STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001175	A. BUILDING 00 B. WING	10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Q 0000 Bldg. 00	This visit was for a federal recertification survey of an ambulatory surgery center and a focused infection control survey. Facility number: 012278 Dates: 10/13-14/20 QA: 10/16/20	Q 0000		
Q 0084 Bldg. 00	416.43(e) GOVERNING BODY RESPONSIBILITIES The governing body must ensure that the QAPI program- (1) Is defined, implemented, and maintained by the ASC. (2) Addresses the ASC's priorities and that all improvements are evaluated for effectiveness. (3) Specifies data collection methods, frequency, and details. (4) Clearly establishes its expectations for safety. (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. Based on document review and interview, the governing body (GB) failed to ensure that the quality assessment and performance improvement (QAPI) program implemented and maintained an effective, organized, center-wide comprehensive quality assessment and performance improvement (QAPI) program by: 1) failing to establish a QAPI Committee in accordance with the policies and 2) failing to implement a data-driven QAPI program that specified data collection methods, frequency and details and 3) failing to document, at a	O 0084	**Q 0084:** 1) The Governing Board will establish a QAPI Committee in accordance with ASC policies at its next meeting, by 11/30/2020. Representation will include the Medical Director, Administrator, and representation from all areas within the ASC as indicated on the revised organizational chart (attached). 2) The Administrator revised QAPI	12/01/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	minimum, the reason(s) for implementing performance improvement (PI) project(s) and a description of the project's results for the projects that were being conducted, as per their policies for 1 facility. Findings include: 1. Review of facility policies, approved 8/20/20, indicated the following: Title: IV. Quality Assessment and Performance Improvement: 1. Governing Body (GB) Responsibilities. A. Preamble: The GB...has developed, defined, implemented and continues to maintain an ongoing, data-driven QAPI program by addressing (The Center's) priorities and that all improvements are evaluated for effectiveness, specifying data collection methods, frequency, and details... The GB has established the QAPI Committee to assess and improve the quality of care provided... The QAPI program is data-driven as it identifies in a systematic manner what data it will collect to measure...; the frequency of data collection; how the data will be collected and analyzed; and evidence that the program uses the data collected to assess quality and stimulate performance improvement. Implementation of the QAPI program is the responsibility of QAPI committees composed of professional and administrative personnel, a physician, including the medical director, review physicians and various other physicians. IV. Quality Assessment and Performance Improvement. 3. Performance Improvement Projects and Evaluation. A. Scope: (The Center) documents the projects that are being conducted.		policies (attached) on 11/6/2020 to specify data collection methods, frequency and details. Revised policies will be presented to the MEC and Governing Board for approval; by 11/30/2020. The Administrator will be responsible for the implementation of the revised QAPI monitoring, which will begin on 12/1/2020. 3) Documentation of current PI projects was completed by the Administrator on 11/8/2020 (attached). The Administrator will be responsible for documenting all PI activities, and presenting findings to the QAPI Committee, MEC and Governing Board on a quarterly basis.	

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	The documentation, at a minimum, includes the reason(s) for implementing the project and a description of the project's results. 2. Review of committee lists on the document titled "Organizational Chart" lacked documentation of a QAPI committee. 3. Review of facility documents lacked documentation of reasons for implementing projects and/or results of any projects being conducted. 4. On 10/14/20, between approximately 11:15 AM and 12:45 PM, A1, Administrator, verified that the facility had not established a QAPI committee as described by policy, that the program had not specified data collection methods, frequency and details for their monitors/quality indicators and that the program had not included review of nursing, radiology, transcription or infection control in their QAPI program/reports. A1 also verified that the center/QAPI program had not documented reasons for implementing PI projects nor project results.			
Q 0121 Bldg. 00	416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel. Based on document review and interview, the center failed to ensure privileges for 5 of 5 initially appointed physicians (MD1, MD3, MD6, MD7 and MD8) and 3 of 3 allied health members (AH1, AH2 and AH3) were granted in accordance with	O 0121	**Q 0121:** The Administrator created a letter (Experience and Competence Letter - attached) and a Practice Evaluation Request (attached) on 11/3/2020 that will	01/01/2021

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	their bylaws for experience and competence. Findings include: 1. Review of the Medical Staff (MS) Bylaws, approved 5/30/19, indicated the following: Article I. Section B.2. Responsibilities of the MS: To credential Practitioners and Allied Health Personnel... Article II. Section A. 2. The applicant shall be of such background, experience, training and demonstrated competence as to assure the MS that any patient treated by such applicant will be given medical care in accordance with the standards of care in the community...The applicant's education, training, and experience shall be relevant to the Clinical Privileges requested. Section A. 4. The applicant shall provide documentation of ...current competence and ability to perform the clinical privileges for which he/she is applying... 2. Review of credential files for the initial appointment of pain management physicians MD1, MD3, MD6, MD7 and MD8 as well as the files for allied health certified registered nurse anesthetist (CRNA) members AH1, AH2 and AH3 indicated the following: MD1 was granted privileges to perform procedures in the center on 10/1/20 MD3 was granted privileges to perform procedures in the center on 8/20/20 MD6 was granted privileges to perform procedures in the center on 11/12/19 MD7 was granted full (initial) privileges to perform procedures in the center on 1/1/19 MD1 was granted privileges to perform procedures in the center on 10/9/20 AH1 was granted privileges to perform		be included in the credential packet for all persons requesting appointment to the Medical Staff at Advanced Ambulatory Surgery Center, LLC . The letter requests documentation of both experience i.e. case/procedure log summary and competence i.e. completion of a practice evaluation form. The Administrator will be responsible to sending this information to persons requesting privileges in the ASC, and for ensuring the documentation has been received prior to forwarding the credential packet to the Governing Board for approval. The Administrator will be responsible for sending the above-mentioned letter and Practice Evaluation Request forms to the 5 physicians and 3 allied health members (CRNAs) whose credential files were found to be lacking the required documentation during the recent survey. The Administrator will be responsible for mailing these documents by 12/1/2020, and the completed information will be requested by 1/1/2021.	

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	anesthesia in the center on 1/2/20 AH2 was granted privileges to perform anesthesia in the center on 2/3/20 AH3 was granted privileges to perform anesthesia in the center on 6/10/19 The files lacked documentation of the experience relevant to the Clinical Privileges requested and current competence of the providers to perform the clinical privileges for which he/she had applied. 3. On 10/13/20, between approximately 3:15 PM and 4:00 PM, A1, Administrator, verified that the center had not collected and the MS had not reviewed experience relevant to privileges granted or current competence of the providers prior to having granted privileges at the center.			
Q 0241 Bldg. 00	416.51(a) SANITARY ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. Based on document review, observation and interview, the facility failed to provide a sanitary environment in 2 of 2 Operating Rooms and the staff women's dressing room. Findings include: 1. Policy titled Infection Prevention and Control in the recovery room, (no number), last updated 8/2020, indicated: Materials/Equipment: All surfaces and non-disposable equipment is to be cleaned with facility germicide.	O 0241	**Q 0241:** The Administrator thoroughly cleaned the women's dressing room floor and shoe cubicles on 10/16/2020. On 10/19/2020 ASC staff was instructed to store shoes in the cubicles to provide adequate space for the cleaning company to sweep and mop the dressing rooms. The Administrator notified the contracted cleaning company of the survey findings on 11/2/2020 and stressed the importance of maintaining strict adherence to	11/20/2020

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	2. On 10/14/2020, at approximately 1000 to 1130 hours, while touring the Operating Suites and the staff women's dressing room, the following observations were noted: A. OR #1 was noted to have a layer of dust on: 2 sterilite supply drawer shelves (all horizontal surfaces), on C-arm lower surfaces, 2 wall sharps containers, back top of C-arm display cart, and horizontal surfaces of anesthesia cart. B. OR #2 was noted to have a layer of dust on: 1 sterilite supply drawer shelves (all horizontal surfaces), on C-arm lower surfaces, 1 wall sharps container, and horizontal surfaces of anesthesia cart. C. Observation of staff women's dressing room indicated that there was a heavy layer of blackish dust on the floor and in 8 shoe cubicles where staff store their facility shoes to be worn into the ORs. 3. On 10/14/20 at approximately 1230 hours, staff member #A1, Administrator, agreed with the above findings.		cleanliness in the ASC. The Administrator will be responsible for monitoring the cleaning of the ASC on a weekly basis until compliance is confirmed, after which cleaning will be monitored by the Administrator on a monthly then quarterly basis. The Administrator developed a monthly cleaning schedule for the ASC staff (Staff Cleaning Schedule – attached) on 11/3/2020. The Administrator also provided an inservice to the staff on the cleaning schedule on 11/3/2020. The deadline for completion of this citation is 11/20/20 to allow sufficient time for all staff to review inservice and schedule, as 3 staff members are currently off work.	
S 0000 Bldg. 00	This visit was for a state licensure survey of an ambulatory surgery center. Facility number: 012278 Dates: 10/13-14/20 QA: 10/16/20	S 0000		
S 0116 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(2)(A-D)			

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	The governing body shall do the following: (2) Ensure the following: (A) The requests of practitioners, for appointment or reappointment to practice in the center are acted upon, with the advice and recommendation of the medical staff. (B) Reappointments are acted upon at least biennially. (C) Practitioners are granted privileges consistent with their individual training, experience, and other qualifications. (D) This process occurs within a reasonable period of time as specified by the medical staff bylaws.			
	Based on document review and interview, the Governing Body (GB) failed to ensure privileges for 5 of 5 initially appointed physicians (MD1, MD3, MD6, MD7 and MD8) and 3 of 3 allied health members (AH1, AH2 and AH3) were granted in accordance with their bylaws for experience and competence. Findings include: 1. Review of the Medical Staff (MS) Bylaws, approved 5/30/19, indicated the following: Article I. Section B.2. Responsibilities of the MS: To credential Practitioners and Allied Health Personnel... Article II.Section A. 2. The applicant shall be of such background, experience, training and demonstrated competence as to assure the MS that any patient treated by such applicant will	S 0116	S 0116: The Administrator created a letter (Experience and Competence Letter - attached) and a Practice Evaluation Request (attached) on 11/3/2020 that will be included in the credential packet for all persons requesting appointment to the Medical Staff at Advanced Ambulatory Surgery Center, LLC . The letter requests documentation of both experience i.e. case/procedure log summary and competence i.e. completion of a practice evaluation form. The Administrator will be responsible to sending this information to persons requesting privileges in the ASC, and for ensuring the documentation has been received	01/01/2021

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	be given medical care in accordance with the standards of care in the community...The applicant's education, training, and experience shall be relevant to the Clinical Privileges requested. Section A. 4. The applicant shall provide documentation of ...current competence and ability to perform the clinical privileges for which he/she is applying... 2. Review of credential files for the initial appointment of pain management physicians MD1, MD3, MD6, MD7 and MD8 as well as the files for allied health certified registered nurse anesthetist (CRNA) members AH1, AH2 and AH3 indicated the following: MD1 was granted privileges to perform procedures in the center on 10/1/20 MD3 was granted privileges to perform procedures in the center on 8/20/20 MD6 was granted privileges to perform procedures in the center on 11/12/19 MD7 was granted full (initial) privileges to perform procedures in the center on 1/1/19 MD1 was granted privileges to perform procedures in the center on 10/9/20 AH1 was granted privileges to perform anesthesia in the center on 1/2/20 AH2 was granted privileges to perform anesthesia in the center on 2/3/20 AH3 was granted privileges to perform anesthesia in the center on 6/10/19 The files lacked documentation of the experience relevant to the Clinical Privileges requested and current competence of the providers to perform the clinical privileges for which he/she had applied. 3. On 10/13/20, between approximately 3:15 PM and 4:00 PM, A1, Administrator, verified that the		prior to forwarding the credential packet to the Governing Board for approval. The Administrator will be responsible for sending the above-mentioned letter and Practice Evaluation Request forms to the 5 physicians and 3 allied health members (CRNAs) whose credential files were found to be lacking the required documentation during the recent survey. The Administrator will be responsible for mailing these documents by 12/1/2020, and the completed information will be requested by 1/1/2021.	

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	center had not collected and the MS had not reviewed experience relevant to privileges granted or current competence of the providers prior to having granted privileges at the center.			
S 0300 Bldg. 00	410 IAC 15-2.4-2 QUALITY ASSESSMENT AND IMPROVEMENT 410 IAC 15-2.4-2(a) (a) The center must develop, implement, and maintain an effective, organized, center-wide, comprehensive quality assessment and improvement program in which all areas of the center participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: Based on document review and interview, the center failed to implement and maintain an effective, organized, center-wide comprehensive quality assessment and performance improvement (QAPI) program by: 1) failing to establish a QAPI Committee in accordance with the policies; 2) failing to implement a data-driven QAPI program that specified data collection methods, frequency and details as per their policies; 3) failing to include 2 of 2 direct services (nursing and radiology), 1 of 8 contracted services (transcription) and 1 of 5 functions (infection control) in their review for the past 4 quarters. Findings include: 1. Review of facility policies, approved 8/20/20, indicated the following: Title: IV. Quality Assessment and Performance Improvement: 1. Governing Body (GB) Responsibilities. A. Preamble:	S 0300	**S 0300:** 1) The Governing Board will establish a QAPI Committee in accordance with ASC policies at its next meeting, by 11/30/2020. Representation will include the Medical Director, Administrator, and representation from all areas within the ASC as indicated on the revised organizational chart (attached). 2) The Administrator revised QAPI policies (attached) on 11/6/2020 to specify data collection methods, frequency and details. Revised policies will be presented to the MEC and Governing Board for approval; by 11/30/2020. The Administrator will be responsible for the implementation of the revised QAPI monitoring, which will begin on 12/1/2020.	12/01/2020

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	The GB...has developed, defined, implemented and continues to maintain an ongoing, data-driven QAPI program by addressing (The Center's) priorities and that all improvements are evaluated for effectiveness, specifying data collection methods, frequency, and details... The GB has established the QAPI Committee to assess and improve the quality of care provided... The QAPI program is data-driven as it identifies in a systematic manner what data it will collect to measure...; the frequency of data collection; how the data will be collected and analyzed; and evidence that the program uses the data collected to assess quality and stimulate performance improvement. Implementation of the QAPI program is the responsibility of QAPI committees composed of professional and administrative personnel, a physician, including the medical director, review physicians and various other physicians. 2. Review of committee lists on the document titled "Organizational Chart" lacked documentation of a QAPI committee. 3. On 10/14/20, between approximately 11:15 AM and 12:45 PM, A1, Administrator, verified that the facility had not established a QAPI committee as described by policy, that the program had not specified data collection methods, frequency and details for their monitors/quality indicators and that the program had not included review of nursing, radiology, transcription or infection control in their QAPI program/reports.		3) Nursing and radiology were added to the direct services, transcription to the contracted services, and infection control to functions for ASC monitoring and review by the Administrator on 11/6/2020 (attached). The Administrator will be responsible for the ongoing review and monitoring of all QAPI indicators, and for reporting the findings to the QAPI Committee, MEC and Governing Board on a quarterly basis.	
S 0400 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(a)			

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	(a) The center shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on document review, observation and interview, the facility failed to provide a sanitary environment in 2 of 2 Operating Rooms and the staff women's dressing room. Findings include: 1. Policy titled Infection Prevention and Control in the recovery room, (no number), last updated 8/2020, indicated: Materials/Equipment: All surfaces and non-disposable equipment is to be cleaned with facility germicide. 2. On 10/14/2020, at approximately 1000 to 1130 hours, while touring the Operating Suites and the staff women's dressing room, the following observations were noted: A. OR #1 was noted to have a layer of dust on: 2 sterilite supply drawer shelves (all horizontal surfaces), on C-arm lower surfaces, 2 wall sharps containers, back top of C-arm display cart, and horizontal surfaces of anesthesia cart. B. OR #2 was noted to have a layer of dust on: 1 sterilite supply drawer shelves (all horizontal surfaces), on C-arm lower surfaces, 1 wall sharps container, and horizontal surfaces of anesthesia cart. C. Observation of staff women's dressing room indicated that there was a heavy layer of blackish dust on the floor and in 8 shoe cubicles where staff store their facility shoes to be worn into the ORs. 3. On 10/14/20 at approximately 1230 hours, staff	S 0400	**S 400:** The Administrator thoroughly cleaned the women's dressing room floor and shoe cubicles on 10/16/2020. On 10/19/2020 ASC staff was instructed to store shoes in the cubicles to provide adequate space for the cleaning company to sweep and mop the dressing rooms. The Administrator notified the contracted cleaning company of the survey findings on 11/2/2020 and stressed the importance of maintaining strict adherence to cleanliness in the ASC. The Administrator will be responsible for monitoring the cleaning of the ASC on a weekly basis until compliance is confirmed, after which cleaning will be monitored by the Administrator on a monthly then quarterly basis. The Administrator developed a monthly cleaning schedule for the ASC staff (Staff Cleaning Schedule – attached) on 11/3/2020. The Administrator also provided an inservice to the staff on the cleaning schedule on 11/3/2020. The deadline for completion of this citation is 11/20/20 to allow sufficient time for	11/20/2020

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	member #A1, Administrator, agreed with the above findings.		all staff to review inservice and schedule, as 3 staff members are currently off work.	
S 0734 Bldg. 00	410 IAC 15-2.5-4 MEDICAL STAFF; ANESTHESIA AND SURGICAL 410 IAC 15-2.5-4(b)(3)(A) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (A) A description of the medical staff organization structure. If the organization calls for an executive committee, a majority of the members must be practitioners on the active medical staff. Based on document review and interview, the Governing Body (GB) failed to form/appoint an appropriate Medical Executive Committee (MEC) for 1 facility. Findings include: 1. Review of the Medical Staff Bylaws, approved 5/30/19, indicated the following: Definitions: Medical Executive Committee (MEC) - a committee comprised of the Medical Director and at least representative Medical Staff members from each major specialty of the Medical Staff... 2. A. Review of the document titled "Organizational Chart" indicated the MEC consisted of the Medical Director, the Business Office Manager and the Administrator.	S 0734	**S 0734:** 1. The Administrator notified the Medical Director of the need to add additional Medical Staff to the Medical Executive Committee (MEC) on 11/1/2020. The Governing Board will appoint an appropriate Medical Executive Committee (MEC) per its Medical Staff Bylaws at it's next meeting; by 11/30/2020. The ASC organizational chart (attached) was revised on 11/2/2020 by the Administrator.	11/30/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001175	A. BUILDING 00 B. WING	10/14/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	3. On 10/13/20, between approximately 3:15 PM and 4:00 PM, A1, Administrator, verified the center MEC lacked inclusion of any MS members other than the Medical Director.			