the Clinical Director and reported to the Medical Executive Committee. Any trends of non-compliance will be reported to the Governing Body.</p> <p><b>WHO</b>Identify the title of the person responsible for the corrective action and ongoing compliance. The Medical Director with the</p>	01/05/2015

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	<p>anesthesia record form for pt. #10 (Anesthesiologist #62).</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Authentication and Completion of Medical Records", MR 16, with a last review/revision date of 11/2012, indicated:</p> <p>a. Under "Procedure", it read in section B.: "...All chart orders and sections must be completed...".</p> <p>2. Review of the policy and procedure "Guidelines for Maintaining the Medical Record as a Medical-legal Document", MR 04, with a last review/revision date of 6/2012, indicated:</p> <p>a. Under "Procedure", it read: "H. All blanks should be completed on special forms:...".</p> <p>3. Review of medical records indicated:</p> <p>a. Anesthesiologist #62 only cared for patient #10 (out of 13 patients, nine of which received a general anesthesia).</p> <p>b. The "Anesthesia Record" form for pt. #10 (who had a general anesthesia) was incomplete for the "Time" of the pre operative anesthesia evaluation, the "Reassessment in OR (operating room) Prior to Induction" (to indicate the patient's "Status Changed" or "Unchanged"), the "Postoperative</p>		<p>assistance of the Clinical Director is responsible for the corrective action and ongoing compliance for this measure.</p> <p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b></p> <p>* An educational poster was created to remind all physicians of the requirement of completing medical records appropriately in accordance with the Medical Staff Bylaws Section 7.3.3 as well as the Medical Staff Rules and Regulations section VIII, and policy MR04 "Guidelines for Maintaining the Medical Record as a Medical-legal Document". This poster was placed in the physician's lounge and changing rooms. * The poster also reminds physicians that proper authentication requires a signature, date, and time.</p> <p><b>WHEN Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</b></p> <p>The educational poster was completed and displayed on 01-05-15.</p> <p><b>HOW Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</b></p> <p>Data for medical record deficiencies will be provided to the Clinical Director from staff audits as well as quarterly</p>	

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S000658	<p>Anesthesia Note", the area "Anesthesia Complications" (to mark yes, or no), whether the patient was "Awake, Arousable, Extubated in the OR or PACU (post anesthesia care unit), and the "Time" of the post op vital signs.</p> <p>4. At 9: 30 AM on 10/29/14, interview with staff member #51, the quality and PI (performance improvement) staff member, indicated:</p> <p>a. It is expected that the anesthesiologists will complete all areas of their "Anesthesia Record" form.</p> <p>b. Anesthesiologist #62 failed to complete the "Anesthesia Record" form for pt. #10, as listed in 3. b., above, as required by facility policy.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(f)(6)</p> <p>All patient records must document and contain, at a minimum, the following:</p> <p>(6) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law.</p> <p>Based on document review, observation,</p>	S000658	<p>reviews from a contracted medical record reviewer. The Clinical Director will track medical record deficiencies for trends. These trends will be reported to the Medical Executive Committee and the Governing Body and will be one element that is presented for consideration for each physician during the reappointment process.</p> <p><b>WHO identify the title of the person responsible for the</b></p>	01/30/2015

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	<p>and interview, the center failed to ensure that appropriate documentation of informed consent is present in the medical record for 12 of 17 ( PT01, PT02, PT03, PT04, PT05, PT07, PT08, PT09, PT10, PT22, PT25 and PT27) medical records (MR) reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The medical staff Rules and Regulations (approved 11-13) indicated the following: "All physician entries into medical record must be dated, timed, and signed when entry is made to verify compliance ..."</li> <li>The policy/procedure Informed Consent (approved 2-14) indicated the following: "The consent form should be signed, dated, and witnessed." The policy/procedure failed to indicate a requirement for documenting a time when signing and dating the informed consent to verify that consent was obtained prior to a procedure being performed.</li> <li>The Informed Consent for PT22, PT25 and PT27 failed to indicate a date or time when signed by the physician to document that the consent was properly executed prior to the procedure and failed to indicate the correct name of the center</li> </ol>		<p><b>corrective action and ongoing compliance.</b> The Clinical Director is responsible for the corrective action and ongoing compliance for this measure.</p> <p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b> 1-3. * Policy ADM 18 Informed Consent was revised to include verbiage that proper authentication requires signature, date, and time prior to the start of the procedure. * An educational poster was posted in the physician's lounge on 09-16-14 to remind all physicians of the requirement of completing medical records appropriately in accordance with the Medical Staff Bylaws Section 7.3.3 as well as the Medical Staff Rules and Regulations section VII &amp; VIII, and policy MR04 "Guidelines for Maintaining the Medical Record as a Medical-legal Document". This poster was posted in the physician's lounge and changing rooms. The poster also reminds physicians that proper authentication requires a signature, date, and time as well as a reminder that telephone orders or verbal orders must be authenticated as soon as possible but not later than 30 days. * A "hard stop" was implemented to not allow a patient to proceed to the operating room until the informed consent has been signed, dated, and timed by the</p>				

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	<p>where services were being provided.</p> <p>4. The Informed Consent for PT01, PT02, PT03, PT04, PT05, PT07, PT08, PT09 and PT10 failed to indicate the correct name of the center where services were being provided.</p> <p>5. During an interview on 10-29-14 at 1645 hours, QA manager A3 confirmed that the Informed Consent for PT22, PT25, and PT27 failed to indicate a date or time when signed by the physician, the patient, or the witness and confirmed that the Informed Consent documentation failed to indicate the correct name of the center where services were being provided.</p>		<p>physician. 4-5. The Informed Consent form is being revised to include the correct name of Premier Surgery Center. The new form will be presented to the Medical Executive Committee for approval on 01-13-15 and the Governing Body on 01-15-15.</p> <p><b>WHEN</b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</p> <p>1-3. * The policy ADM18 "Informed Consent" was completed and presented to Medical Executive Committee and approved on 11-13-14 and approved by Governing Body on 12-18-14. The educational poster for physicians was completed and displayed on 01-05-15. Nurses were educated on the new process of flagging forms when verbal / telephone orders are missing a physician signature at the staff meeting on 01-22-15.</p> <p>4-5. The Informed Consent form revision will be presented to the Medical Executive Committee on 01-13-15 and the Governing Body on 01-15-15. The forms will be printed and implemented by 01-30-15.</p> <p><b>HOW</b>Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</p> <p>2. Clinical staff have been educated that no patient will be</p>		

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S000772	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(M)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(M) A requirement that a medical history and physical examination be performed as follows:</p> <p>(i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed.</p>		<p>taken to the OR unless the informed consent is completed properly including physician signature, date, and time in order to ensure compliance with this measure. * Data for medical record deficiencies will be provided to the Clinical Director from monthly medical record audits as well as quarterly reviews from a contracted medical record reviewer. The Clinical Director will track medical record deficiencies for trends. These trends will be reported to the Medical Executive Committee and the Governing Body and will be one element that is presented for consideration for each physician during the reappointment process.</p>		

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	<p>(ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff.</p> <p>(iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy.</p> <p>Based on document review and interview, the medical staff failed to enforce its medical staff bylaws, rules and regulations regarding documentation of history and physical exams for 4 of 7 ( PT22, PT23, PT25 and PT27) medical records (MR) reviewed.</p> <p>Findings:</p> <p>1. The medical staff Rules and Regulations (approved 11-13) indicated the following: "All physician entries into medical record must be dated, timed, and signed when entry is made to verify compliance of chart completion ...The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient he/she admits ..."</p> <p>2. The History and Physical for PT22, PT23, PT25 and PT27 failed to indicate a</p>	S000772	<p><b>WHO</b>Identify the title of the person responsible for the corrective action and ongoing compliance.</p> <p>The Clinical Director is responsible for the corrective action and ongoing compliance for this measure.</p> <p><b>WHAT</b>Describe the action(s) taken and how the standard was addressed.</p> <p>An educational poster was created to remind all physicians of the requirement of completing medical records appropriately in accordance with the Medical Staff Bylaws Section 7.3.3 as well as the Medical Staff Rules and Regulations section VII &amp; VIII, and policy MR04 "Guidelines for Maintaining the Medical Record as a Medical-legal Document". This poster was placed in the physician's lounge and changing rooms. * The poster also reminds physicians that proper authentication requires a signature, date, and time.</p> <p><b>WHEN</b>Indicate a date</p>	01/05/2015

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S000780	<p>date and/or time when signed by the physician to document that the H&amp;P was completed prior to the procedure.</p> <p>3. During an interview on 10-29-14 at 1645 hours, QA manager A3 confirmed that the History and Physical for PT22, PT23, PT25, and PT27 failed to indicate a date and/or time when signed by the physician.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(N)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(N) A requirement that all practitioner orders are in writing or acceptable computerized form and must</p>		<p><b>when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</b></p> <p>The educational poster was completed and displayed on 01-05-15.</p> <p><b>HOW Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</b></p> <p>Data for medical record deficiencies will be provided to the Clinical Director from staff audits as well as quarterly reviews from a contracted medical record reviewer. The Clinical Director will track medical record deficiencies for trends. These trends will be reported to the Medical Executive Committee and the Governing Body and will be one element that is presented for consideration for each physician during the reappointment process.</p>		

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	<p>be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days.</p> <p>Based on policy and procedure review, medical staff rules and regulations review, medical record review, and staff interview, the medical staff failed to ensure that physicians authenticated telephone orders per their rules and regulations for 1 of 1 patient cared for by physician #60 (pt. #6) and 2 of 2 patients cared for by physician #61 (Pts. #7 and #10) and failed to ensure orders indicated a date or time when signed by the physician (MD14) for 3 (PT22, PT25, and PT27) of 3 medical records (MR) reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the policy and procedure "Medicine and/or Physician's Orders", PC 338, last reviewed/revised 12/2012, indicated: <ol style="list-style-type: none"> <li>On page two, in section 9., it reads: "Telephone orders are to be indicated with a T.O....The ordering physician must sign off on the order when available."</li> </ol> </li> <li>Review of the medical staff rules and regulations, last approved on 11/12/13, indicated: <ol style="list-style-type: none"> <li>Under section "VII.", it reads: "...All</li> </ol> </li> </ol>	S000780	<p><b>WHO</b>Identify the title of the person responsible for the corrective action and ongoing compliance.</p> <p>The Medical Director and The Clinical Director are responsible for the corrective action and ongoing compliance for this measure.</p> <p><b>WHAT</b>Describe the action(s) taken and how the standard was addressed.</p> <p>* An educational poster was created to remind all physicians of the requirement of completing medical records appropriately in accordance with the Medical Staff Bylaws Section 7.3.3 as well as the Medical Staff Rules and Regulations section VII &amp; VIII, and policy MR04 "Guidelines for Maintaining the Medical Record as a Medical-legal Document". This poster was placed in the physician's lounge and changing rooms. The poster also reminds physicians that proper authentication requires a signature, date, and time and also reminds that telephone orders or verbal orders must be authenticated as soon as possible but not later than 30 days.* Staff were reminded to review charts and flag areas where charting deficiencies exist so that they can</p>	01/08/2015

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	<p>orders shall be in writing. An order shall be considered to be in writing if dictated to a registered nurse and signed by the attending physician. All orders on the patient chart must be signed, dated and timed by physician when available. All physician entries into the medical record must be dated, timed and signed when entry is made to verify compliance of chart completion within thirty (30) days."</p> <p>3. Review of medical records indicated:</p> <p>a. Patient #6 had surgery on 6/23/14 by physician #60 , with a telephone order written at 10 AM that day, that has not been authenticated.</p> <p>b. Patient #7 had surgery on 6/19/14 by physician #61, with a telephone order at 2:15 PM that day, that has not been authenticated.</p> <p>c. Patient #10 had surgery by physician #61 on 1/28/14 and had telephone orders at 8:40 AM and 9:15 AM that day, that are not authenticated.</p> <p>4. At 9:30 AM on 10/29/14, interview with staff member #51, the quality and PI (performance improvement) staff member, indicated:</p> <p>a. The telephone orders for patients #6, #7, and #10, as listed in 2. above, should have been authenticated by the physicians who ordered them, within 30 days, as per the medical staff rules and regulations.</p>		<p>be placed for physicians to review and complete.* When a verbal / telephone order is received and the physician is out of the Center, the nurse receiving the order will place a flag on the order form to designate that a physician signature is required. This will alert the medical records personnel to place the chart in the appropriate physician's file for outstanding documentation that needs to be completed.</p> <p><b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</b></p> <p>* The educational poster was completed and displayed on 01-05-15.* The staff were educated on the process for flagging charts which have verbal / telephone orders with an outstanding physician signature at a staff meeting on 01-08-15.</p> <p><b>HOWDescribe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</b></p> <p>Data for medical record deficiencies will be provided to the Clinical Director from staff audits as well as quarterly reviews from a contracted medical record reviewer. The Clinical Director will track medical record deficiencies for trends. These trends will be reported to the Medical Executive Committee and the Governing Body and will</p>				

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S000882	<p>5. The medical staff Rules and Regulations (approved 11-13) indicated the following: "All physician entries into medical record must be dated, timed, and signed when entry is made to verify compliance of chart completion ..."</p> <p>6. Physician orders by MD14 for PT22 (date of service 9-15-14), PT27 (date of service 9-15-14) and PT25 (date of service 10-02-14) failed to indicate that the physician had dated or timed the orders.</p> <p>7. During an interview on 10-29-14 at 1640 hours, quality manager A3 confirmed that the MR orders failed to indicate a date or time when signed by MD14.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(D)</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>(D) A requirement for adequate</p>		be one element that is presented for consideration for each physician during the reappointment process.				

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	<p>provision of immediate postoperative care.</p> <p>Based on document review and interview, the center failed to follow its policy/procedures and ensure that required emergency supplies and equipment were maintained and available for use if needed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The policy/procedure Crash Cart (approved 2-14) indicated the following: "The crash cart will be checked for completeness according to the emergency crash cart checklist on the cart. All drugs on the cart are checked according to the Drug Checklist (see attached list) for expiration dates..The employee checks the cart according to the crash cart list and is personally responsible for assuring its completeness..."</li> <li>The policy/procedure Medication Ordering and Distribution (approved 2-14) indicated the following: "Expiration dates are checked on a monthly basis."</li> <li>Center documentation titled Adult Emergency Cart Checklist dated August 2014, September 2014 and October 2014 failed to indicate a staff signature and date of completion for the monthly crash</li> </ol>	S000882	<p><b>WHO</b>Identify the title of the person responsible for the corrective action and ongoing compliance. The Clinical Director is responsible for the corrective action and ongoing compliance for this measure.</p> <p><b>WHAT</b>Describe the action(s) taken and how the standard was addressed. 1-3. The Adult Emergency Cart Checklist was revised to include a place for the staff members initials/signature and date of when the cart was checked.4-5. The Code CartDrug Checklist was revised to include a staff members' initials/signature and date of completion for the monthly expiration date verification.</p> <p><b>WHEN</b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action. The Adult Emergency Cart Checklist and the Code Cart Drug Checklist was revised on 01-05-15. Staff were educated on 01-08-15.</p> <p><b>HOW</b>Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance. The Clinical Director will ensure ongoing compliance by performing random checks</p>	01/08/2015

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S001146	<p>cart checks.</p> <p>4. Center documentation titled Code Cart Drug Checklist failed to indicate a staff signature or initials and date of completion for the monthly expiration date verification.</p> <p>5. During an interview on 10-28-14 at 1445 hours, quality manager A3 and clinical director A6 confirmed that the crash cart documentation failed to indicate that the emergency equipment and supplies were maintained and available for use in the event of an emergency.</p> <p>410I AC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(2)</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>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p> <p>Based on document review, observation, and interview, the facility failed to ensure that no condition was created that might</p>	S001146	<p>throughout the month to ensure that the checklists are being completed appropriately. This will be reported to the Medical Executive Committee.</p> <p><b>WHO identify the title of the person responsible for the corrective action and ongoing compliance.</b></p>	01/30/2015			

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	<p>be a hazard to patients in regard to expired sutures in the surgical supply, storage, area.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the forms "OR (operating room) Daily Checklist", indicated that the surgical storage room/area is not listed on the two page form where nursing staff checks various areas when "Opening" and "Closing" on each surgery day.</li> <li>At 9:50 AM on 10/28/14, while touring the surgery area of the facility, it was observed that &gt;15 packages of TriCon Suture, 4-0, had expired 7/14.</li> <li>At 10:00 AM on 10/28/14 and 10:45 AM on 10/29/14, interview with staff member #51, the quality/PI (performance improvement) staff person, indicated: <ol style="list-style-type: none"> <li>The box of TriCon suture had expired in July of 2014.</li> <li>There is no policy/procedure related to checking for outdated supplies.</li> <li>The form "OR Daily Checklist" does not address periodic checking for expiration dates on supplies.</li> </ol> </li> </ol>		<p>The Clinical Director is responsible for the corrective action and ongoing compliance for this measure.</p> <p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b></p> <p>* The policy ADM 28 "Supplies - Inventory, Ordering, and Monitoring" was revised with the addition of the following verbiage under Section D which is underlined: "Expired items are removed from storage areas through a regular, systematic process. <u>Staff will document on the appropriate checklist whenever a review of supplies for expired items is performed (not less than monthly).</u> Items that have expired will be disposed of properly.* Staff will develop a checklist to document the surveillance activities of checking supplies for outdates, sterile packaging intact, etc. which will include the date and staff initials / signature completing the activity.</p> <p><b>WHEN Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</b></p> <p>The policy ADM 28 was revised on 12-31-14. It will be presented to the Medical Executive Committee on 01-13-15 and the Governing Body on 01-15-15 for approval. Following the appropriate approvals, staff will be educated at a staff meeting on 01-22-15 and the new process</p>				

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S001172	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)</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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following: Based on observation and interview, the contracted building management services failed to maintain the break room and recovery room ceiling ventilation grilles and ductwork in a sanitary condition without the presence of dust and particulate matter.</p>	S001172	<p>will begin by 01-30-15. <b>HOW</b> Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance. The Clinical Director will monitor ongoing compliance through random observations of the checklist and random checks of supplies for outdates at least quarterly. These activities will be reported to the Medical Executive Committee.</p> <p><b>WHO</b> Identify the title of the person responsible for the corrective action and ongoing compliance. The Clinical Director is responsible for the corrective action and ongoing compliance for this measure. <b>WHAT</b> Describe the action(s)</p>	12/30/2014	

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	<p>Findings:</p> <ol style="list-style-type: none"> <li>1. During an observation on 10-27-14 at 1450 hours, the following condition was observed in the employee break room area of the center: A heavy accumulation of dust and particulate material was observed in the gaps between the ceiling 24" x 24" ventilation grille.</li> <li>2. During an interview on 10-27-14 at 1450 hours, building management staff A4 and A5 confirmed the break room observation of accumulated dust on the ventilation grille.</li> <li>3. During an observation on 10-28-14 at 0945 hours, the following condition was observed in the recovery room area between bay 2 and bay 9: A heavy accumulation of dust and particulate material was observed in the gaps between the ceiling 24" x 24" ventilation grille.</li> <li>3. During an interview on 10-28-14 at 0945 hours, building management staff A4 and A5 confirmed the recovery room observation of accumulated dust on the ventilation grille and confirmed that the ductwork had not been maintained in a sanitary condition.</li> </ol>		<p><b>taken and how the standard was addressed.</b></p> <p>1-2. The contracted housekeeping staff was contacted regarding the accumulation of dust and particulate material as identified by the surveyors. All areas of concern were cleaned prior to the surveyors exiting the building. The Clinical Director spoke with the contracted service's supervisor and cleaning of the ventilation grilles was added to the cleaning responsibilities with an appropriate frequency. 3. The contracted building management staff has a preventive maintenance schedule for air handler filters. The dust was noted on return air grilles which are located before the air filtration portion of the ductwork; therefore it is not unusual to have dust accumulate on these grilles. An increased frequency of cleaning will take care of the problem.</p> <p><b>WHEN</b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</p> <p>Cleaning of the ventilation grilles and frequency was added to the contracted services' cleaning responsibilities on 12-30-14.</p> <p><b>HOW</b>Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</p> <p>The Clinical Director will perform</p>				

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S001174	<p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(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>(5) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, must be kept clean and orderly in accordance with current standards of practice, including the following:</p> <p>(A) Environmental services must be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following:</p> <p>(i) Asepsis. (ii) Cross-contamination prevention. (iii) Safe practice.</p> <p>Based on policy and procedure review, observation, and interview, the facility failed to ensure the cleanliness in both men's and women's dressing rooms, failed to update the environmental cleaning policy when a change in cleaning product occurred, and failed to</p>	S001174	<p>quarterly rounds to include observation of the ventilation ducts for dust buildup to sustain compliance with this measure.</p> <p><b>WHO identify the title of the person responsible for the corrective action and ongoing compliance.</b> The Clinical Director, with the assistance of the Infection Prevention Committee chair, is responsible for the corrective</p>	01/15/2015

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	<p>give oversight to the contracted housekeeping staff.</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Environmental Cleaning", EC 40, last date reviewed/revised 2/2012, (signature page of the policy binder indicated that all policies were reviewed on 2/11/14) indicated:</p> <p>a. On page one under "Supplies", it read: "Micro Fiber container with diluted SaniMaster 4 (1 oz. per gallon of water),...".</p> <p>b. On page 2 under "3. Terminal Bed Sanitizing", it read: "A. Using, SaniMaster 4 solution...".</p> <p>c. On page 3 under "4. Floor Sanitizing", it read: "A. Using SaniMaster 4 solution, run the mop around the perimeter of the room,...".</p> <p>2. At 2:05 PM on 10/27/14, while on tour of the surgery area of the facility, it was observed that the housekeeping closet contained Wayne Concept 256 for cleaning, and that no SaniMaster 4 was seen.</p> <p>3. At 2:05 PM on 10/27/14, interview with staff member #52, the contracted housekeeper, indicated:</p> <p>a. The cleaning product used on all surfaces (beds, floors, walls, ceilings,</p>		<p>action and ongoing compliance for this measure.</p> <p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b></p> <p>1-3 &amp; 6. The policy EC40 "Environmental Cleaning" was revised. Where verbiage noted a specific cleaning chemical name it was changed to indicated the type of cleaning chemical, i.e. "SaniMaster 4" was replaced with "approved low level disinfectant". A list of approved cleaning, disinfecting, and sanitizing chemical products was added to the policy which includes the approved product name, approved use, and directions. This will reflect the current practice of the center. The Infection Control Committee will add an agenda item to their quarterly meetings to address and changes in cleaning products.4-5 (a-c). The contracted housekeeping staff was contacted regarding the accumulation of dust and particulate material as identified by the surveyors. All areas of concern were cleaned prior to the surveyors exiting the building. The Clinical Director spoke with the contracted service's supervisor and cleaning of the locker rooms and this was added to the cleaning responsibilities with an appropriate frequency. 5 (d). The Clinical Director, or designee, will perform unannounced observations of</p>				

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	<p>countertops) is Wayne Concept 256, an EPA approved, hospital grade disinfectant.</p> <p>b. The Wayne Concept product has been used at this facility for "a few years".</p> <p>c. This staff member is responsible for the cleaning of the men's and women's dressing/locker rooms.</p> <p>4. At 2:00 PM on 10/27/14, it was observed in the women's and men's dressing rooms that there was a large accumulation of dust on the tops of the lockers in both rooms.</p> <p>5. At 2:02 PM on 10/27/14, interview with staff member #50, the clinical director, indicated:</p> <p>a. It was agreed that the lockers were very dusty.</p> <p>b. It is the responsibility of the contracted housekeeping staff to clean the locker rooms.</p> <p>c. This staff member began in their role in June of 2014, but was interim clinical director (on a part time basis) since February 2014.</p> <p>d. This staff member has never visually observed the contracted housekeeping staff, when they are working, to see that they are cleaning per facility expectations.</p>		<p>cleaning process at least quarterly to evaluate the appropriateness of cleaning and that proper policies and procedures are being performed. These evaluations will be documented and reported to the Infection Control Committee.</p> <p><b>WHEN</b>Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action. 1-3 &amp; 6. The policy EC40 was revised on 12-30-14. It will be presented to the Medical Executive Committee on 01-13-15 and the Governing Body on 01-15-15 for approval. 4-5 (a-c). The cleaning of the locker rooms and frequency was added to the contracted services' cleaning responsibilities on 12-30-14. 5 (d). The observations of the housekeeping personnel will begin by 01-12-15.</p> <p><b>HOW</b>Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance. 1-3 &amp;6. The Infection Control Committee will review cleaning, disinfecting, and sanitizing products for approval prior to using the chemicals. This will help to ensure ongoing compliance with a current list of approved products.4-5 (a-c). The Clinical Director will perform quarterly rounds to include observation of the ventilation ducts for dust</p>	

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S001198	<p>6. At 4:12 PM on 10/27/14, interview with staff member #51, the quality and PI (performance improvement) staff member, indicated:</p> <p>a. The EC 40 policy does not indicate the proper disinfectant to be used in cleaning the facility.</p> <p>b. This staff member is "not sure" when the facility changed from SaniMaster to Wayne Concept, but it was "a long time ago".</p> <p>c. When all policies were approved in February of 2014, a change to the policy EC 40 should have taken place at that time.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(c)(6)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(6) Emergency and disaster preparedness coordinated with appropriate community, state, and federal agencies.</p> <p>Based 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>	S001198	<p>buildup to sustain compliance with this measure.5 (d). The cleaning observations will be reported to the Infection Control Committee to ensure ongoing compliance.</p> <p><b>WHO identify the title of the person responsible for the corrective action and ongoing compliance.</b> The Clinical Director is responsible for the corrective action and ongoing compliance for this measure.</p>	11/11/2014	

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	<p>1. On 10-27-14 at 1015 hours, staff A1 was requested to provide documentation of emergency and disaster management drills and evidence of participation with appropriate local, state, and federal agencies and none was provided prior to exit.</p> <p>2. The policy/procedure Security/Safety Management Plan (approved 8-13) indicated the following: "The Safety Officer is responsible for the development, implementation and monitoring of safety management programs. The Safety Officer has the authority and responsibility to act in the event of an emergency and to activate any necessary emergency procedures. The Safety Officer shall collect data related to the center 's established safety management plans ..."</p> <p>3. During an interview on 10-29-14 at 1240 hours, clinical director A2 indicated that no emergency preparedness drill had been performed in 2014 and confirmed that no documentation of participation and/or coordination with a local, regional or other emergency preparedness agency was available.</p> <p>4. During an interview on 10-29-14 at 1440 hours, the safety officer A7 confirmed that no documentation of a recent center disaster preparedness drill or exercise with an emergency preparedness agency was available.</p>		<p><b>WHAT Describe the action(s) taken and how the standard was addressed.</b></p> <p>* The Center registers each year with the Fort Wayne - Allen County office of Homeland Security to notify them of our willingness to participate in disaster situations and the types and amounts of resources we have at the Center. That was last updated April 2014.* The Center participated in conjunction with Parkview Regional Medical Center in a disaster training event on 11-11-14.* The Center has partnered with Parkview Regional Medical Center's Safety Coordinator to be involved in planning and participate in future disaster training or drill opportunities.</p> <p><b>WHEN Indicate a date when each action was or will be completed. If multiple actions are noted, specific dates must correlate to the specific action.</b></p> <p>The disaster drill with Parkview Regional Medical Center occurred on 11-11-14.</p> <p><b>HOW Describe how the actions described in the 'What' section were implemented and the process for sustaining compliance.</b></p> <p>Emergency Preparedness Activities has been added as a standing agenda item for the Safety Committee to discuss at each Safety Committee meeting to help ensure ongoing compliance and knowledge of the</p>		

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

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FORM APPROVED

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			activities the Center is involved with.		