

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001047	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/08/2015
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NAME OF PROVIDER OR SUPPLIER  WHITEWATER SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 CHESTER BLVD RICHMOND, IN 47374
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S 0000  Bldg. 00	This visit was for a State licensure survey.  Facility Number: 001222  Survey Date: 7-6/8-2015  QA: cjl 07/20/15	S 0000		
S 0103  Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(a)(1)(B)  The governing body shall do the following:  (1) Ensure that the center: (B) makes available to the commissioner or representatives of the department upon request all reports, records, minutes, documentation, information, and files required for licensure.  Based on document review, observation and interview, the facility failed to ensure someone was available to provide access to the facility to the commissioner's representatives of the department, failed to provide documentation necessary to conduct a state licensure survey, and failed to inform the Indiana State	S 0103	Effective immediately Practice Manager or Clinical Director, will notify the Indiana State Department of Health via e-mail or phone call in the event the facility will be closed on a normally operative day. The Administrator, Medical Director and Clinical Director will discuss ASC dates of closure in advance	07/22/2015

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>Department of Health that it would be closed on a day it was normally open, in 1 instance.</p> <p>Findings:</p> <p>1. On July 6, 2015 at 9:55 am, the commissioner's representatives arrived at the facility to enter the facility to begin a State licensure survey.</p> <p>2. On July 6, 2015 at 9:55 am, review of the front door area indicated there were times posted indicating the facility was Open M-F 8-5. Review of a sign on the front door indicated in observation of Independence Day, call (listed number) if you have an urgent matter. It was observed when the commissioner's representative attempted to open the front door, it was locked and the representatives could not enter the facility. It was also observed there were no other vehicles in the facility's parking area.</p> <p>2. On July 6, 2014 at 9:57 am, the commissioner's representative made a telephone call to the representative's supervisor and in telephone interview, the supervisor was informed of the situation. The supervisor indicated the department had received no communication that the facility would be closed on a day when it</p>		<p>to ensure the Practice Manager or Clinical Director notifies ISDH. <b>Monitor:</b>The Clinical Director will ensure the ISDH was contacted regarding days the office is closed.</p>	

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S 0110 Bldg. 00	<p>was normally open.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5)</p> <p>The governing body shall do the following:</p> <p>(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.</p> <p>Based on document review and interview, the facility's governing board failed to review reports of the quality assessment performance improvement (QAPI) program for 1 (first quarter) of 4 quarters in calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the governing board meeting minutes for calendar year 2014 indicated the governing board reviewed QAPI activities on May 19, July 16, and October 17, but none in the first quarter of year 2014.</li> <li>In interview, on 7-8-2015 at 3:20 pm,</li> </ol>	S 0110	<p>Effective immediately the Clinical Director, has set quarterly QAPI meetings on the first Thursday of each quarter in January, April, July, &amp; October. These meeting minutes will be presented to the Governing Board on the last Tuesday of each quarter in January, April, July &amp; October reporting results from previous quarter for approval. <b>Monitor:</b> The Clinical Director will notify the Governing Body of pre-scheduled dates for GB meetings. E-mail reminders will be sent one week prior to every meeting. The Clinical director will ensure GB meetings are held and GB meeting minutes include documentation of the QAPI program.</p>	07/30/2015

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S 0153 Bldg. 00	<p>employee #A1, Clinical Director, confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(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 document review and interview, the chief executive officer failed to ensure that the contracted cleaning staff were oriented to facility policies and processes for cleaning the surgery suites, pre, and post op areas of the facility.</p> <p>Findings: 1. Review of the staff, and contracted, employee files indicated there was no file for staff member #58, the contracted housekeeper.</p>	S 0153	<p>Effective August 10, 2015 the new housekeeping company were given a tour and instructions regarding our policies &amp; procedures by the Clinical Director. The Infection Control Coordinator will assemble a file for the contracted housekeeping staff by August 19, 2015. This file will include immunizations, documentation of orientation to the facility, initial and annual follow up training on how to terminally clean the surgery center. Annual training will be done by the Infection Control Coordinator.</p> <p><b>Monitor:</b> The Clinical Director or</p>	08/19/2015

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	<p>2. At 5:30 PM on 7/7/15, interview with contracted staff member #58 indicated:</p> <p>a. This staff member has been cleaning here for several months.</p> <p>b. Staff member #58 stated they use 5 oz of Spartan product's "HDQ Neutral" in 1 gallon of water when the bottle indicates 1 oz/gallon is the dilution rate.</p> <p>c. When asked how often the walls and ceilings of the facility are washed/disinfected, the staff member did not know and deferred to the company owner.</p> <p>d. Staff member #58 stated they use a Spartan product "Spar creme" on sinks and counter tops.</p> <p>3. At 10:30 AM on 7/8/15, interview with the infection control practitioner, #52, and the clinic director, #50, indicated:</p> <p>a. The facility does not have an employee file, or any documentation, that would indicate there was orientation and training of staff member #58, nor does the contracted housekeeping company have any such documentation.</p> <p>b. Spartan's "Spar creme" is not to be used on counter tops, the HDQ product is to be used.</p> <p>c. Spartan's HDQ Neutral is not to be used with 5 oz/gallon.</p> <p>d. It was not known by staff members #50 and #52 that staff member #58 was</p>		<p>an assigned staff member will perform quarterly unannounced visits on an ongoing basis to evaluate housekeeping performance. Documentation of visits and findings will be reported at the quarterly Infection Control Committee and Governing Body meetings.</p>	

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S 0162  Bldg. 00	<p>using products incorrectly as no observations of their process had been observed by them.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (c)(5) (G)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care.</p> <p>Based on document review and interview, the chief executive officer failed to ensure the CPR (cardio pulmonary resuscitation) competence of 3 of 8 employees (Staff members N1, N3, and N6).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of the job descriptions for an "Instrument Technician", and for nursing staff, indicated in the "Minimum Requirements" section: "...Current BLS (basic life support)."</li> <li>2. Review of employee records</li> </ol>	S 0162	Effective August 4, 2015 a BLS class will be conducted at this facility given by an RN, current BLS instructor, for the 3 of 8 employees (N1, N3 and N6) as required by their job descriptions. Upon successful completion of the course current certification cards will be filed in their personnel file. <b>Monitor:</b> The Clinical Director or designated personnel will monitor all personnel files and complete a dashboard indicating the expiration dates of all required certification cards. Staff will be instructed to complete a BLS training/certification course prior	08/04/2015

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S 0212	<p>410 IAC 15-2.4-1</p> <p>indicated:</p> <p>a. Staff member N1 was hired 1/6/14 as a LPN (licensed practical nurse) and had documentation that their CPR certification ended/expired 3/31/15.</p> <p>b. Staff member N3 was a surgical/instrument tech hired 3/3/15 who had no documentation of having CPR certification.</p> <p>c. Staff member N6 was a surgical/instrument tech hired 1/6/15 whose CPR certification had expired "March 2015" per the card copy located in their employee file.</p> <p>3. At 12:05 PM on 7/8/15, interview with staff member #50, the clinic director, indicated:</p> <p>a. It was unknown that the instrument techs were required to have CPR, per their job descriptions, as they do not do direct patient care.</p> <p>b. Staff member N1 has changed positions and now works front desk, they do not work as a LPN/nurse and do not provide direct patient care, but currently the job description still requires BLS competence.</p> <p>c. Per the job descriptions, as listed in 2. above, N1, N3, and N6 are required to have current BLS/CPR, and they do not.</p>		to the expiration date of the current card.	

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Bldg. 00	<p>GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(d)(2)(A &amp; B)</p> <p>(d) In accordance with center policy, the governing body shall do the following:</p> <p>(2) Ensure the following:</p> <p>(A) The center develops, implements, and maintains written medical staff policies and procedures for emergencies, initial treatment, and transfer.</p> <p>(B) The center provides immediate lifesaving measures within the scope of service available, to all persons in the center, to include, but not be limited to, the following:</p> <p>(i) Timely assessment. (ii) Basic life support. (iii) Proper transfer mode.</p> <p>Based on document review and interview, the facility failed to implement its policy related to patient transfers for 1 of 1 patients who was transferred, pt. #19.</p> <p>Findings: 1. Review of the policy "Interfacility Transfer: Non-Emergency, no policy number, last approved 7/2014, indicated: a. Staff were to: "Complete the Interactivity Transfer Non-Emergency Form in duplicate. Place the transfer documentation in an envelope..."</p>	S 0212	<p>Effective 7/17/15 a mandatory skills day, organized by the clinical director, was attended by 50% of the nursing staff which included an inservice regarding the Interfacility Transfer: Non-Emergency policy including the requirement to complete the interactivity transfer non-emergency form in duplicate and sending a copy of the information to the receiving facility. Any staff not in attendance was e-mailed this information and a copy of this e-mail was placed in the management communication</p>	08/13/2015
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S 0230 Bldg. 00	<p>b. On page 2 under "Transfer Documentation", it reads; "...An Interfacility Transfer Non-Emergency Form is to be completed by the nursing staff...".</p> <p>2. Review of the medical record for patients #17 and #18, (with surgery on 10/14/14 and 11/18/14) same patient as #19, indicated there is no chart documentation, including no transfer form, for the 10/28/14 transfer to the local ED (emergency department) as written on a facility incident report form and report log.</p> <p>3. At 4:05 PM on 7/8/15, interview with staff member #50, the clinic director, indicated no chart for the surgery date of 10/28/14 could be found for pt. #19, and no transfer form could be found.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(5)</p> <p>The governing body is responsible for services delivered in the center whether or not they are delivered under contracts. The governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a</p>		<p>binder for them to sign next time they work stating they have read and understand this policy. Effective July 30, 2015 all staff were e-mailed about lost paperwork on pt #19 and will be reviewed again at the next scheduled staff meeting August 13th, 2015 given by the Clinical Director. They will be required to sign an in-service log stating their understanding of accurate medical documentation.</p> <p><b>Monitor:</b> In the event of a patient transfer, the Clinical Director, or RN in charge during her absence, will ensure all required documentation including the interfacility transfer form is sent to the receiving facility with the patient.</p>		

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S 0310	<p>utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the facility failed to provide for a periodic review of the facility and its operation by a utilization review committee composed of three (3) or more duly licensed physicians having no financial interest (ownership) in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of facility documents indicated there was no documentation of a periodic review of the facility and its operation by a utilization review committee composed of three (3) or more duly licensed physicians having no financial interest (ownership) in the facility.</li> <li>2. In interview, on 7-7-2015 at 12:50 pm, employee #A1, Clinical Director, confirmed the above and no other documentation was provided prior to exit.</li> </ol>	S 0230	<p>Effective July 29, 2015 past Utilization Review committee members were e-mailed by the clinical director, asking to continue participation in this periodic review of the facility. A committee will be assembled by August 17, 2015. Documentation of the review will be reported to in the QAPI meeting minutes</p> <p><b>Monitor:</b> The Clinical Director will schedule periodic utilization reviews and report findings to QAPI to be approved by Governing Board.</p>	08/17/2015	

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Bldg. 00	<p><b>QUALITY ASSESSMENT AND IMPROVEMENT</b> 410 IAC 15-2.4-2(a)(1)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to include a monitor and standard for 1 service furnished by a contractor in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for one of the contracted services of laboratory.</p> <p>2. In interview, on 7-8-2015 at 3:20 pm, employee #A1, Clinical Director, confirmed the above and no other documentation was provided prior to exit.</p>	S 0310	<p>Effective August 4, 2015 at the third quarter QAPI meeting which got rescheduled from July 8, 2015 due to ISDH inspection, a new monitor and standard will be implemented for missing contracted lab service. The University of Michigan lab has been contacted about a current CLIA and Certificate of Liability and this will be filed in the contracts binder. The services provided by the lab will be reviewed on an annual basis and the evaluation form will be filed with the contract. All pathology reports returned from the University of Michigan lab are reviewed and signed by the surgeon. Any abnormal findings as well as "within normal limits" reports will be discussed at the quarterly QAPI and GB meetings and documented in the minutes.</p> <p><b>Monitor:</b>The Clinical Director will ensure annual review of the services contract is complete and documented. The Clinical Director or assigned staff member will ensure all pathology reports are signed by the</p>	08/04/2015			

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S 0320 Bldg. 00	<p>410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a)(2)</p> <p>The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following:</p> <p>(2) All functions, including, but not limited to, the following:</p> <p>(A) Discharge and transfer. (B) Infection control. (C) Medication errors. (D) Response to patient emergencies.</p> <p>Based on document review and interview, the facility failed to include a monitor and standard for the activity of discharges in its quality assessment and performance improvement (QAPI) program.</p> <p>Findings:</p> <p>1. Review of the facility's QAPI program indicated it did not include a monitor and standard for the activity of discharges.</p> <p>2. In interview, on 7-8-2015 at 3:20 pm, employee #A1, Clinical Director, confirmed the above and no further documentation was provided prior to</p>	S 0320	<p>attending surgeon and results are documented in the quarterly QAPI and GB meeting minutes.</p> <p>Effective August 4, 2015 at the 3rd quarter QAPI meeting, which got rescheduled from July 8, 2015 due to ISDH inspection, a new monitor and standard will be implemented for all activity regarding discharges. Monitor: Sarah Jefferis RN, Clinical Director, or other assigned staff member will monitor all activity re: discharges that are reported to the QAPI committee</p>	08/04/2015

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S 0414 Bldg. 00	<p>exit.</p> <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 facility, and infection control practitioner, failed to ensure that a member of the medical staff participated in 2 of 4 meetings reviewed.</p> <p>Findings: 1. Review of the "Infection Control</p>	S 0414	On 7/29/15 the members of the Infection Control Committee were specified including Dr. Kevin Scripture. The Infection Control Plan and the Organizational Chart were both edited on 7/29/15 to include the names of the staff members serving on the committee. Infection Control Committee meetings will be held	07/29/2015

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S 0442 Bldg. 00	<p>Plan" indicated the plan did not specify who the members of the infection committee were.</p> <p>2. Review of four "Quality Assessment and Performance Improvement Committee" (QAPI) meetings dated: 5/19/14, 10/15/14; 12/11/14, and 3/18/15, indicated:</p> <p>a. The 10/15/14 meeting minutes read, in the "Discussion" area: "Per [the physicians'] request, they will no longer sit on the QAPI committee...".</p> <p>b. The 12/11/14 and 3/18/15 meetings lacked the presence of a physician at these two meetings.</p> <p>3. At 11:45 AM on 7/7/15, interview with staff member #50, the clinic director, indicated:</p> <p>a. There is no written documentation of what staff the infection control committee consists of.</p> <p>b. The infection committee meetings are part of the QAPI meetings, and not held separately.</p> <p>c. It was unknown that a medical provider/physician was required to attend infection committee meetings and be on the committee.</p>		<p>quarterly.</p> <p><b>Monitor:</b> The Clinical Director will schedule quarterly infection control committee meetings on the first Thursday of January, April, July, &amp; October. Reminders will go out a week in advance to all committee members. These meetings will be held on an ongoing basis. Meeting minutes will be submitted to the QAPI committee.</p>				
	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)						

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	<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 document review and interview, the infection control practitioner, and the infection control committee, failed to implement its policy related to the immunization status of 5 of 8 staff, N1, N4, N5, N7, and N8.</p> <p>Findings:</p> <p>1. Review of the policy "Employee Health Program", no policy number, last approved 7/2014, indicated:</p> <p>a. Under "Policy", on page 1, it reads: "...This physical examination will include the following items and expenses that will be the responsibility of the facility:...Employees need to provide vaccination documentation or a titer of the following...Hepatitis B Measles, Mumps, Rubella (MMR) Varicella (unless employee has documented history</p>	S 0442	<p>Effective July 30, 2015 all employees were contacted via e-mail to update on necessity of titers and boosters for immunizations. Employees N1, N4, N5, N7 &amp; N8 were contacted regarding needing titers drawn for MMR &amp;/or Varicella by the ICC at our contracted lab service, Mid America free of charge to the employee. Effective August 19, 2015 proper documentation will be filed in employees medical records in regards to titer results and boosters given. If employees are not compliant by August 19, 2015 they will be unable to work until these are complete.</p> <p><b>Monitor:</b> The Clinical Director or designated employee will ensure medical record files are completed on all employees including but not limited to vaccination documentation or a titer of Hepatitis B, Measles,</p>	08/19/2015

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	<p>of the disease)...Employees will be offered the Hepatitis B vaccine as outlined in Hepatitis B Vaccination Plan...".</p> <p>2. Review of employee health files indicated:</p> <p>a. N1 was a LPN (licensed practical nurse) hired 1/6/14 who lacked documentation of vaccination or titer for Rubella and Rubeola.</p> <p>b. N4 was hired as a RN (registered nurse) on 1/6/15 who had a self reported notation of having had Varicella as a child, but lacked documentation of vaccination or titer for Rubella, Rubeola and Varicella.</p> <p>c. N5 was a RN hired 8/25/14 who had a self reported notation of having had Varicella as a child, but lacked documentation of vaccination or titer for Varicella.</p> <p>d. N7 was a RN hired 1/6/15 who had a self reported notation of having had Varicella as a child, but lacked documentation of vaccination or titer for Varicella.</p> <p>e. N8 was a family liaison hired 7/2012 who lacked documentation of vaccination or titer for Rubella and Rubeola, and had a Varicella that was &lt;0.90 (with a negative range of 0.00 to 0.90), making this staff member negative for Varicella.</p>		<p>Mumps, Rubella and Varicella unless the employee has a documented history of the disease. Medical record charts will be audited within 30 days after hire to ensure documentation is complete and on file.</p>	

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S 0466 Bldg. 00	<p>3. At 12:05 PM on 7/8/15, interview with staff members #50, the clinic director, and #52, the infection control nurse, indicated:</p> <p>a. Staff did not realized that a self reported Varicella documentation was not allowed even though the infection control plan indicates the facility follows the CDC (centers for disease control) recommendations, including those for immunization requirements of health care workers.</p> <p>b. There is no documentation that the negative Varicella was followed up on for staff member N8.</p> <p>c. It is assumed that with a change in clinic directors in August of 2014, that new staff were missed in regard to immunization status, as required by the facility policy listed in 1. above.</p> <p>d. Immunization status is lacking for staff as listed in 2. above.</p> <p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(g)(3)</p> <p>Sterilization services must be directed by a qualified person or persons and must provide for the following:</p> <p>(3) Records of results must be</p>			

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	<p>maintained and evaluated periodically in accordance with 410 IAC 15-2.4-2 to include, but not limited to, the following:</p> <p>(A) Records of recording thermometers or a daily record of the sterilizing cycle (date, time, temperature, pressure, and contents) for each sterilizer load.</p> <p>(B) Results of biological indicators used in testing the sterilizing processes.</p> <p>Based on document review and interview, the infection control practitioner failed to ensure that evaluation of sterilization services and biological testing was evaluated at quality/infection control meetings in 4 meetings reviewed.</p> <p>Findings:</p> <p>1. Review of combined quality and infection committee meetings dated: 5/19/14, 10/15/14; 12/11/14, and 3/18/15, indicated there was no documentation of any reporting of biologicals and sterilization processes at the meetings.</p> <p>2. At 1:00 PM on 7/8/15, interview with staff member #55, a LPN (licensed practical nurse), indicated:</p> <p>a. This staff member supervises sterilization processes, and instrument techs, at the facility in assistance with the infection control nurse.</p>	S 0466	<p>Effective August 4, 2015 at the third quarter QAPI meeting, which got rescheduled from July 8, 2015 due to ISDH inspection, records and results will be reported regarding daily biological indicator tests performed and date, time, temp, pressure and contents for each sterilizer load. This will continue to be reported periodically by nursing staff representative of the ICC.</p> <p><b>Monitor:</b> The Clinical Director is a member of the Infection Control Committee and will ensure documentation of biological and sterilization processes are included in the meeting minutes and reported to the Governing Board on an ongoing basis.</p>	08/04/2015			

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S 0472 Bldg. 00	<p>b. Even though processes are reviewed by this staff member routinely, there is no report made to the quality/infection committee, as required.</p> <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 document review, observation, and interview, the infection control practitioner, and infection control committee, failed to ensure that the facility cleaning, by both the contracted housekeeping staff and the facility staff, met facility expectations.</p> <p>Findings: 1. Review of QAPI (quality assessment and performance improvement) committee meetings, which included infection committee attendance and information, indicated: a. At the 10/15/14 meeting, in the "Housekeeping" section, it reads: "...It was discussed with housekeeper for surgery side regarding terminal cleans in</p>	S 0472	Effective immediately, July 9th, 2015 the air vent in the OR and the crash cart were cleaned Effective August 10, 2015 proper documentation will be provided by new housekeeping contracted service regarding proper training of cleaning crew as outlined in our policy & procedure. Annual evaluations will be conducted as to the effectiveness of the contracted cleaning staff according to our policy and procedure. The requirement to read and follow the MDUs of any and all products in the ASC was reviewed with the staff. Effective August 13, 2015 at the next scheduled staff meeting an inservice will be conducted regarding the facility's cleaning procedures as outlined in our	08/13/2015

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	<p>OR (operating room), using different mop heads for each room and not re-dipping the mop head into cleaning solution after use on floor...Also discussed with housekeeper for OR cleaning requirements of putting on surgical scrubs, hat and shoe covers anytime they are entering OR areas."</p> <p>b. At the 3/18/15 meeting, it was noted that: "[staff member #53] caught housekeeping wearing street clothes. Employee said he/she was told, but has never done it. Blood found on floor on Monday here scrub remembered seeing it on Friday."</p> <p>c. In the "Action Taken" section of the 3/18/15 minutes, it reads: "...Plan to surprise visit once/week or month...".</p> <p>2. At 5:30 PM on 7/7/15, interview with contracted housekeeping staff member #58 indicated:</p> <p>a. Staff member #58 stated they use 5 oz of Spartan product's "HDQ Neutral" in 1 gallon of water when the bottle/jug indicated 1 oz/gallon is the dilution rate.</p> <p>b. When asked how often the walls and ceilings of the facility are washed/disinfected, the staff member did not know and deferred to the company owner.</p> <p>c. This staff member related that they may "double dip" the mop head if more cleaning solution is needed in the OR</p>		<p>policy &amp; procedures. The requirement to read and follow the MDUs of any and all products in the ASC was reviewed with the staff and those employee's will sign an in-service record stating they understand this requirement Effective August 3, 2015 the crash cart policy will be updated to indicate routine cleaning is performed by the clinical director. <b>Monitor:</b> The Clinical Director or an assigned staff member will perform quarterly unannounced visits on an ongoing basis to evaluate housekeeping performance and perform and annual evaluation of cleaning services after hours. Documentation of visits and findings will be reported at the quarterly Infection Control Committee and Governing Body meetings.</p>				

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	<p>suite to disinfect the floors properly.</p> <p>3. At 3:45 PM and 4:45 PM on 7/7/15, and 10:30 AM on 7/8/15, interview with the infection control practitioner, #52, and the clinic director, #50, indicated:</p> <ul style="list-style-type: none"> <li>a. Spartan's HDQ Neutral is not to be used with 5 oz/gallon.</li> <li>b. It was not known by staff members #50 and #52 that staff member #58 was using products incorrectly as no observations of their process had been observed by them.</li> <li>c. It was not known that the cleaning person was "double dipping" the mop head occasionally.</li> <li>d. It was agreed that at the 3/18/15 QAPI meeting surprise visits would be made to observe proper cleaning technique, proper attire, and proper dilution of products, but this has not occurred.</li> <li>e. Staff member #50 has "re educated" staff member #58 "a couple of times" and once found them not wearing proper attire while cleaning, but has no documentation of this.</li> </ul> <p>4. At 1:45 PM on 7/7/15, while on tour of OR suite #1, in the company of surgical tech #54, it was observed that the back wall air vent face plate had an accumulation of dust present when swiped.</p>			

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S 0612 Bldg. 00	<p>5. Staff member #54 observed, and agreed, that the face plate in OR #1 was dusty.</p> <p>6. At 2:10 PM on 7/7/15, while on tour of the post op area of the facility in the company of staff member #50, the clinic director, it was observed that there was a large amount of dust accumulation on the back board attached to the back of the code cart and on the back of the Ldefibrillator.</p> <p>7. Interview with staff member #50 at 2:15 PM on 7/7/15, indicated the code cart policy does not address routine cleaning of the code cart, but monthly cleaning is expected.</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 document review and</p>	S 0612	Effective July 30th, 2015	08/13/2015

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	<p>interview, the facility failed to ensure that pediatric medical records were accurate for 2 of 3 pediatric patients (patients #13 and #14) and 1 of 4 patients cared for by physician #56 (patient #17).</p> <p>Findings:</p> <p>1. Review of the policy Documentation Standards, no policy number, last approved July 2014, indicated:</p> <p>a. On page 2, it reads under "Entry Guidelines": "All entries in the medical record shall be consistent with the following guidelines:...Clear, concise, factual, objective and accurate...".</p> <p>2. Review of patient medical records indicated:</p> <p>a. Pt. #13 had surgery on 6/8/15 for lacrimal duct probing and had:</p> <p>A. A consent for a MAC (monitored anesthesia care) anesthesia, but documentation on the Anesthesia Record form that a general anesthesia was given.</p> <p>b. Pt. #14 was a 2 year old who had surgery (lacrimal duct probing) on 6/8/15 and had:</p> <p>A. No time of discharge written on the "Post Op Record" form.</p> <p>B. An "Authorization for Medical and/or Surgical Treatment" form that indicated a "General anesthesia" was to be given with the surgery.</p>		<p>anesthesiology physicians were contacted via e-mail regarding improper documentation on anesthesia records by the Clinical Director. These doctors were instructed to reply via e-mail stating understanding and sign an in-service record next time they work</p> <p>Effective August 13, 2015 at the next scheduled staff meeting these charts for patients #13, #14, #17 will be reviewed with staff and policy &amp; procedures will be inserviced by the Clinical Director. The inservice will include but not limited to the requirement to authenticate all entries by signing, dating and timing physician orders, history and physicals and operative reports. Staff will sign an in-service log to state understanding of accurate medical documentation</p> <p><b>Monitor:</b> The Clinical Director will conduct 10 random chart audits every month to ensure the medical records are complete. Findings will be reported to the QAPI and Governing Body meetings. Audits will continue on an ongoing monthly basis.</p>				

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S 0616 Bldg. 00	<p>C. An Anesthesia record form that had a MAC checked as the type of anesthesia given.</p> <p>D. A "Surgery Record" form that had a "General" box checked for the "Type of Anesthesia" given.</p> <p>c. Pt. #17 had surgery on 11/18/14 by physician #56 and had:</p> <p>A. No surgeon checked on the Anesthesia Record form to indicate which of the two surgeons was performing the operation on 11/18/14.</p> <p>B. No anesthesiologist checked on the General Consent form to indicate which of the 5 anesthesiologists listed was administering the MAC anesthetic for the surgery to be performed.</p> <p>3. At 3:15 PM on 7/8/15, interview with staff members #50, the clinic director, and #51, a staff RN (registered nurse), indicated the medical records, as listed in 2. above, were inaccurate and incomplete.</p> <p>410 IAC 15-2.5-3 MEDICAL RECORDS, STORAGE, AND ADMIN. 410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of</p>						

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	<p>service rendered for each patient of the center as follows:</p> <p>(3) The center shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. Each entry must be authenticated in accordance with the center and medical staff policies.</p> <p>Based on document review and interview, the medical staff failed to authenticate their patient records, according to facility policy, for 6 of 18 patients (Patients #2, #8, #10, #11, #12, and #18).</p> <p>Findings:</p> <p>1. Review of the "Medical Staff Rules and Regulations", last approved 7/16/14, indicated:</p> <p>a. On page 5, under "Staff Requirements", it reads: "...All members of the medical staff must abide by the policies of Whitewater Surgery Center."</p> <p>2. Review of the policy "Documentation Standards", (no policy number), last approved on 7/2014, indicated:</p> <p>a. On page 2 under "Entry Guidelines", it reads: "All entries in the medical record shall be consistent with the following guidelines:...Legible, signed and dated..."</p>	S 0616	<p>Effective immediately, by the clinical director, all staff was informed verbally and via e-mail regarding the need to date the authentication of the H&amp;P and operative reports by the physician before surgery. All medical records will be reviewed by the front desk receptionist for accuracy before the chart is filed. All staff will sign an in-service log indicating their understanding of accurate medical documentation</p> <p><b>Monitor:</b> The Clinical Director will conduct 10 random chart audits every month to ensure the medical record is complete. Findings will be reported to the QAPI and Governing Body meetings. Audits will continue on an ongoing monthly basis.</p>	07/31/2015			

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S 0736  Bldg. 00	<p>3. Review of patient medical records indicated:</p> <p>a. Pts. #2, #8, and #12 had authentication of the operative report, but lacked the date of authentication noted by the physician.</p> <p>b. Pts. #10, #11 and #18 had an authentication on the history and physical that lacked a date of authentication noted by the physician.</p> <p>4. At 4:05 PM on 7/8/15, interview with staff member #50, the clinic director, indicated authentication on the 6 medical records listed in 3. above was lacking a date of authentication, as required per facility policy.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(B)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(B) Meeting requirements of the medical staff to include, at a minimum, the following:</p> <p>(i) Frequency, at least quarterly. (ii) Attendance.</p>			

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S 0772 Bldg. 00	<p>Based on document review and interview, the facility's medical staff failed to meet for 2 of 4 quarters in calendar year 2014.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the medical staff minutes of year 2014 indicated the medical staff did not meet in the first or third quarters.</li> <li>In interview, on 7-8-2015 at 4:15 pm, employee #A1, Clinical Director, confirmed the above and no other documentation was provided prior to exit.</li> </ol> <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>	S 0736	<p>Effective immediately, July 30, 2015, the Clinical director has set quarterly Medical Advisory Committee Meetings on or around the last Tuesday of each quarter Jan, April, July, &amp; October reporting results of previous quarter for approval by the Governing board. The next Medical Advisory Committee meeting will be held on 8/25/15 rescheduled from July 28th 2015 and will continue on a quarterly basis.</p> <p><b>Monitor:</b> The Clinical Director will schedule Medical Advisory Committee meetings on the last Tuesday of every month.</p>	07/30/2015	

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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 ensure that an update of the history and physical was documented on the day of surgery for 1 of 4 patients with surgeon #56, patient #3.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the medical staff rules and regulations, approved on 7/16/14, indicated on page one under "Admission": "...A comprehensive history and physical examination, current within 30 days, which contains a provisional diagnosis and current medications, shall be on the patient chart prior to the surgical procedure...".</li> <li>Review of medical records indicated pt. #3 had a history and physical dated 6/5/15 with surgery on 6/9/15, and no update (or documentation of no changes) was noted on the day of surgery.</li> </ol>	S 0772	<p>Effective July 30, 2015 the surgeons were contacted either verbally or via e-mail, by Clinical Director, regarding our policy stating that any H&amp;P done on prior days before surgery had to be reviewed, signed &amp; dated prior to surgery. The update note will document any changes or state that there were no changes in the H&amp;P since the H&amp;P was performed. The update note will be signed and dated by the surgeon. All medical staff will sign an in-service log indicating their understanding of accurate medical documentation. All medical records will be reviewed by the front desk receptionist for accuracy before charts are filed.</p> <p><b>Monitor:</b> The Clinical Director will conduct 10 random chart audits every month to ensure the medical record is complete. Findings will be reported to the QAPI and Governing Body meetings. Audits will continue on an ongoing monthly basis.</p>	07/31/2015

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S 0780 Bldg. 00	<p>3. At 3:15 PM on 7/8/15, interview with staff members #50, the clinic director, and #51, a staff RN (registered nurse), indicated:</p> <p>a. The medical staff rules and regulations lack the requirement to update, and note if any changes, the history and physical, for patients on their surgical day, when the history and physical is done prior to the day of surgery.</p> <p>b. Pt. #3 had a history and physical done on 6/5/15, and had no documentation on the day of surgery, 6/9/15, by physician #56, that the history and physical was reviewed and updated, or had no changes.</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 be authenticated by a responsible practitioner as allowed by medical</p>						

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	<p>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 document review and interview, the medical staff failed to ensure that their rules and regulations were implemented, and facility policies were followed, in regard to the lack of a pain medication order for 1 of 3 pediatric patients, pt. #15; the lack of an order to transfer a patient for 1 of 1 transfer records reviewed, pt. #19; and the authentication of standing orders for 1 of 4 patients of physician #56, pt. #3.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>Review of the "Medical Staff Rules and Regulations", last approved 7/16/14, indicated: <ol style="list-style-type: none"> <li>At the top of page three: "All orders for treatment shall be in writing..."</li> <li>On page 5, under "Staff Requirements", it reads: "...All members of the medical staff must abide by the policies of Whitewater Surgery Center."</li> </ol> </li> <li>Review of the policy "Interfacility Transfer: Non-Emergency", (no policy number), last approved 7/2014, indicated: <ol style="list-style-type: none"> <li>Under "Policy": "All patients with a physician's order to transfer from this facility to local hospital will be managed by an efficient and expedient transfer process..."</li> </ol> </li> </ol>	S 0780	<p>Effective immediately the documentation standards policy was reviewed by the Clinical Director and delinquent charts will be addressed and brought to the attention of attending physicians Effective July 29, 2015 anesthesia was e-mailed by the Clinical Director regarding writing orders for all medications given outside of standing orders. Effective July 30, 2015 physicians were notified verbally &amp;/or e-mail regarding policy on authenticating standing orders by the Clinical Director. All staff will sign an in-service log indicating their understanding of accurate medical documentation.</p> <p>Effective August 13, 2015 at the next scheduled staff meeting the Clinical Director will hold an inservice for employee's on proper documentation of obtaining and writing a verbal order. For transfers or medications not previously indicated on standing orders. All staff will sign an in-service log indicating their understanding of accurate medical documentation <b>Monitor:</b> The Clinical Director will conduct 10 random chart audits every month to ensure the medical record is complete. Findings will be reported to the QAPI and Governing Body meetings. Audits</p>	08/13/2015

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	<p>b, On page 2 under "Transfer Documentation" it reads: "A physician's order is required for transfer of a patient...".</p> <p>3. Review of the policy "Documentation Standards", no policy number, last approved on 7/2014, indicated under "Procedure": "...Medical records remaining incomplete for one month following the patient's discharge will be considered delinquent and must be brought to the attention of the physician for completion...".</p> <p>4. Review of patient records indicated:</p> <p>a. Pt. #15 was a 17 year old who had surgery on 6/8/15 and documentation:</p> <p>A. On the "Post Op Record" form that "Fentanyl mg" was given "IVP" (intravenous push) at 11:17 AM.</p> <p>B. Lacking for an order for Fentanyl in the medical record, and lacked the documentation of how many mg were given/ordered.</p> <p>b. Pt. #19 had an incident report form that documented the transfer of this patient to the local ED (emergency department) after an assessment by the anesthesiologist on 10/28/14, but had no order for transfer in the medical record.</p> <p>c. Pt. #3 had standing pre op, intra op, and post operative orders from 6/9/15 that were not signed off on/authenticated</p>		will continue on an ongoing monthly basis.	

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S 0834  Bldg. 00	<p>by the surgeon.</p> <p>5. At 3:15 PM on 7/8/15, interview with staff member #51, a staff RN (registered nurse), indicated:</p> <p>b. There was no order in the medical record for pt. #15 for Fentanyl to be given IVP.</p> <p>a. There was no documentation for an order to transfer for patient #19.</p> <p>6. At 4:05 PM on 7/8/15, interview with staff member #50, the clinic director, indicated:</p> <p>a. No order to transfer could be found for patient #19.</p> <p>b. The medical staff rules and regulations do not address the time frame for authenticating the standing orders for surgical patients.</p> <p>c. It is assumed that the 30 days to complete a chart, based on the Documentation Standards policy, would be the expectation, but chart #3 is beyond the 30 days and is delinquent.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(c)(1)(F)(iii)</p> <p>The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include</p>						

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	<p>but are not limited to, the following:</p> <p>(F) The delineation of preanesthesia, intra-operative, and postanesthesia as follows:</p> <p>(iii) The completion of a postanesthetic evaluation for proper anesthesia recovery of each patient prior to discharge in accordance with written policies and procedures approved by the medical staff. Based on document review and interview, the medical staff and clinic director failed to ensure that the PACU (post anesthesia care unit) policy was implemented for 6 of 18 patients. (Patients #2, #8, #10, #11, #15, and #18.)</p> <p>Findings:</p> <p>1. Review of the policy "Admission to PACU", no number, last approved 7/2014, indicated on page two under "Records and Observations": "On arrival, every 15 minutes and then PRN (as needed), until discharge: Vital signs...".</p> <p>2. Review of patient medical records indicated:</p> <p>a. Pt. #2 was admitted to the PACU on 6/19/15 at 11:13 AM and discharged at 11:36 AM (23 minutes), with only one set of vital signs taken at 11:13 AM.</p> <p>b. Pt. #8 was admitted to the PACU on 6/19/15 at 10:11 AM and discharged at</p>	S 0834	<p>Effective immediately 7/31/15 all staff were informed verbally and via e-mail by Clinical Director of policy &amp; procedure statement regarding vital signs are to be obtained every 15 min than PRN until discharge. All staff will sign an in-service log indicating their understanding of accurate medical documentation. All charts will be reviewed by front desk receptionist's for accuracy before chart is filed</p> <p><b>Monitor:</b> The Clinical Director will conduct 10 random chart audits every month to ensure the medical record is complete. Findings will be reported to the QAPI and Governing Body meetings. Audits will continue on an ongoing basis.</p>	07/31/2015

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	<p>10:34 AM (23 minutes), with only one set of vital signs taken at 10:11 AM.</p> <p>c. Pt. #10 was admitted to PACU on 6/8/15 at 3:25 PM and discharged at 3:45 PM (20 minutes), with only one set of vital signs taken at 3:25 PM.</p> <p>d. Pt. #11 was admitted to PACU on 6/18/15 at 2:44 PM and discharged at 3:03 PM (19 minutes), with only one set of vital signs taken at 2:44 PM.</p> <p>e. Pt. #15 was admitted to PACU on 6/8/15 at 11:08 AM and discharged at 11:52 AM (44 minutes), with only one set of vital signs taken at 11:08 AM.</p> <p>f. Pt. #18 was admitted to PACU at 3:10 PM and discharged at 5:15 PM, (over 2 hours) with only one set of vital signs taken at 3:10 PM.</p> <p>3. At 9:25 AM on 7/8/15, interview with staff member #50, the clinic director, indicated:</p> <p>a. Most eye patients are discharged at, or about, 15 minutes after arrival to PACU.</p> <p>b. It was unknown that the facility policy indicated vital signs to be taken on arrival and every 15 minutes until stable.</p> <p>c. Pt. #18 was waiting 2 hours for a ride back to the ECF (extended care facility), not because of any health, or post op, issues.</p>			

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S 0888  Bldg. 00	<p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(d)(2)(F)</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>(F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.</p> <p>Based on document review and interview, the medical staff failed to ensure that the operative note was written/dictated immediately following the procedure for 1 of 4 patients of physician #56, (patient #3), and 3 of 4 patients for physician #57, (patients #2, #8, and #12).</p> <p>Findings: 1. Review of the Medical Staff Rules and Regulations, last approved 7/16/14, indicated on page 2, under "Medical Records": "...The medical record must contain an operative summary with a</p>			S 0888	<p>Effective 7/31/15 all physicians were e-mailed by the Clinical Director regarding Operative summaries must go on the chart immediately post op and Operative Reports must have a dictated date as well as a date transcribed and be in the medical record within 30 days. All medical staff will sign an in-service log indicating their understanding of accurate medical documentation next time they work. Effective 7/22/15 contracted dictation service was contacted regarding this change as well.</p> <p><b>Monitor:</b> The Clinical Director will conduct 10 random chart audits every month to ensure the</p>		08/13/2015

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	<p>complete description of the operative procedure, any complications and the physician's signature. Prognosis and infection classification, when appropriate, should be included...".</p> <p>2. Review of medical records indicated:</p> <p>a. Pt. #2 had a bilateral upper eyelid blepharoplasty on 6/19/15, done by physician #57, that had a transcribed date of the operative report as 7/2/15.</p> <p>b. Pt. #3 had surgery for a left conjunctival aneurysm ablation on 6/9/15, performed by physician #56, that lacked an operative note within the medical record.</p> <p>c. Pt. #8 had surgery for a right upper eyelid lesion excision, by physician #57, on 6/19/15 and had an operative report transcribed on 7/2/15.</p> <p>d. Pt. #12 had a cosmetic left brow lift on 6/19/15 and had an operative report, dictated by physician #57, that was transcribed on 7/2/15.</p> <p>3. At 3:15 PM on 7/8/15, interview with staff members #50, the clinic director, and #51, a staff RN (registered nurse), indicated:</p> <p>a. The Medical Staff Rules and Regulations fail to address what the expectation/time frame is for the writing/dictating of the operative report "immediately following" the surgical</p>		<p>medical record is complete. Findings will be reported to the QAPI and Governing Body meetings. Audits will continue on an ongoing basis.</p>	

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S 1010 Bldg. 00	<p>procedure.</p> <p>b. There is no operative note within the medical record of patient #3, and indicated that this was an "unusual case" so was dictated.</p> <p>c. It cannot be determined, since the reports lack a date of dictation, that the operative reports for physician #57 (patients #2, #8, and #12) were dictated immediately following the surgical procedure.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>Based on document review, observation, and interview, the facility failed to ensure that single dose vials of Lidocaine 1% were only used for a single patient as observed in both OR (operating room)</p>	S 1010	<p>Effective immediately, 7/22/15, multi-dose vials of preservative free lidocaine were ordered by the OR team leader. All ASC clinical staff will be inserviced at the upcoming staff meeting on August 13, 2015</p>	08/19/2015
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	<p>suites, #1 and #2.</p> <p>Findings:</p> <p>1. Review of the policy and procedure "Multiple-Dose Vials", no policy number, last approved July 2014, indicated a bullet point just under the middle of page one, that reads: "Opened single-doe vials/ampules shall not be stored for any period of time."</p> <p>2. At 1:42 PM on 7/7/15, while on tour of the OR suite #1 in the company of staff member #54, a surgical tech, it was observed that a CLAVE (brand name) access port was in the rubber septum of a 30 ml vial of Lidocaine 1%, that was listed on the label as "single use", "preservative free".</p> <p>3. At 1:55 PM on 7/7/15, while on tour of the OR suite #2 in the company of staff member #54, it was observed that a CLAVE access port was in the rubber septum of a 30 ml vial of Lidocaine 1%, listed as "single use", "preservative free".</p> <p>4. At 3:45 PM on 7/7/15, interview with staff nurse #55, indicated a confirmation that the Lidocaine found in OR suites #1 and #2 had writing on the vials stating these were "preservative free" and "single use" and that it was unknown, by this staff member, that single use vials could</p>		<p>by the Clinical Director, to review the policy Single Dose Vials which states that single dose vials are not to be used on multiple patients. Any staff not at this meeting will be sent the meeting minutes including scanned in policy for review and asked to sign the in-service log when they work next <b>Monitor:</b> The Clinical Director or an assigned staff member will conduct OR inspections on a monthly basis for the next 6 months to ensure single dose vials are not used on multiple patients. Findings will be reported to the QAPI and Governing Body and recorded in the meeting minutes.</p>				

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S 1026 Bldg. 00	<p>not be used on multiple patients.</p> <p>5. At 8:30 AM on 7/8/15, interview with staff member #50, the clinic director, indicated the facility does not have a policy related to single use vials, other than the one statement in the multi dose vial policy, as listed in 1. above.</p> <p>410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(E)(i)</p> <p>Pharmaceutical services must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>(i) Drug cabinets must be accessible only to authorized personnel.</p> <p>Based on observation and interview, the facility failed to ensure that the medication refrigerator, located near the post op area, was not accessible to unauthorized personnel.</p>	S 1026	Effective 7/15/15 a refrigerator lock was purchased and secured to the medication refrigerator by maintenance. The policy, Medication Refrigerator, was edited to include the medication refrigerator will be locked when the ASC is closed. The	07/15/2015

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S 1146  Bldg. 00	<p><b>Findings:</b></p> <p>1. At 2:15 PM on 7/7/15, while on tour of the post op area in the company of staff member #50, the clinic director, it was observed that the medication refrigerator, with eye drops and two boxes of Influenza vaccine, had no method of being locked and secured.</p> <p>2. At 2:20 PM on 7/7/15, staff member #50, the clinic director, confirmed that the medication refrigerator had no locking mechanism present.</p> <p>3. At 8:30 AM on 7/8/15, interview with staff member #50, the clinic director, indicated:</p> <p>a. The unlocked medication refrigerator would be accessible to unauthorized persons, such as contracted housekeeping staff and patients' family members.</p> <p>B. A pharmacy policy regarding the security and inaccessibility of the medication refrigerator was requested at this time and none was presented prior to exit.</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</p>		<p>medication refrigerator is in the nurse's station and will always be monitored during business hours. Staff was instructed to lock the medication refrigerator at the end of the day prior to ASC closure.</p> <p><b>Monitor:</b> The Clinical Director or an assigned staff member will physically check the medication refrigerator to ensure it is locked at the end of day prior to the ASC closure. Non-compliance will be reported at the quarterly QAPI and Governing Body meeting and documented in the minutes.</p>				

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	<p>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 observation, document review, and interview, the facility failed to ensure that no condition was created that might present a hazard to patients, employees, or the public, in regard to the patient snack/soda refrigerator in the recovery area.</p> <p>Findings:</p> <p>1. On line research indicated refrigerator temps, per the FDA (food and drug administration), should range between 32 degrees and 40 degrees.</p> <p>2. At 2:05 PM on 7/7/15, while on tour of the recovery/post op area in the company of staff member #50, the clinic director, it was observed that the patient refrigerator had soft drinks for patients in the lower portion, and bags of peas (for ice bags), and other ice bags for patient use, in the upper freezer section. Posted on the front was a form titled "Medication Refrigerator Temperature Log" with the "acceptable range of temperature" noted as 36 degrees to 46 degrees.</p>	S 1146	<p>Effective 7/16/15 a temperature log for the patient nourishment refrigerator was posted on the side of the refrigerator and includes the statement: <b>IMPORTANT:</b> The acceptable range of temperature is 32-40 ° F. If you are unable to obtain or adjust the levels to the recommended temperature, please contact your Clinical Director. The Medication Refrigerator policy was revised to include a statement regarding patient nourishment. The policy will be reviewed and approved by the Governing Body on August 10, 2015. <b>Monitor:</b> The Clinical Director or an assigned staff member will review the nourishment refrigerator temperature log on a monthly basis to ensure the temperature is recorded every day the facility is open as well as report any out of range temperatures to the CD. Findings will be reported to the QAPI committee and recorded in the minutes.</p>	07/16/2015

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S 1154 Bldg. 00	<p>3. At 8:30 AM on 7/8/15, interview with staff member #50, the clinic director, indicated:</p> <p>A. Corporate/administrative staff informed this staff member that the facility does not need a food refrigerator policy, and staff are not required to monitor the patient drink refrigerator temperatures.</p> <p>B. The current, posted, log is titled as a medication log, not a food log.</p> <p>C. It was unknown that food temperature requirements were different from medication requirements.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(3)(C)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(3) Provision must be made for the periodic inspection, preventive maintenance, and repair of the physical plant and equipment by qualified personnel as follows:</p> <p>(C) Operational and maintenance control records must be established</p>			

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S 1164	<p>and analyzed at least triennially. These records must be readily available on the premises. Based on interview, the facility failed to document operational and maintenance control records having been analyzed at least triennially for 6 systems of equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 7-8-2015 at 11:15 am, employee #A1, Director of Nursing, was requested to provide documentation of the operational and maintenance control records for the heating, ventilation, and air conditioning (HVAC) system, fire alarm and/or smoke detector system, and emergency generator, having been analyzed at least triennially.</li> <li>In interview on 7-8-2015 at 3:50 pm, employee #A2, Family Liaison, confirmed all the above and no other documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT</p>	S 1154	<p>Effective August 3, 2015 the autoclave safety, electrosurgical cautery unit safety, electrical equipment safety, equipment management, utility maintenance, &amp; HVAC system failure policy's was updated to state all operational &amp; maintenance control records must be established and analyzed at least triennially. Effective August 12, 2015 a meeting has been arranged for the clinical director and maintenance crew to establish and analyze the operational and maintenance control records of the 6 systems of equipment heating, ventilation, air conditioning (HVAC) system, fire alarm &amp; smoke detector system and emergency generator. An operational and maintenance control check of the HVAC system was done March 25, 2015, fire alarm and/or smoke detector system on March 20, 2015, and on the emergency generator on April 1, 2015. These checks are scheduled to be performed quarterly with a triennial analysis. <b>Monitor:</b>The Clinical Director will monitor the triennial analysis to ensure the checks are performed and documentation is on file.</p>	08/12/2015			

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Bldg. 00	<p>MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(i)</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>(i) All patient care equipment must be on a documented maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule. Based on document review and interview, the facility failed to maintain 1 of 10 pieces of patient care equipment in accordance with acceptable standards of practice.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On 7-7-2015 at 10:30 am, employee #A1, Clinical Director, was requested to provide documentation of a policy to perform maintenance of the emergency call (code) system once per year.</li> <li>In interview, on 7-8-2015 at 3:50 pm,</li> </ol>	S 1164	Effective 7/15/15 the code blue, medical alert, system was checked via the phone service house wide by the Clinical Director and OSHA/Safety compliance officer. It was determined to be in full working operation and documented on the mock code blue critique record. On 7/22/15 the staff was inserviced regarding the all phone alert system for calling a code blue. Documentation of the test and inservice will be included in the QAPI meeting minutes on 8/5/15. Effective 8/3/15 the code blue policy was revised to include an annual check of the emergency call system.	08/03/2015

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S 1166 Bldg. 00	<p>employee #A2, Family Liaison, indicated there was no above-requested documentation and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(4)(B)(ii)</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>(ii) There must be evidence of preventive maintenance on all patient care equipment.</p> <p>Based on document review and interview, the facility failed to provide evidence of preventive maintenance (PM) on 3 of 10 pieces of patient care equipment.</p> <p>Findings:</p> <p>1. Review of the facility's PM reports indicated there was no documentation of</p>	S 1166	<p><b>Monitor:</b> The Clinical Director will ensure annual testing of the phone alert system and file record of the testing in the Life Safety Code manual.</p> <p>Effective August 4, 2015 documentation of PM on defibrillator, cardiac monitor, &amp; code blue call system will be securely put in maintenance contract binder</p> <p>Monitor: The Clinical Director or assigned clinical staff will check documentation is securely put in the maintenance contract binder</p>	08/04/2015	

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S 1168 Bldg. 00	<p>PM for a defibrillator, cardiac monitor, and emergency call (code) system.</p> <p>2. In interview, on 7-8-2015 at 3:50 pm, employee #A2, Family Liaison confirmed the above and no other documentation was provided prior to exit.</p> <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 facility failed to document current leakage checks for 4 of 8 pieces</p>	S 1168	It is still under investigation and we are reaching out to our contracted service companies regarding leakage tests that were	08/13/2015

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S 1178	<p>of patient care equipment and failed to conduct triennial analysis of preventive maintenance (PM) for 10 of 10 pieces of patient care equipment.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. Review of documentation for 10 pieces of patient care equipment indicated a current leakage check was not performed on a defibrillator, cardiac monitor, laser, and emergency call (code) system.</li> <li>2. Review of documentation for 10 pieces of patient care equipment indicated a triennial analysis of PM was not performed on an anesthesia machine, defibrillator, cardiac monitor, laser, emergency call (code) system, overhead operating room lights, patient stretcher, sterilizer, suction machine, and wheelchair.</li> <li>3. In interview, on 7-8-2015 at 3:50 pm, employee #A2, Family Liaison, confirmed all the above and no other documentation was provided prior to exit.</li> </ol> <p>410 IAC 15-2.5-7</p>		<p>performed on the defibrillator, cardiac monitor, laser, and emergency call code system. It is still under investigation and we are reaching out to our contracted service companies regarding an analysis of the PM of anesthesia machine, defibrillator, cardiac monitor, laser, emergency call code system, overhead operating room lights, patient stretcher, sterilizer, suction machine and wheelchair that were performed with the last PM's. We are having a maintenance records and triennial analysis meeting on August 12, 2015 to finalize this tag</p> <p><b>Monitor:</b> The Clinical Director will monitor the completion of leakage tests and triennial PM checks to ensure the checks are performed and documentation is on file.</p>		

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Bldg. 00	<p>PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAC 15-2.5-7(b)(5)(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>(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>(B) Refuse, biohazards, infectious wastes, and garbage must be collected, transported, sorted and disposed of by methods that will minimize nuisances or hazards according to federal, state, and local laws and rules. Based on document review and interview, the facility failed to have a policy for the collection, transportation, sorting, storage and disposal of refuse and garbage in 1 instance.</p> <p>Findings:</p> <p>1. Review of facility policies indicated there was no policy for the collection, transportation, sorting, storage and disposal of refuse and garbage.</p> <p>2. In interview, on 7-8-2015 at 4:15 pm, employee #A1, Clinical Director,</p>	S 1178	<p>Two refuse &amp; garbage disposal policies have been uploaded. I can not recall why you were not presented with these policies the day of the visit. One was located in our infection control manual and the other in our OSHA manual.</p> <p><b>Monitor:</b>The Clinical Director will ensure these policies are readily available for our next ISDH inspection.</p>	08/03/2015
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S 1196 Bldg. 00	<p>confirmed the above and no other documentation was provided prior to exit.</p> <p>410 IAC 15-2.5-7 PHYSICAL PLANT, EQUIPMENT MAINTENANCE, 410 IAc 15-2.5-7(c)(5)</p> <p>(c) A safety management program must include, but not be limited to, the following:</p> <p>(5) Maintenance of written evidence of regular inspection and approval by state or local fire control agencies in accordance with center policy and state and local regulations. Based on document review and interview, the facility failed to maintain documentation of regular inspection and approval of the facility, or request for same, by a state or local fire control agency in 1 instance.</p> <p>Findings:</p> <p>1. On 7-7-2015 at 10:30 am, employee #A1, Clinical Director, was requested to provide documentation of regular inspection and approval of the facility by a state or local fire control agency, or request for same, for calendar year 2014 and year-to-date of year 2015.</p>	S 1196	<p>A facility inspection was conducted by the local fire marshal on February 2, 2015. Documentation of the inspection is on file in the Facility Compliance Binder and a copy was uploaded to this site</p> <p><b>Monitor:</b>The Clinical Director will ensure the annual inspection is performed by notifying the fire marshal on an annual basis. This duty may be assigned to another staff member, however, the Clinical Director is responsible for ensuring it is completed and maintaining documentation in the facility compliance binder.</p>	07/31/2015

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NAME OF PROVIDER OR SUPPLIER  WHITEWATER SURGERY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 CHESTER BLVD RICHMOND, IN 47374
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 1198 Bldg. 00	<p>2. In interview, on 7-8-15 at 4:15 pm, employee #A1 confirmed the above and no other documentation was provided prior to exit.</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 on document review and interview, the facility failed to coordinate emergency disaster and preparedness with an appropriate governmental agency in 1 instance.</p> <p>Findings:</p> <p>1. On 7-7-2015 at 10:30 am, employee #A1 was requested to provide documentation of the coordination of emergency disaster and preparedness with an appropriate governmental agency</p> <p>2. In interview, on 7-8-2015 at 4:15 pm, employee #A1, Clinical Director, indicated there was no documentation of</p>	S 1198	Effective 7/30/15 the Clinical director uploaded the agreement with Wayne County Health Dept dated 2010 and e-mailed regarding any future meetings in regards to specific disaster training. On 8/3/15 I received a voicemail back from the WCHD and will be reaching out again today to determine future meeting dates & possibly an updated emergency disaster & preparedness plan. <b>Monitor: The clinical director will ensure the emergency disaster &amp; preparedness plan stays current with our local government agency</b>	08/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15C0001047	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/08/2015
NAME OF PROVIDER OR SUPPLIER  WHITEWATER SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 CHESTER BLVD RICHMOND, IN 47374		
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	the coordination of emergency disaster and preparedness with an appropriate governmental agency and no other documentation was provided prior to exit.				