

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001197	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/30/2016
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NAME OF PROVIDER OR SUPPLIER SURGERY CENTER OF EYE SPECIALISTS OF INDIANA, PC	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 W 86TH STREET INDIANAPOLIS, IN 46260
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S 0000 Bldg. 00	<p>This visit was for a State licensure survey.</p> <p>Facility Number: 013451</p> <p>Survey Date: 03-28/30-2016</p> <p>QA: cjl 05/13/16</p>	S 0000	Survey received	
S 0156 Bldg. 00	<p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES</p> <p>410 IAC 15-2.4-1 (c)(5) (E)</p> <p>Require that the chief executive officer develop and implement policies and programs for the following:</p> <p>(E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.</p> <p>Based on document review and interview, the Chief Executive Officer failed to ensure an annual performance evaluation for 1 of 2 RNs (Registered Nurses), (N2) and 1 of 1 contracted</p>	S 0156	S156 This tag is related to the performance evaluation on a contracted services employee (housekeeper N9) The contracted service of City Wide is evaluated on a quarterly basis to	04/19/2016

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>Housekeepers (N9).</p> <p>Findings Include:</p> <p>1. Review of policy/ procedure PERSONNEL POLICY 3.01 Employee Handbook, indicated on page xlvi the following: PERFORMANCE REVIEWS It is difficult for an employee to improve their performance unless they understand what they need to do better. Constructive and clear feedback is essential to improvement. Performance reviews consist of two primary components: the performance of the specific job, and the contribution to the personal and corporate growth. Performance reviews for all employees are scheduled annually generally on or around the employee's anniversary. New employees generally receive an informal performance review after being employed three to six months. Each employee is required to have a formal evaluation at least once each year by their direct supervisor and a member of Administration. Reviews will be kept in the employee's personnel file. This policy/ procedure was last reviewed/ revised on January 14, 2016.</p> <p>2. Review of personnel files indicated a lack of documentation for an annual performance evaluation for RN N2, Director of Nursing/Infection Control and</p>		<p>ensure they are performing the required cleaning task of the facility The housekeeper is not a direct member of the staff and is employed by City Wide not the facility Therefore, a performance review of the employee of the contracted service will only be completed by the facility if an issue is present with the cleaning on the facility on the quarterly contract services evaluation. Each area of the facility is evaluated such as Perioperative and Operating Room areas during the quarterly review</p> <p>1.(410 IAC 15-2.4-1 (c)(5) (E)) Yearly performance reviews for RN N2, Director of Nursing/Infection Control were located in administration office after the survey had concluded. The dates of these performance reviews were: 2/27/2015 and 2/27/2016. Reviews are attached in supporting documents. Policy 8.13 has been modified and approved by the Medical Staff and Governing Body stating that contracted vendors will be evaluated on a quarterly basis in lieu of an annual review by the facility. Also, that employees of the contracted service will only be given an individual review if a issues presents on the contract services quarterly evaluation form. The contracted vendors housekeeping personnel will receive an annual in service provided by contracted vendor, which will include blood borne</p>		

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S 0228 Bldg. 00	<p>contracted Housekeeper N9.</p> <p>3. Interview on 3-29-16 at 1312 hours with RN N2, Director of Nursing/Infection Control confirmed the finding.</p> <p>410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(4)</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>(4) Ensure that the center maintains a written transfer agreement with one (1) or more hospitals for immediate acceptance of patients who develop complications or require postoperative confinement, and that all physicians, dentists, and podiatrists performing surgery in the center maintain admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the</p>		<p>pathogens and sterile cleaning techniques. See supporting documents for revised policy 8.13.</p> <p>2 Ensuring a completed quarterly contracted service evaluation is done on the contracted service of housekeeping and an individual review is completed is necessary. This will be reported to the governing body and ensure that this deficiency is resolved 3 Jennifer Knepp and Katie Ralston are responsible 4 Deficiency corrected on the date of the governing body approval of policy revision 4/19/2016</p>	

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S 0230 Bldg. 00	<p>center is located. Based on document review and interview, the governing board failed to assure that physicians performing surgery in the facility maintained admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located for 1 (MD#4) of 4 medical staff credential files reviewed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Review of 4 medical staff credential files indicated file MD#4 did not have documentation of admitting privileges at one (1) or more hospitals in the same county or in an Indiana county adjacent to the county in which the facility is located. In interview of employee #A2, Administrator, on 03-30-2016 at 9:30 am, the above was confirmed and no other documentation was provided prior to exit. <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</p>	S 0228	<p>1 (410-IAC 15 2.4-1 (e)(4)- At the Governing Body meeting, 4/19/16, Dr Craig Beyer (MD#4) had his privileges at the Surgery Center of Eye Specialists of Indiana, PC, suspended pending approval from St Vincents hospital granting admitting and surgical privileges Application for admitting and surgical privileges was received from St Vincents hospital on March 31st, 2016, and is awaiting completion by Dr Craig Beyer (MD#4) at this time</p> <p>2 Ensuring that the credentialing committee receives documentation of admitting and surgical privileges prior to granting privileges at the Surgery Center of Eye Specialists of Indiana, PC will resolve future deficiencies</p> <p>3 Credentialing committee (Jennifer Knepp and Katie Ralston) are responsible</p> <p>4 Deficiency corrected on 3/30/16 by suspension of MD#4's privileges until proper documentation is obtained</p>	03/30/2016			

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	<p>governing body shall do the following:</p> <p>(5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility.</p> <p>Based on document review and interview, the facility failed to provide 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 in 1 instance.</p> <p>Findings include:</p> <p>1. Review of a facility document entitled Surgery Center of Eye Specialists of Indiana, PC. Utilization Review Committee Quarterly Meeting November 5, 2015, indicated there was only 1 physician, MD#1, an ophthalmologist as part of the committee.</p> <p>2. In interview, on 03-28-2016 at 12:50 pm, employee #A2, Administrator, confirmed there was only 1 physician on the Committee and that the physician, MD#1, has a financial interest in the facility. No other documentation was provided prior to exit.</p>	S 0230	<p>1 (410 IAC 15-2 4-1 (e)(5)- The Governing Body met on 4/19/2016 and approved the following licensed physicians as members of the Utilization review committee: Dr William Shultz, Dr Clark Springs, and Dr Craig Beyer These physicians have no financial interest (ownership) in the facility The purpose of the Utilization Review Committee is to provide periodic review of the center and its operation</p> <p>2 Having three licensed physicians with no ownership in the facility serve on the Utilization Review Committee prevents further deficiency</p> <p>3 The Governing Board is responsible for electing the three physicians to serve on the Utilization Review Committee Jennifer Knepp and Katie Ralston are responsible in ensuring that this is done by the Governing Board</p> <p>4 Deficiency corrected on 4/19/2016 when the Governing Board met and approved the physicans/Utilization Review Committee</p>	04/19/2016

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S 0442 Bldg. 00	<p>410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(f)(2)(E)(viii)</p> <p>The infection control committee responsibilities must include, but are not limited to:</p> <p>(E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:</p> <p>(viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies.</p> <p>Based on document review and interview, the infection control committee failed to implement policy as related to Hepatitis B for 1 of 1 contracted Housekeepers (N9).</p> <p>Findings Include:</p> <p>1. Review of policy/procedure INFECTION CONTROL AND EXPOSURE CONTROL POLICY 10.07 Bloodborne Pathogen Exposure Control Plan, indicated on page 3 the following: HBV Immunization The practice offers free vaccination for hepatitis B to all current and new employees who perform at-risk tasks.</p>	S 0442	<p>1 (410 IAC 15-2 5-1 (f)(2)(E)(viii)- Housekeeper N9 is contracted through City Wide Cleaning, the contracted cleaning company Surgery Center of Eye Specialists of Indiana will offer the Hepatitis B vaccination to all contracted housekeeping staff If the housekeeping staff refuses the vaccination they will be required to complete a declination of vaccination form.</p> <p>2 By the contracted housekeeping staff receiving the Hepatitis B vaccination from the Surgery Center of Eye Specialists of Indiana or signing the declination form this will correct the deficiency 3 Katie Ralston and Jennifer Knepp responsible 4 The</p>	07/07/2016
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S 0710 Bldg. 00	<p>Those who decline vaccination are required to sign a declination form. This policy/ procedure was last reviewed/ revised on January 14, 2016.</p> <p>2. Review of personnel files indicated a lack of documentation for Hepatitis B vaccination or a vaccination declination form for Housekeeper N9.</p> <p>3. Interview on 3-29-16 at 1358 hours with RN N2, Director of Nursing, confirmed the finding.</p> <p>410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(a)(4)</p> <p>The medical staff shall do the following:</p> <p>(4) Maintain a reasonably accessible hard copy or electronic file for each member of the medical staff, which includes, but is not limited to, the following:</p> <p>(A) A completed, signed application.</p> <p>(B) The date and year of completion of all Accreditation Council for Graduate Medical Education (ACGME) accredited residency training programs, if</p>		deficiency was corrected 7/7/2016 thus correcting further deficiencies		

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	<p>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> <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</p>			

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S 0756	<p>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, for 1 of 4 medical staff credential files reviewed, the facility failed to include in the credential file of physician MD#4, that the physician had privileges to perform surgical procedures in at least one hospital within the county or an Indiana county adjacent to the county in which the ambulatory surgical center is located</p> <p>Findings:</p> <p>1. Review of 4 medical staff credential files indicated file of MD#4 did not have documentation to perform surgical procedures, from at least one hospital within the county or an Indiana county adjacent to the county in which the ambulatory surgical center is located.</p> <p>2. In interview, on 03-30-2016 at 9:30 am, employee #A2, Administrator, confirmed the above and no further documentation was provided prior to exit.</p>	S 0710	<p>1 (410-IAC 15-2 5-4 (a)(4)- As stated in tag S228, as of 4/19/2016, the Governing Body has suspended Dr Craig Beyers privileges at the Surgery Center of Eye Specialists of Indiana, PC pending approval from St Vincents hospital granting admitting and surgical privileges Application was received from St Vincents hospital on March 31st, 2016, and is awaiting completion by Dr Craig Beyer (MD#4) at this time</p> <p>2 Ensuring that the credentialing committee receives documentation of admitting and surgical privileges prior to granting privileges at the Surgery Center of Eye Specialists of Indiana, PC will resolve future deficiencies</p> <p>3 Credentialing committee (Jennifer Knepp and Katie Ralston,) are responsible</p> <p>4 Deficiency corrected on 4/19/2016 by suspension of MD#4's privileges until proper documentation received</p>	04/19/2016

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Bldg. 00	<p>MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(J)</p> <p>These bylaws and rules must be as follows:</p> <p>(3) Include, at a minimum, the following:</p> <p>(J) A requirement that each physician's services, , dentist's services, and podiatrist's services are to be reviewed and analyzed at specified intervals at regular meetings, including, but not limited to, the following:</p> <p>(i) Appropriateness of diagnoses and treatments rendered related to a standard of care and anticipated or expected results. (ii) Performance evaluation based on clinical performance indicated in part by the results or outcome of surgical intervention. (iii) Scope and frequency of procedures.</p> <p>Based on document review and interview, the facility failed to include the scope and frequency of procedures as part of performance evaluations on physicians in 1 instance.</p> <p>Findings include:</p> <p>1. Review of facility Policy 3.11, entitled Provider Credentialing approved by the medical staff on 01-14-2016, did not indicate the performance evaluations on</p>	S 0756	1 (410 IAC 15-2 5-4 (b)(3)(J)- On April 19th, 2016, the Governing Body and Medical Staff Committees' approved a revision to Policy 3- 11, Provider Credentialing, to include scope and frequency of procedures The Medical Staff Credentialing/Re-Credentialing evaluation form was modified to include Procedure Logs for the last 24 months or an option to list procedures/cases and the total volume of the listed procedures/cases See attached	04/19/2016

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	<p>physicians would include the scope and frequency of procedures.</p> <p>2. Review of forms used for the evaluation, entitled Credentialing Evaluation Form, and SURGEON PEER REVIEW EVALUATION, which were a part of the procedure, also did not have any place to make entry for the scope and frequency of procedures as part the review.</p> <p>3. On 03-28-2016 at 9:45 am, employee #A2, Administrator, was requested to provide documentation of performance review for the facility's surgeons.</p> <p>4. The employee provided a document for an ophthalmic surgeon, MD#2, entitled Credentialing Evaluation Form, dated 12-22-15. Review of this document indicated there was no data included as to the scope and frequency of procedures.</p> <p>5. In interview, on 03-29-2016 at 12:40 pm, employee #A2 confirmed all the above and no other documentation was provided prior to exit.</p>		<p>policy, Medical Staff Credentialing/Recredentialing evaluation, and Surgeon Peer Review sheets</p> <p>2 Ensuring that the Medical Staff submits procedure logs and frequency of procedures to the annual Utilization Review Committee corrects future deficiencies</p> <p>3 Credentialing Committee, Jennifer Knepp and Katie Ralston, responsible</p> <p>4 Deficiency corrected at the April 19th Governing Body and Medical Staff meeting when policy revisions were accepted</p>	

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S 0928 Bldg. 00	<p>410 IAC 15-2.5-5 PATIENT CARE SERVICES 410 IAC 15-2.5-5(b)(4)</p> <p>(b) Written patient care policies and procedures shall be available and shall include, but not be limited to, the following:</p> <p>(4) A provision that facilities, reusable equipment, and supplies shall be thoroughly cleaned and/or sterilized following use according to center policies and procedures. Based on document review and interview, the facility failed to ensure proper cleaning of the glucometer testing machine after each use.</p> <p>Findings Include:</p> <p>1. Review of policy/procedure MEDICAL MANAGEMENT POLICY 7.03 Out of Laboratory Blood Glucose Testing, indicated the following: PROCEDURE: Glucometers will be cleaned after each use per manufacture guidelines. If cleaning not specified the glucometer will be considered single use. This policy/ procedure was last reviewed/ revised on January 14, 2016.</p> <p>2. Review of the Contour XT Blood Glucose Monitoring System User Guide,</p>	S 0928	<p>1 (410 IAC 15-2 5-5(b)(4) The glucometer will be cleaned with Clorox bleach wipes, containing 1 part bleach and 9 parts water The staff attended an inservice on this practice, and alcohol wipes will no longer be used to clean the glucometer 2 Staff inservices will be held yearly, as well as upon new hire, on how to properly clean the glucometer/ this will correct future deficiencies. 3 The staff will be monitored and watched on a daily basis to ensure the alcohol wipes are no longer used but the bleach wipes are used for cleaning instead 4 Katie Ralston and Jennifer Knepp responsible 5 Deficiency corrected 5/17/2016 upon receipt of the clorox wipes that were ordered on 5/16/2016 A staff inservice was held prior to the start of the surgery day on this practice</p>	05/17/2016

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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 1154 Bldg. 00	<p>indicated on page 12 the following: Cleaning Your Meter The exterior of the Contour XT meter can be cleaned using a moist (not wet) lint free tissue with a mild detergent or disinfectant solution, such as 1 part bleach mixed with 9 parts water. Wipe dry with lint free tissue after cleaning.</p> <p>3. Interview on 3-29-16 at 1312 hours with RN N2, Director of Nursing/Infection Control indicated and confirmed that facility practice for cleaning the blood glucose meter after each use was to clean with alcohol wipes.</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</p>			

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	<p>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 having been analyzed at least triennially for 3 of 6 systems of equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 03-28-2016 at 9:45 am, employee #A2, Administrator, was requested to provide documentation of the operational and maintenance control records for the heating, ventilation, air conditioning, emergency generator, smoke detector, and fire alarm systems having been analyzed at least triennially to determine if the process used to conduct the preventive maintenance was current and in accordance with manufacturer's recommendations. Review of facility documents indicated there was no documentation for the heating, ventilation, and air conditioning systems having been analyzed at least triennially to determine if the process used to conduct the preventive maintenance was current and in accordance with manufacturer's recommendations. 	S 1154	<ol style="list-style-type: none"> (410 IAC 15-2 5-7 (b)(3)(C) Irish Mechanical services was contacted and provided attached documentation that the heating, cooling, and ventilation systems are checked according to manufacturer specifications, and a list is attached Requesting a more detailed checklist of what was completed each quarter will prevent future deficiencies Katie Ralston and Jennifer Knepp will inspect all future invoices received This deficiency is now correct as of 5/17/2016, and will be more detailed following future quarterly inspections 	05/17/2016

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S 1168 Bldg. 00	<p>3. Interview of employee #A2, on 03-30-2106 at 9:30 am, confirmed there was no above-requested documentation. 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 electrical current leakage checks for 1 of 8 pieces of patient care equipment and failed to conduct triennial analysis of the procedures to conduct preventive</p>	S 1168	1 (410 IAC 15-2 5-7 (b)(4)(B)(iii)-Getinge and K&R Medical were contacted in regards to the triennial analysis of the procedures to conduct PM for the sterilizer Getinge will continue to do Preventative Maintenance on the steam sterilizers and provide	05/17/2016

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	<p>maintenance (PM) for 1 (sterilizer) of 8 pieces of patient care equipment.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 03-28-2016 at 9:30 am, employee #A2, Administrator, was requested to provide documentation of electrical current leakage checks for 8 pieces of patient care equipment. 2. Review of facility documentation provided indicated there was no documentation of current electrical leakage checks for the sterilizer. 3. Interview of employee #A2 on 03-30-2016 at 9:30 am confirmed there was no documentation of current electrical leakage checks for the sterilizer and no other documentation was provided prior to exit. 4. On 03-28-2016 at 9:30 am, employee #A2, Administrator, was requested to provide documentation of a triennial analysis of the procedures to conduct PM for 8 pieces of patient care equipment. 5. Review of facility documentation provided indicated there was no documentation of a triennial analysis of the procedures to conduct PM for the sterilizer. 		<p>proper documentation K&R Medical will continue the electrical leakage checks and provide proper documentation</p> <p>2 Providing proper documentation of exactly what was done and what standards were used will prevent further deficiencies\</p> <p>3 Katie Ralston and Jennifer Knepp will look at all the reports and make sure that the correct information is on the report</p> <p>4 This is correct as of 5/17/2016, and will be further corrected on the next scheduled quarterly inspection by Getinge and the next biannual inspection by K&R medical</p>	

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	6. Interview of employee #A2 on 03-30-2016 at 9:30 am confirmed there was no documentation of a triennial analysis of the procedures to conduct PM for the sterilizer and no other documentation was provided prior to exit.				