

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 230122441	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER METRO SPECIALTY SURGERY CENTER LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 MISSOURI AVE, BLDG 18 , JEFFERSONVILLE, Indiana, 47130	
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S0000	INITIAL COMMENTS This visit was for a state licensure survey of an Ambulatory Surgery Center. Facility Number: 012244 Survey Dates: 4/15/24 to 4/16/24 QA: 4/29/2024	S0000		
S0153	GOVERNING BODY; POWERS AND DUTIES CFR(s): 410 IAC 15-2.4-1 410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, facility failed to complete orientation for 4 of 7 personnel files reviewed. (N2 [Registered Nurse-RN], N3 [Radiology Technician-RT], N4 [Surgical Technician-ST], and N5 [Sterile Processing Technician]) Findings include: 1 Facility policy titled, Orientation and Training, policy number 3.16, last revised 12/5/2022, indicated	S0153		05/31/2024

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S0153	Continued from page 1 on page 2, 4. Initial orientation and training shall be: a. Completed within thirty (30) days of commencement of employment. 2. Personnel file review completed on 4/16/2024 indicated N2, N3, N4 and N5 lacked documentation of completed orientation. 3. In interview on 4/16/2024 at approximately 1330 hours with A2 (Operating Room Manager), he/she confirmed N2, N3, N4, and N5 personnel files lacked completed orientation.	S0153		
S0154	GOVERNING BODY; POWERS AND DUTIES CFR(s): 410 IAC 15-2.4-1 410 IAC 15-2.4-1 (c)(5) (D) Require that the chief executive officer develop and implement policies and programs for the following: (D) Ensuring that all health care workers, including contract and agency personnel, for whom a license, registration, or certification is required, maintain current license, registration, or certification and keep documentation of same so that it can be made available upon request. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, facility failed to maintain documentation of current license for 1 of 7 personnel files reviewed. (N7, Registered Nurse) Findings include: 1. Facility policy titled, Qualifications and Training of Employees, policy number 4.01, last revised 12/5/2022, indicated Procedure: 2. Licenses will be	S0154		05/03/2024

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S0154	Continued from page 2 current and will be maintained in the employee's personnel file. 2. Personnel file review completed on 4/16/2024 indicated N7 lacked documentation of current nursing license. 3. In interview on 4/16/2024 at approximately 1330 hours with A2 (Operating Room Manager), he/she confirmed N7 personnel file lacked a current nursing license.	S0154		
S0780	MEDICAL STAFF; ANESTHESIA AND SURGICAL CFR(s): 410 IAC 15-2.5-4 410 IAC 15-2.5-4(b)(3)(N) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (N) A requirement that all practitioner orders are in writing or acceptable computerized form and must be authenticated by a responsible practitioner as allowed by medical staff policies and within the time frames specified by the medical staff and center policy not to exceed thirty (30) days. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, facility failed to authenticate provider verbal transfer order for 1 of 5 transfer records reviewed. (Patient # 29) Findings include: 1. Facility policy titled, Standards For Clinical	S0780		05/31/2024

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S0780	Continued from page 3 Records, policy number 6.01, last revised 12/5/2022, indicated on page 3, 9. The ordering physician must sign verbal orders within 7 days. 2. Medical Record review completed on 4/16/2024 indicated a verbal order for patient transfer was given by provider on 3/16/2023 for patient #29. Order lacked verification signature by provider. 3. In interview on 4/16/2024 at approximately 1330 hours with A2 (Operating room manager), he/she confirmed lack of verification signature by provider on patient #29 transfer order.	S0780		
S0888	MEDICAL STAFF; ANESTHESIA AND SURGICAL CFR(s): 410 IAC 15-2.5-4 410 IAC 15-2.5-4(d)(2)(F) Requirement for surgical services include: (2) Surgical services shall develop, implement, and maintain written policies governing surgical care designed to assure the achievement and maintenance of standards of medical and patient care as follows: (F) A requirement for an operative report describing techniques, findings, and tissue removed or altered to be written or dictated immediately following surgery and authenticated by the surgeon in accordance with center policy and governing body approval.	S0888		05/01/2024

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S0888	Continued from page 4 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview, facility failed to authenticate operative note according to facility policy for 3 of 30 medical records reviewed. (P10, P16, and P19) Findings include: 1. Facility policy titled, Standards for Clinical Records, policy number 6.01, last revised 12/5/2022, indicated on page 3, 7. The surgeon must dictate operative/procedure report in a timely manner after the date of surgery/procedure. Transcription is completed within 24 hours following the procedure. The surgeon must sign the operative report within 30 days indicating the dictation is completed and correct. 2. Medical record review completed on 4/16/2024 indicated the following: a. P10 date of surgery was 12/13/2023, operative report was signed by surgeon on 2/1/2024. b. P16 date of surgery was 12/27/2023, operative report was signed by surgeon on 2/1/2024. c. P19 date of surgery was 2/14/2024, operative report was signed by surgeon on 3/28/2024. 3. In interview on 4/16/2024 at approximately 1330 hours with A2 (Operating Room Manager), he/she confirmed operative reports for P10, P16, and P19 were not signed within the 30 days per policy.	S0888		
S1010	PHARMACEUTICAL SERVICES CFR(s): 410 IAC 15-2.5-6 410 IAC 15-2.5-6(3)(A) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel,	S1010		05/31/2024

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S1010	<p>Continued from page 5 including, but not limited to, the following:</p> <p>(A) Drug handling, storing, labeling, and dispensing.</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on document review, observation and interview, the facility stored in anesthesia cart, expired medication available for patient administration for 2 of 4 medications observed (albuterol inhalers x [times] 2); and facility failed to discard multi-use medication vials after initial opening in patient area according to policy for 2 of 4 medications observed in anesthesia cart. (Labetalol IV (intravenous) and 2% Lidocaine Hydrochloride IV)</p> <p>Findings include:</p> <p>1 Facility policy titled, Medication Administration, policy number 11.04, last revised 12/5/2022, indicated on page 4, 5. Check drugs at least monthly for expiration.</p> <p>2. Facility policy titled, Safe Injection Policy, policy number 11.05, last revised 12/5/2022, indicated under Procedure: 8. Clinical staff will not keep multidose vials in the immediate patient treatment area.</p> <p>3. During observation of anesthesia cart on 4/16/2024, accompanied by A3 (PAT [Preadmission Testing], Pre-op [Preoperative], and PACU [Post Anesthesia Care Unit] Manager), indicated:</p> <p>a. 2 albuterol inhalers had an expiration date of 01/2024.</p> <p>b. Labetalol IV and Lidocaine Hydrochloride IV medication vials were previously used and stored in anesthesia cart.</p> <p>4. In interview on 4/16/2024 at approximately 1045 hours, A3 confirmed expired albuterol inhalers stored in the anesthesia cart for patient use. A3 also confirmed IV medication vials of Labetalol and lidocaine had been used previously and should have been discarded according to facility policy.</p>	S1010		
S1024	PHARMACEUTICAL SERVICES	S1024		05/31/2024

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S1024	<p>Continued from page 6</p> <p>CFR(s): 410 IAC 15-2.5-6</p> <p>410 IAC 15-2.5-6(3)(E)</p> <p>Pharmaceutical service must have the following:</p> <p>(3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following:</p> <p>(E) Drugs must be accurately and clearly labeled and stored in specially-designated, well-illuminated cabinets, closets, or storerooms and the following:</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on document review, observation, and interview facility failed to label a multi-dose medication bottle according to policy after initial opening for 1 of 3 controlled substances reviewed (Midazolam Hydrochloride); and facility failed to label solution with additives according to policy for 1 of 4 medications reviewed in crash cart (Tranexamic Acid pre-mixed intravenous solution)</p> <p>Findings include:</p> <p>1 Facility policy titled, Medication Administration, policy number 11.04, last revised 12/5/2022, indicated on page 4, d. All solutions with additives will be labeled with date, time, patient's name, drug name, amount of additive and person who added the drug. f. Any multi-dose vial or ophthalmic drops shall be dated and initialed for expiration within 28 days of initial puncture of vial or access to the drops.</p>	S1024		

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S1024	Continued from page 7 2. During observation of medication storage on 4/16/2024 at approximately 1045 hours, accompanied by A3 (PAT [Preadmission Testing], Pre-op [Pre-operative], and PACU [Post Anesthesia Care Unit] Manager), indicated: a. An opened bottle of Midazolam Hydrochloride Syrup 2mg (milligrams)/ml (milliliter) was opened and stored in controlled substance cabinet, medication was not labeled with date of opening. b. In anesthesia cart, a pre-mixed IV (intravenous) bag was found stored and available for patient use without date, time, patient's name, amount of additive and person who added the drug. 3. In interview on 4/16/2024 at approximately 1045 hours, A3 indicated lack of knowledge of when the midazolam bottle had been initially accessed and confirmed the lack of label with date of initial access. A3 also confirmed bag of pre-mixed IV solution was not labeled according to policy.	S1024		
S1168	PHYSICAL PLANT, EQUIPMENT MAINTENANCE, CFR(s): 410 IAC 15-2.5-7 410 IAC 15-2.5-7(b)(4)(B)(iii) (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: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows:	S1168		05/03/2024

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S1168	<p>Continued from page 8</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>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on document review and interview, the facility failed to maintain preventive maintenance records for triennial analysis on 3 of 3 wheelchairs.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled, 8.05 Equipment Maintenance, last approved 12/5/22, indicated on page 1 under Policy section (bulleted points), equipment used on patients will be checked every six (6) months by a biomedical engineer contracted by the facility and documentation will be maintained in the center. 2. Review of Preventive Maintenance Logs lacked preventive maintenance on 3 of 3 wheelchairs. 3. In interview on 4/16/24 at approximately 9:50 am, A2 (Operating Room Manager) verified there was no preventive maintenance done on the 3 wheelchairs. 	S1168		