

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001149	X(2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X(3) DATE SURVEY COMPLETED 06/07/2011
NAME OF PROVIDER OR SUPPLIER EAGLE HIGHLANDS SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6850 PARKDALE PLACE INDIANAPOLIS, IN46254		
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S0000	<p>This visit was for a licensure survey.</p> <p>Facility Number: 004756</p> <p>Survey Date: 6-6/7-11</p> <p>Surveyors: Jack I. Cohen, MHA Medical Surveyor</p> <p>John Lee, RN Public Health Nurse Surveyor</p> <p>Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: claughlin 06/14/11</p>	S0000	This was a wonderful learning experience.		

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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S0444	<p>410 IAC 15-2.5-1(f)(2)(E)(ix)</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>(ix) Requirements for personal hygiene and attire that meet acceptable standards of practice.</p> <p>Based on observation, policy review, and interview, the facility failed to ensure the surgical staff followed their dress code policy regarding surgical masks.</p> <p>Findings included:</p> <p>1. On 06/07/11, between 10:30 AM and 11:30 AM, 10 different staff members were observed coming from the surgical area into the pre/post-op areas with masks hanging around their necks, then returning to the surgical area. One RN was observed bringing a patient from the OR to post-op with a mask hanging around his/her neck. He/she took another patient from the pre-op area back to the OR and pulled the same mask over his/her face before entering the OR suite. He/she returned a third time with the mask hanging around the neck. Another staff</p>			S0444	<p>The clinical manager of the operating room is responsible for implementation of the action plan below. Plan: Staff education complete by 06/30/2011, followed immediately with continuous monitoring 1. Staff education emphasizing policy ADM 3.02 titled Dress Code: Perioperative Practice Domain. Emphasis will be placed on infection risks 2. Monitor compliance of rule 3. Physician noncompliance reported to Medical Director</p>		06/30/2011

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	<p>member was observed with a mask hanging around his/her neck and tucked down through the top of the scrub shirt.</p> <p>2. Review of the facility policy entitled "Dress Code: Perioperative Practice Domain", last approved October 27, 2010, indicated on page 3, "...4. Masks are to cover the mouth and nose completely and will be secured to prevent venting from occurring at the sides. Masks will be worn either on or off, rather than hanging around the neck, and must be changed at minimum between cases or more often when soiled. Masks are not to be worn outside the perioperative area."</p> <p>3. At 9:45 AM on 06/07/11, the dress code policy was discussed with the Operating Room (OR) Clinical Manager, staff member A1. He/she indicated the surgical masks should be changed between surgical cases and should not be worn hanging around the neck.</p>				

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S0616	<p>410 IAC 15-2.5-3(c)(3)</p> <p>An adequate medical record must be maintained with documentation of 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 facility failed to ensure a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries and that each entry must be authenticated in accordance with the center and medical staff policies for 8 of 20 medical records (MR) reviewed (Patient #2, 3, 7, 10, 13, 15, 18 and 19).</p> <p>Findings include:</p> <p>1. Review of policy/procedure MS2.03, Completion of Medical Records, indicated the following: "Reports dictated and transcribed through Health Information Management require surgeon authentication by using SoftMed's Electronic Signature Authentication - ESA</p>	S0616	The clinical director is responsible for the implementation of the plan of correction. Plan: 1. Revise policy MS 2.03, Completion of Medical Record, to designate a means for signature authentication and security for electronic signatures in systems other than the softmed system. Policy updates to be approved by the board of managers via written consent in lieu of a meeting by 06/30/2011. 2. Obtain a signed signature authentication form and a signed confidentiality agreement from physicians using an electronic signature in systems other than the softmed system. Documentation to be placed in credentialing files by 07/07/2011.	07/07/2011	

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	<p>application." This policy/procedure was last reviewed/revised on 07-28-10. The policy/procedure did not address other electronic dictations not done through Health Information Management, how electronic signatures would be authenticated and how the integrity and security of the electronic signature would be protected.</p> <p>2. Review of patient #2, 3, 7, 10, 13, 15, 18 and 19's MR indicated the Operative Report was signed by MD #1 with an electronic signature.</p> <p>3. On 06-06-11 at 1510 hours, staff #43 confirmed that MDs #1 had not dictated his/her Operative Reports through Health Information Management. On 06-06-11 at 1515 hours, staff #40 confirmed that MD #1 had not signed a statement that the electronic signature code was his/her own and would not share the electronic signature code with others.</p>				

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S0630	<p>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, the facility failed to follow facility policy and procedure and ensure that the medical record contained sufficient information to justify discharging the patient from the surgery center for 7 of 20 medical records (MR) reviewed (Patient #1, 4, 8, 12, 14, 17 and 18).</p> <p>Findings include:</p> <p>1. Review of policy/procedure DT 10.02, Patient Release to Home, indicated the following: "V. Policy Statements A. All patients must have a signed discharge order and must meet discharge criteria." This policy/procedure was last reviewed/revised on 10-27-10.</p> <p>2. Review of the following MRs indicated the following: Patient #1 was admitted to the facility on 02-01-11 and lacked documentation of a</p>	S0630	<p>The clinical director is responsible for the implementation of the plan of correction. Plan: To implement a means for all patients to have a documented discharge order from the attending physician 1. Discharge order stating, "Discharge Patient When Discharge Criteria is Met" added to order sheet on 06/22/2011. Order to be signed by attending physician. 2. Staff and Physician Education completed on 6/24/2011. 3. Monitor charts for compliance</p>	06/24/2011			

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S0640	<p>discharge order.</p> <p>Patient #4 was admitted to the facility on 01-04-11 and lacked documentation of a discharge order.</p> <p>Patient #8 was admitted to the facility on 01-11-11 and lacked documentation of a discharge order.</p> <p>Patient #12 was admitted to the facility on 02-08-11 and lacked documentation of a discharge order.</p> <p>Patient #14 was admitted to the facility on 02-22-11 and lacked documentation of a discharge order.</p> <p>Patient #17 was admitted to the facility on 04-19-11 and lacked documentation of a discharge order.</p> <p>Patient #18 was admitted to the facility on 01-20-11 and lacked documentation of a discharge order.</p> <p>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.</p> <p>Based on document review and interview, the facility failed to ensure all entries in the medical record were legible and complete and that errors were corrected according to policy in 5 of 5 transfer patient records reviewed (P21, P22, P23, P24, and P25).</p>	S0640	<p>The clinical director is responsible for the implementation of the plan of correction. Plan: Staff education complete by 06/30/2011, followed immediately with continuous monitoring 1. Staff education regarding policy CLR 6.00, Content of Medical Records, placing emphasis on proper steps for correcting an</p>	06/30/2011			

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	<p>Findings included:</p> <p>1. Review of the facility policy entitled "Content of Medical Records", last reviewed 05/20/09, indicated on page 3, "C. The following apply to all entries in the Medical Record: ...3. All handwritten entries made in the medical record must be legible and written with permanent ink. Likewise, all printed entries must be clear and complete. 4. Corrections to previously recorded and signed entries may be made by the individual who made the entry or a supervising physician as follows: a. A single line is drawn through the incorrect documentation with the notation 'error'. b. The correction is entered and authenticated by signature, title, and date."</p> <p>2. The medical record for transfer patient #P21 indicated entries written over/changed on the History and Physical form dated 05/25/10, the Progress Note dated 05/25/10, the Universal Protocol Checklist dated 03/25/10, and the Post-Operative Record pages 1 and 2, dated 05/25/10. The entries were not corrected according to the facility policy.</p> <p>3. The medical record for transfer patient #P22 indicated times written over/changed on the Transfer Form and the Anesthesia Record from 03/09/11.</p>		<p>entry in the medical record.2. Monitor compliance of rule 3. Physician noncompliance reported to Medical Director</p>				

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	<p>The record also had entries totally scribbled out on the Transfer Form and Post-Anesthesia Evaluation from 03/09/11.</p> <p>4. The medical record for transfer patient #P23 indicated 2 entries written over/changed on the Anesthesia Record from 05/21/10.</p> <p>5. The medical record for transfer patient #P24 indicated 2 entries written over/changed on the Anesthesia Record from 10/18/10.</p> <p>6. The medical record for transfer patient #P25 indicated entries written over/changed on the Pre-Operative Record and the Universal Protocol Checklist from 04/20/11. A time was written over/changed on the Post-Anesthesia Care Orders from 04/20/11.</p> <p>7. At 2:00 PM on 06/07/11, staff member A2 confirmed the medical record findings.</p>				

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S0710	<p>410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if applicable.</p> <p>(C) A current copy of the individual's:</p> <p>(i) Indiana license showing date of licensure and number or available data provided by the health professions bureau. A copy of practice restrictions, if any, shall be attached to the license issued by the health professions bureau through the appropriate licensing board.</p> <p>(ii) Indiana controlled substance registration showing number as applicable.</p> <p>(iii) Drug Enforcement Agency registration showing number as applicable.</p> <p>(iv) Documentation of experience in the practice of medicine.</p>						

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	<p>(v) Documentation of specialty board certification as applicable.</p> <p>(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).</p> <p>(D) Category of medical staff appointment and delineation of privileges approved.</p> <p>(E) A signed statement to abide by the rules of the center.</p> <p>(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.</p> <p>(G) Other items specified by the center and medical staff.</p> <p>Based on document review and interview, the medical staff failed to approve privileges for 3 of 3 supervised allied health practitioner files reviewed.</p> <p>Findings:</p> <p>1. Review of the Medical Staff Bylaws, Article V, entitled PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT, indicated an applicant for appointment or reappointment to the Medical Staff shall specify the clinical privileges desired.</p> <p>2. Review of 3 supervised allied health</p>	S0710	The clinical director is responsible for the implementation of the plan of correction. Plan: Develop appropriate privilege forms for Supervised Allied Health personnel, delineating specific privileges requested. Request approval from the Credentialing Committee and the Board of Managers for current Supervised Allied Health Personnel. 1. Complete revision to Supervised Allied Health privilege form by 6/30/2011, to be approved by BOM via written consent in lieu of a meeting 2. Request updated privilege forms be completed on all Supervised allied health personnel currently privileged at the center. Updated privilege	07/30/2011	

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	<p>practitioner files indicated files AH#1, AH#2 and AH#3 had no documentation specifying the clinical privileges desired. On 6-7-11 at 3:05 pm, upon interview, employee #A5 confirmed this and no documentation was provided prior to exit.</p> <p>3. Review of the Medical Staff Bylaws, entitled PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT, indicated upon completion of its investigations and deliberations, or those of its designee, the Credentials Committee and the Medical Director shall make a written report to the Managing Board. Such report shall state the Credentials Committee and the Medical Director's recommendation that the application for Medical Staff clinical privileges be accepted, rejected or deferred, in whole or in part.</p> <p>4. Since review of the 3 supervised allied health practitioner files indicated files AH#1, AH#2 and AH#3 had no documentation specifying the clinical privileges desired, the Credential Committee and the Medical Director could not have made a written report to the Managing Board, stating the Credentials Committee and the Medical Director's recommendation that the application for Medical Staff clinical</p>		forms to be returned by 07/25/2011.3. Obtain approval for revised Allied Health Credentialing forms by board of managers on 07/27/2011.		

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	<p>privileges be accepted, rejected or deferred, in whole or in part.</p> <p>5. On 6-7-11 at 3:05 pm, upon interview, employee #A5 confirmed there was no written report to the Managing Board, stating the Credentials Committee and the Medical Director's recommendation that the application for Medical Staff clinical privileges be accepted, rejected or deferred, in whole or in part, and no documentation was provided prior to exit.</p>				

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S0772	<p>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>(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 policy review, medical record review and interview, the facility failed to ensure the History and Physical was performed according to policy for 2 of 5 transfer patient records reviewed (#P23 and P24).</p> <p>Findings included:</p>	S0772	The clinical director is responsible for the implementation of the plan of correction. Plan: Provide education to physicians regarding requirements of History and Physicals1. Physician Education on policy CLR 6.00, Content of Medical Records, with emphasis on History & Physical dumentation requirements and policy review to be completed by 7/06/2011 2. Continuous	07/06/2011	

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	<p>1. Review of the facility policy entitled "Content of Medical Records", last reviewed 05/20/09, indicated on page 5, "E. Content of the Medical Record includes: 1. History and Physical Examination: a. A complete history and physical examination shall be completed prior to surgery. The history should include the following: chief complaint, inventory of body systems including mental status, current physical examination, allergies/medications/dosage/reactions, conclusions, impressions drawn from admission history and physical examinations, and plan of action".</p> <p>2. The medical record for transfer patient #P23 failed to indicate any notations in the columns for systemic review and physical exam on the Outpatient Surgery History and Physical form signed on 05/21/10, the day of surgery.</p> <p>3. At 2:00 PM on 06/07/11, staff member A2 confirmed the form was incomplete and could not determine the comments written on the form, but thought they were just the plan for surgery.</p> <p>4. The medical record for transfer patient #P24 failed to indicate any notations in the columns for systemic review and physical exam or in the comments</p>		<p>monitoring of records for completeness 3. Report noncompliance to medical director</p>		

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S1154	<p>sections on the Outpatient Surgery History and Physical form. The date of the exam was 10/18/10, the date of surgery, but the physician signature was timed at 1200 and dated 10/15/10.</p> <p>5. At 2:00 PM on 06/07/11, staff member A2 confirmed the form was incomplete and the dates were confusing.</p> <p>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 and analyzed at least triennially. These records must be readily available on the premises.</p> <p>Based on document review and interview, the facility failed to document operational and maintenance control records for the heating, ventilation, and air conditioning (HVAC) and fire alarm systems being analyzed at least triennially.</p>	S1154	The Building Manager is responsible for the implementation of the plan of correction. The clinical director is responsible to ensure appropriate documentation is completed and available on site. Plan: Review requirements for triennial analysis with Building	07/30/2011	

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	<p>Findings:</p> <p>1. On 6-6-11 at 10:00 am, employees #A1 #A3 and #A4 were requested to provide documentation of triennial analysis of HVAC and fire alarm systems to determine the preventive maintenance conducted was in accordance with the manufacturer 's recommendation or facility policy.</p> <p>2. On 6-7-11 at 10:15 am, upon interview, employee #A3 indicated there was no documentation of triennial analysis of HVAC and fire alarm systems and no documentation was provided prior to exit.</p>		<p>Manager. Ensure documentation of triennial analysis for HVAC and Fire Alarm System readily onsite. Update PM 8.01, Preventive Maintenance policy to include triennial analysis requirement by 07/06/2011 Building manager will complete analysis of HVAC maintenance and Fire Alarm System maintenance by 07/30/2011 The clinical director will monitor for compliance</p>		

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S1164	<p>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 document maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule for 2 pieces of equipment.</p> <p>Findings:</p> <p>1. On 6-6-11 at 10:00 am, employees #A1 and #A4 were requested to provide documentation of preventive maintenance (PM) on a wheelchair.</p>	S1164	The clinical director is responsible for the implementation of the plan of correction. Plan: Request a waiver from the ISDH to allow Eagle Highlands Surgery Center to deviate from annual inspections and manufacturers' recommended maintenance schedules consistent with the waiver for IU Health's clinical engineering department. 1. Request a waiver for the center to deviate from annual inspections and manufacturers recommended maintenance schedules. The center is contracted with IU Health's clinical engineering department and using their "Risk Based" system. 2. Policy PM 8.00	06/30/2011	

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	<p>2. Review of an e-mail dated 6-6-11 from the biomedical engineering contractor to employee #A1 indicated the wheelchair [is] on our ISDH [Indiana State Department of Health] exclusion list.</p> <p>3. The facility was requested to provide a copy of an ISDH ORDER TO GRANT A WAIVER specific for the surgery center which would allow the facility to deviate from annual inspections and the manufacturer's recommended maintenance schedules.</p> <p>4. Review of a document dated May 7, 2008 from ISDH#1 to Director, Regulatory Compliance Clarian Health Partners, Inc. indicated there was an ORDER TO GRANT A WAIVER, specific for Clarian Health Partners, Inc, DBA Methodist, IU, Riley [Hospitals], Facility #005051, which would allow the hospitals to deviate from annual inspections and the manufacturer's recommended maintenance schedules.</p> <p>5. Since the waiver was applicable to only those hospitals, and not the surgery center, Facility #004756, the surgery center was still responsible to document maintenance schedule of appropriate frequency in accordance with acceptable standards of practice or the manufacturer's recommended maintenance schedule for</p>		<p>- Emergency Call System will be updated to include biannual testing of the emergency call system. The safety officer has developed a checklist for testing. This will be approved by the board of managers via written consent in lieu of a meeting by 06/30/2011.</p>		

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	<p>all patient care equipment.</p> <p>6. On 6-7-11 at 11:30 am, upon interview, employee #A4 indicated there was no documentation for PM on a wheelchair and none was provided prior to exit.</p> <p>7. On 6-6-11 at 10:00, employees #A1 and #A4 were requested to provide documentation of testing of the emergency nurse call system.</p> <p>8. On 6-6-11 at 2:00 pm, upon interview, employee #A4 indicated in a patient care emergency, i.e. code blue, the facility would use the overhead paging system to announce the emergency. The employee was requested to provide a policy and documentation for testing the paging system in year 2010. The employee indicated there was no policy and no documentation for testing this system, and none was provided prior to exit.</p>				

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S1168	<p>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 keep records of preventive maintenance (PM) for 2 pieces of patient care equipment being analyzed at least triennially.</p> <p>Findings:</p> <p>1. On 6-6-11 at 10:00 am, employees #A1 and #A4 were requested to provide documentation of triennial analysis of an anaesthesia machine and EKG (electrocardiograph) machine to determine the PM conducted was in accordance with the manufacturer ' s recommendation or facility policy.</p>	S1168	The clinical director is responsible for the implementation of the plan of correction. Plan: Work with Clinical Engineering to meet triennial analysis requirements for all medical equipment receiving PMs and have documentation of the analysis readily onsite for the EKG and Anesthesia machines by 08/30/2011 1. Advise Clinical Engineering that preventive maintenance process for all medical equipment must be analyzed at least triennially, and documentation must be maintained readily onsite. Communication to be complete by 06/30/20112. Work with Clinical engineering to ensure appropriate records are available	08/30/2011			

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	2. On 6-7-11 at 1:30 pm, upon interview, employee #A4 indicated there was no documentation of triennial analysis of an anesthesia machine and EKG machine and no documentation was provided prior to exit.		for compliance. To be completed by 08/30/2011.		