

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15C0001174</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - METRO SPECIALTY...</b> B. WING	(X3) DATE SURVEY COMPLETED <b>07/13/2023</b>
NAME OF PROVIDER OR SUPPLIER <b>METRO SPECIALTY SURGERY CENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 MISSOURI AVE, BLDG 18 , JEFFERSONVILLE, Indiana, 47130</b>	
(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
K0000  Bldg. 01	<p><b>INITIAL COMMENTS</b></p> <p>Paper compliance to the Post Survey Revisit (PSR) that exited on 06/28/23 for the Life Safety Code Recertification Survey that exited on 05/17/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Review Date: 07/13/23</p> <p>Facility Number: 012244</p> <p>Provider Number: 15C0001174</p> <p>AIM Number: NA</p> <p>Metro Specialty Surgery Center LLC was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection throughout the facility.</p>	K0000		

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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