

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 01P001	(X3) Date Survey Completed 03/29/2018
Name of Provider or Supplier Legacy Of Hope	Street Address, City, State 516 20th Street South, Birmingham, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
Z0084	<p>ADMINISTRATION AND GOVERNING BODY CFR(s): 486.324</p> <p>Administration and governing body.</p> <p>This CONDITION is not met as evidenced by: Based on record review and staff interview, the Organ Procurement Organization's (OPO's) Governing Body (Operating Committee) failed to ensure effective administration of the organization took place in the following areas: 1) Verification of Advisory Board members qualifications, 2) Ensured the Advisory Board had a Transplant Surgeon from each Transplant Hospital as a member, 3) Established bylaws of the OPO's Operating Committee (OC), 4) Defined the timeframe for OPO staff initial response onsite at the Donor Hospital, 5) Validated written Donor Record review was completed by the Medical Director and 6) that Quality Improvement measured and evaluated the timeliness of chart review and initial response onsite after hospital referral. The OPO's cumulative lack of compliance at Standards Z085, Z090, Z094, Z121, Z168 & Z200 rose to the Condition Level of non-compliance. The OPO had a high likelihood of missed donations due to lack of oversight by the Governing Body (Operating Committee) as evidenced by: onsite response times after hospital referral that ranged from 5 hours to 4 days for 7 of 10 donor records reviewed and tissue processing delays of at least 90 days for at least 60 Tissue donor records due to staffing and delays in completing chart audits. The findings include: Cross Refer to Z085: Based on staff interview and review of the Advisory Board Bylaws the Organ procurement Organization (OPO) failed to verify qualifications of the Advisory Board members. Cross Refer to Z090: Based on staff interview, document review and review of the Advisory Board Membership, the Organ Procurement Organization (OPO) failed to ensure a transplant surgeon was on the Advisory Board from each of the three (3) transplant hospitals. Cross Refer to Z094: Based on document review and staff interview, the Organ Procurement</p>

Organization (OPO) failed to have bylaws for its Governing Body (Operating Committee) for four of four (4 of 4) years. Cross Refer to Z121: Based on donor record review, staff interview and review of the "Responding to a Potential Donor" policy, the Organ Procurement Organization (OPO) failed to arrive promptly onsite for seven (7) of 10 donors and failed to define the timeframe for initial response onsite at the donor hospital within their policy. Cross Refer to Z168: Based on staff interview, donor record review and review of the "Quality Assurance Review/Audit of Donor Records" policy, the Organ Procurement Organization (OPO) failed to ensure donor records were reviewed by the Medical Director for nine of nine (9 of 9) Donors. Cross Refer to Z200: Based on document review and staff interview, the Organ Procurement Organization (OPO) failed to include measures to evaluate and improve 1) the timeliness of on-site response to hospital referrals and 2) delays in completing chart audits required prior to tissue donation processing. The OPO had a high likelihood of missed donations due to lack of oversight by the Governing Body (Operating Committee) as evidenced by: onsite response times after hospital referral that ranged from 5 hours to 4 days for 7 of 10 donor records reviewed and tissue processing delays of at least 90 days for at least 60 Tissue donor records due to staffing and delays in completing chart audits.