


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/03/2022	
NAME OF PROVIDER OR SUPPLIER METRO SPECIALTY SURGERY CENTER LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 MISSOURI AVE, BLDG 18, JEFFERSONVILLE, IN, 47130		
(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
S0000	<p>INITIAL COMMENTS</p> <p>This visit was for a state licensure survey of an ambulatory surgery center.</p> <p>Facility number: 012244</p> <p>Dates: 8/2/22 - 8/3/22</p> <p>QA: 9/16/2022</p>	S0000		2022-11-09
S0228	<p>GOVERNING BODY; POWERS AND DUTIES</p> <p>410 IAC 15-2.4-1</p>	S0228	<p>Deficiency will be corrected by obtaining written evidence of admitting privileges from Clark Memorial Hospital from the Medical Staff Office and placing in each facility owners credentialing file under the "Hospital Affiliations" section. This will be complete by</p>	2022-11-09

410 IAC 15-2.4-1(e)(4)

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:

(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 center is located.

Based on document review and interview, the governing body (GB) failed to ensure that 3 of 3 physicians (MD3, MD4 and MD5) privileged to perform surgery in the center maintained admitting privileges at one or more hospitals in the same county or in an Indiana county

November 9th, 2022 and overseen by the Metro Specialty Credentialing Coordinator. Compliance monitoring will occur at the time of credentialing and re-credentialing on 100% of the required files.

located.

Findings include:

1. Review of the credential files for MD3, MD4, and MD5 lacked evidence of their having admitting privileges at one or more hospitals in the same county or in an Indiana county adjacent to the county in which the center is located. The files indicated MD3 was appointed and approved for surgical privileges in the center on 7/14/22; MD4 was appointed and approved for surgical privileges in the center on 5/26/22, and MD5 was appointed and approved for surgical privileges in the center on 5/26/22.

2. On 8/3/22, beginning at approximately 3:00 PM, A4, Registered Nurse/Credentialing Coordinator, verified the center did not have documentation of surgeons MD3, MD4, or MD5

	<p>having admitting privileges in the same county or in an Indiana county adjacent to the county in which the center is located.</p>			
<p>S0710</p>	<p>MEDICAL STAFF; ANESTHESIA AND SURGICAL</p> <p>410 IAC 15-2.5-4</p> <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>S0710</p>	<p>Deficiency will be corrected by obtaining written evidence of surgical privileges from Clark Memorial Hospital from the Medical Staff Office and placing in each facility owners credentialing file under the "Hospital Affiliations" section. This will be complete by November 9th, 2022 and overseen by the Metro Specialty Credentialing Coordinator. Compliance monitoring will occur at the time of credentialing and re-credentialing on 100% of the required files.</p>	<p>2022-11-09</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.

(ii) Indiana controlled substance registration showing number as applicable.

(iii) Drug Enforcement Agency registration showing number as applicable.

(iv) Documentation of experience in the practice of medicine.

(v) Documentation of specialty board certification as applicable.

(vi) Documentation of privilege to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C).

(D) Category of medical staff appointment and delineation of

privileges approved.

(E) A signed statement to abide by the rules of the center.

(F) Documentation of current health status as established by center and medical staff policy and procedure and federal and state requirements.

(G) Other items specified by the center and medical staff.

Based on document review and interview, the center failed to maintain credential file documentation of privileges to perform surgical procedures in a hospital in accordance with IC 16-18-2-14(3)(C) for 3 of 3 physicians privileged to perform surgery in the center MD3, MD4 and MD5.

Findings include:

1. Review of credential files for MD3, MD4, and MD5 indicated each were privileged to perform surgery in the center. The files lacked documentation of MD3, MD4 and/or MD5 having privileges to perform surgical procedures in a hospital in

	<p>16-18-2-14(3)(C).</p> <p>2. On 8/3/22, beginning at approximately 3:00 PM, A4, Registered Nurse/Credentialing Coordinator, verified the center did not have documentation of surgeons MD3, MD4, or MD5 having privileges to perform surgery in a hospital in accordance with IC 16-18-2-14(3)(C).</p>			
<p>S1146</p>	<p>PHYSICAL PLANT, EQUIPMENT MAINTENANCE,</p> <p>410I AC 15-2.5-7</p> <p>410 IAC 15-2.5-7(b)(2)</p> <p>(b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:</p> <p>(2) No condition may be created or maintained which may result in a hazard to patients, public, or employees.</p>	<p>S1146</p>	<p>Deficiency was corrected on 8/3/2022 by facility administrator. Biohazard/sharps containers were relocated to an available room with a locked door to secure them until pick up from biomedical waste company. A biohazard sign was placed on the door to signal contents of room as required. Compliance monitoring will occur daily by visualization during daily facility rounds by administrator and/or OR Manager.</p>	<p>2022-08-03</p>

Based on observation and interview, the facility failed to store full Sharp's (or Sharpe's) containers in an area to prevent hazard to employees and off of the floor.

Findings include:

1. On 8/3/22 at approximately 9:10 A.M. during tour of facility with A2 (Registered Nurse {RN}, Quality/Safety Director), this writer observed several closed/full Sharp's (or Sharpe's) containers on floor in a hallway to the outside of the facility. The door into the hallway was locked, lacked Biohazard signage. A2 confirmed above statement.

2. Interview on 8/3/22 at approximately 3:15 P.M. with A1 (Administrator) indicated aware Sharp's (or Sharpe's) containers are to be off floor in a storage area designated for biohazard.

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katie Arnold	Administrator	11/7/2022 11:43:57 AM