STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 240122781	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED AMBULATORY SURGERY CENTER LLC	1101 PROFESSIONAL BLVD SUITE 104 , EVANSVILLE, Indiana, 47714

(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	INITIAL COMMENTS This visit was for a State Licensure survey of an Ambulatory Surgery Center. Facility Number: 012278 Survey Dates: 4/30/25 to 5/01/25 QA: 5/13/2025	S0000		
S0230	GOVERNING BODY; POWERS AND DUTIES CFR(s): 410 IAC 15-2.4-1 410 IAC 15-2.4-1(e)(5) 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: (5) Provide for a periodic review of the center and its operation by a utilization review or other committee composed of three (3) or more duly licensed physicians having no financial interest in the facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and interview the facility failed to conduct utilization review of its operations	S0230		05/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S0230	Continued from page 1 in the past two quarters, by a committee comprised of 3 duly licensed physicians having no financial interest in facilities' operations (4th quarter 2024 and 1st quarter 2025) 1.Review of facility Medical Staff Rules & Regulations, last approved 5/25/23, indicated under Article IX - Medical Executive Committee. Section 4. Utilization Review - Committee. 1. Unless otherwise determined by the Governing Board in its discretion, the Utilization Review Committee (URC) will consist of physician members of the Medical Staff, the Center Administrator and Business Office Manager (or such other Center business personnel as are deemed appropriate by the Governing Board, and any other individuals deemed appropriate by the Governing Board. 2. Review of facility Organizational Chart indicated the Utilization Review Committee: The URC consists of at least 3 non-investor physicians. 3. Review of facility Utilization Review Committee (URC) meeting minutes over the previous 2 quarters indicated MD1 (Doctor of Medicine, Medical Director) was one of 2 licensed physicians in attendance of Utilization Review Meetings on 11/13/24 and 2/17/25. 4. Review of facility Utilization Review/Peer Review Audits comprised of MD1's signature for Quarter 4, 2024 and Quarter 1, 2025. 5. In telephone interview on 4/30/25 at approximately 1:00 pm to 1:07 pm, A3 (Administrator) confirmed MD1 is facility owner, and currently performs Utilization Review functions along with MD2 (Doctor of Medicine)/non-investor. A3 confirmed the URC lacks 3 non-investor physicians to perform UR functions.	S0230		
S0434	INFECTION CONTROL PROGRAM CFR(s): 410 IAC 15-2.5-1 410 IAC 15-2.5-1(f)(2)(E)(iv) The infection control committee responsibilities must include, but are not limited to: (E) Reviewing and recommending	S0434		05/22/2025

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S0434	Continued from page 2 changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (iv) Aseptic technique, invasive procedures, and equipment usage. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview staff failed to maintain aseptic technique for 1 of 1 surgical procedures observed. (N7 [Certified Surgical Technician]) Findings include: 1.Facility policy titled X. Infection Prevention and Control, 1. General Principles, D. Compliance Monitoring, no policy number, last reviewed 2/23/25, under 2. Using Gloves, F. Perform hand hygiene after removing gloves. 2. In observation on 4/30/25 at approximately 1025 hours in OR (Operating Room) 1, N7 donned sterile gloves to prefill syringes required for procedure and placed syringes on sterile tray, N7 removed sterile gloves and failed to re-cleanse his/her hands, dropped medication vial on the floor, picked up vial, lifted trash can lid to dispose of medication vials failing to re-cleanse his/her hands. N7 then went into clean supply and retrieved gauze pads, opened gauze and placed on sterile tray. At the end of procedure N7 donned non sterile gloves to clean room. Did not observe N7 re-cleanse hands until leaving operating room. 4. In interview on 5/1/25 at approximately 1110 hours with N1 (Registered Nurse/ Infection Control Preventionist), he/she confirmed N7 should have cleansed hands after removing gloves, touching a soiled surface, and before reapplying gloves.	S0434		
S0888	MEDICAL STAFF; ANESTHESIA AND SURGICAL CFR(s): 410 IAC 15-2.5-4 410 IAC 15-2.5-4(d)(2)(F)	S0888		05/22/2025

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S0888	Continued from page 3 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. 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 7 of 30 medical records reviewed. (P10, P11, P15, P22, P25, P26 and P27) Findings include: 1. Facility policy titled VI. Medical Staff, 3. Staff Management Policies, C. Patient Management, no policy number, last reviewed, 2/23/25, under IV. Patient's Medical Record, 4. Medical Records not completed within (14) days following the patient's discharge are classified as delinquent. 2. Medical record review completed on 4/30/2025 and 5/1/2025 indicated the following:	S0888		

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S0888	Continued from page 4 a. P10 date of surgery was 7/10/2024, operative report was signed by surgeon with no date. b. P11 date of surgery was 7/24/2024, operative report was signed by surgeon on 9/4/2024. c. P15 date of surgery was 10/10/2024, operative report was signed by surgeon with no date. d. P22 date of surgery was 1/16/2025, operative report was signed by surgeon with no date. e. P25 date of surgery was 1/8/2025, operative report was signed by surgeon with no date. f. P26 date of surgery was 1/15/2025, operative report was signed by surgeon with no date. g. P27 date of surgery was 2/5/2025, operative report was signed by surgeon with no date. 3. In interview on 5/1/2025 at approximately 1115 hours with A1 (Manager/ Radiology Technician), he/she confirmed operative reports for P10, P11, P15, P22, P25, P26 and P27 were not signed within the 14 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, including, but not limited to, the following: (A) Drug handling, storing, labeling, and dispensing.	S1010		05/22/2025

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S1010	Continued from page 5 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review, observation, and interview, facility failed to label 2 of 2 pre-drawn syringes in operating room medication cart with drug strength, date, time and initials. (fentanyl and versed) Findings include: 1. Facility policy titled IX. Ancillary Services, 1. Pharmaceutical Services, A. Medication Management, no policy number, last reviewed 5/23/25, under V!. Preparation: vi. Prepared medications will be labeled to minimize errors with the following: Drug name, strength, amount (if not apparent from container), date prepared, diluent added, and the initials of person preparing. 2. In observation of P31 procedure on 4/30/25 at approximately 1045 hours indicated: Two 3 ml (milliliter) pre-drawn syringes (Fentanyl and Versed) in medication cart lacked documentation of drug strength, date, time and initials of person preparing. 3. In interview on 4/30/25 at approximately 1050 hours, A1 (Manager/Radiation Technician) confirmed pre-drawn medication syringes in medication cart should contain documentation of drug strength, date, time and initials of person preparing.	S1010		