

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 04/18/2023
NAME OF PROVIDER OR SUPPLIER METRO SPECIALTY SURGERY CENTER L			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MISSOURI AVE, BLDG 18 , JEFFERSONVILLE, Indiana, 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
Q0000	INITIAL COMMENTS This visit was for a federal re-certification survey. Facility Number: 012244 Survey Date: 04-17-2023 to 04-18-2023 Metro Specialty Surgery Center, LLC. is in compliance with 42 CFR 416.40 through 416.52, requirements for Medicare Conditions of Participation for Ambulatory Surgery Centers. QA: 5/25/2023	Q0000		
Q0100	ENVIRONMENT CFR(s): 416.44 The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was maintained (see tag K345), 2. failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72 (see tag K345) and failed to ensure the fire alarm system was activated during 3 of 4 fire drills performed during the past 12 months (see tag K712). The cumulative effect of these systemic problems resulted in the facility's inability to ensure it had implemented a systemic plan of correction to prevent recurrence, therefore failing to ensure the provision of quality health care in a safe environment.	Q0100		06/05/2023
Q0104	SAFETY FROM FIRE	Q0104		06/05/2023

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
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Q0104	<p>Continued from page 1 CFR(s): 416.44(b)(1)-(3)</p> <p>(b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served, and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).</p> <p>(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.</p> <p>(3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm system was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the Table 14.4.5 Testing Frequencies. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. NFPA 72, 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all occupants.</p> <p>2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually</p>	Q0104		

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Q0104	<p>Continued from page 2 inspected semi-annually:</p> <ul style="list-style-type: none"> a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices <p>This deficient practice could affect all occupants in the facility.</p> <p>1. Based on record review and interview, the facility failed to ensure the fire alarm system was activated during 3 of 4 fire drills performed during the past 12 months. This deficient practice could affect all occupants in the facility.</p> <p>Findings Include:</p> <p>Based on record review on 05/17/23 between 9:00 a.m. and 1:00 p.m. with the Radiology Technician present, there was no smoke detector sensitivity test available to review for the past 24-month period. The most recent smoke detector sensitivity test report available was dated 03/31/21 for all 41 smoke detectors. Based on interview at the time of record review, the Radiology Technician confirmed a smoke detector sensitivity test has not been performed since 03/31/21.</p> <p>This finding was reviewed with the Administrator and Radiology Technician during the exit conference.</p> <p>Based on record review on 05/17/23 between 9:00 a.m. and 1:00 p.m. with the Radiology Technician present, a visual semi-annual fire alarm system inspection report was provided and performed by the facility staff on 01/04/23, however, the report provided only included the testing of pull stations but did not include the visual inspection of smoke detectors and all heat detectors in the facility. Based on interview at the time of record review, the Radiology Technician confirmed the semi-annual visual inspection of the fire alarm system's initiating devices, such as, smoke detectors and heat detectors, were not included on the semi-annual visual inspection performed on 01/04/23.</p> <p>This finding was reviewed with the Administrator and Radiology Technician during the exit conference.</p>	Q0104		

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Q0104	Continued from page 3 Based on record review on 05/17/23 between 9:00 a.m. and 1:00 p.m. with the Radiology Technician present, documentation for fire drills performed on 07/18/22, 10/12/22, and 01/26/23 had a question for each drill that said "Alarm Activated" with a "Yes" or "No" answer. The answer for each of the three fire drills performed was "No". Based on interview at the time of record review, the Radiology Technician said the alarm was not activated during three of the four documented fire drills during the past 12 months, but that issue has been addressed and the alarm will be activated during each fire drill in the future. This finding was reviewed with the Administrator and Radiology Technician during the exit conference.	Q0104		