STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		15C0001095	B. WI	NG		03/14/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ORTHGATE CT, STE 101		
KLEINER	T KUTZ SURGERY	CENTER IN AFFILIATION W/ FLO	Э		LBANY, IN 47150		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S 0000							
Bldg. 00							
	This visit was for	r a State licensure	S 00	000			
	survey.						
	Dates: 3/13/17 t	o 3/14/17					
	Facility #002524	ļ					
	QA: 5/9/17 LH						
	Q 3, 2 , 3, 2, 7						
S 0104	410 IAC 15-2.4-1						
00101		DY; POWERS AND					
Bldg. 00	DUTIES	,					
	410 IAC 15-2.4-1(a)(2)					
	The governing boo	dy shall do tho					
	following:	dy shall do the					
	_						
	(2) Adopt bylaws a	and function					
	accordingly.		0.01	0.4			05/24/2017
		ent review and interview	S 01	04			05/24/2017
		ody (GB) failed to adopt					
	bylaws.				_		
	Findings include	:			1.Kleinert Kutz Surgery Cent severed the part-ownership		
	1				agreement with Floyd Memoria Hospital as Floyd was acquired		
		cility documents lacked			by Baptist Health in Mid 2016.		
		Bylaws or documentation			Until this transfer was complete		
	of requirements	-			the Board of Governors did no		
		the GB in determining,			meet in the last half of 2016 du		
	implementing, an	nd monitoring policies			to uncertainty of Floyd membe The remaining Governing Boa		
	governing the ce	nter's operation and for			members are also members of		
	ensuring that pol	icies are followed so as			the Medical Staff which did me		
	to provide qualit	y health care in a safe			quarterly in 2016 and monitore	ed :	
		-				ŀ	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see 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.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15C0001095	B. WING		03/14/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				ORTHGATE CT, STE 101	
KLEINER	T KUTZ SURGERY	CENTER IN AFFILIATION W/ FLO	O NEW A	LBANY, IN 47150	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	environment.			the operation of the Center.	
				 Kleinert Kutz and Associat owner of the Surgery Center, i 	
	2. On 3/14/17 at	3:00 PM, A1, Director		partnership. The Operating	3 4
	of Surgery, indic	ated the GB had not		Agreement and Bylaws were	
	adopted bylaws.			updated and signed on May 24	4th,
				2017and will be reviewed	
				triennially, mandated by the	
				Governing Board.	
S 0110	410 IAC 15-2.4-1				
		DY; POWERS AND			
Bldg. 00	DUTIES				
	410 IAC 15-2.4-1	(a)(5)			
	The governing boo	ty shall do the			
	following:	ay shall do the			
	Ŭ				
	(5) Review, at least	•			
	reports of manage	-			
	including, but not I				
	patient services pr	mprovement program, rovided, results			
	attained, recomme				
	actions taken, and				
	Based on docum	ent review and	S 0110	1.The Medical Staff did revi	ew 05/11/2017
	interview, the go	overning body (GB)		the QAPI program and patient	
		quarterly review reports		services quarterly. The Governin	g
		operations, including, but		Board reviewed the operations, medical staff minutes, in the first	and
		e quality assessment and		second quarters, and the Medical	and
		ogram and patient		Staff reviewed in the 3rd, 4th	
	services for the p			quarters of 2016 and first quarter	
	services for the p	oast + quartors.		2017.	

State Form Event ID: XR1011 Facility ID: 002524 If continuation sheet Page 2 of 15

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	Ì		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPL	
		15C0001095	B. WI	NG		03/14/	2017
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
עו רוגורה	T KLITZ OLIDOCOV	/ CENTED IN AFFILIATION W// FL	<u>,</u>		ORTHGATE CT, STE 101		
		CENTER IN AFFILIATION W/ FLO			LBANY, IN 47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
					CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	
S 0122 Bldg. 00	Findings include 1. Review of 4 or minutes lacked of have met or revie quarterly since 7 dates for 2016 to and 7/21/16. 2. On 3/14/17 at of Surgery, veriff 2 meetings in 20 2017. 410 IAC 15-2.4-1 GOVERNING BOIDUTIES 410 IAC 15-2.4-1 The governing book (3) Ensure that the approved bylaws at the bylaws and rul approved at least governing body.	quarters of GB meeting documentation of the GB ewed reports at least /21/16. Meeting minute present were 4/21/16 t 3:00 PM, A1, Director fied that the GB had only 16 and none to present in DY; POWERS AND (b)(3) dy shall do the following: e medical staff has and rules, and that les are reviewed and triennially by the		PREFIX TAG	CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2. Now that the ownership transition is complete the Governing Board met on 5-11- and reviewed and approved the 3rd and 4th quarter 2016 committee reports and minutes. The 1st Quarter 2017 minutes be submitted for approval by the Medical Staff at the 2nd Quarter Medical Staff Meeting July 2013. Responsibility: Chairmatof the Governing Board of Managers monitored by quarter meeting schedule.	e. S. will ne er 17.	COMPLETION DATE
	Based on docum interview, the go	ent review and overning body (GB)	S 01	22	1.Triennially review of the Medical Staff by-laws was don	е	05/11/2017
	failed to triennia	lly review and approve			on 7-11-16. The Governing Board reviewed and approved	the	
	medical staff (M	medical staff (MS) bylaws and rules.			changes on 5-11-17. 2.Responsibility:		
	Findings include	:			Administrator/Director schedul quarterly Medical Staff and Governing Board meetings.	es	
	1. Review of GI	B meeting minutes dated			Monitoring: Ongoing.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001095		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 03/14/2017			
		STREE 3605	NORTHGATE CT, STE 101	00/14/2017	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
10/14/15, 4/21/1 documentation of Bylaws or Rules 2. On 3/14/17 at of Surgery, indice meetings in 2016 not have documentation of MS 13:00 PM, A1 vernot have documentation of the provided in	6 and 7/21/16 lacked of GB review of the MS 11:00 AM, A1, Director cated the GB had two 6 and those meetings did centation of GB review or Bylaws or Rules. At rified that the center did centation of GB review of				
DUTIES 410 IAC 15-2.4-1(In accordance with the governing bod following: (4) Ensure that the quality assessment program that evaluate of patient care and Based on document interview, the got failed to ensure the state of the	d)(4) n center policy, y shall do the ere is a center-wide, nt and improvement uates the provision d outcome. ent review and everning body (GB)	S 0216	1.Safety, Infection, Tissue, Medical Records, Patient	05/11/2017	
]	SUMMARY S' (EACH DEFICIEN REGULATORY OR 10/14/15, 4/21/1 documentation of Bylaws or Rules 2. On 3/14/17 at of Surgery, indice meetings in 2016 not have docume approval of MS 3:00 PM, A1 ver not have docume the MS Bylaws of the MS Bylaws of 410 IAC 15-2.4-1 GOVERNING BOI DUTIES 410 IAC 15-2.4-1(In accordance with the governing bod following: (4) Ensure that the quality assessment program that evaluation of patient care and Based on docume interview, the go failed to ensure to	DENTIFICATION NUMBER: 15C0001095 ROVIDER OR SUPPLIER TEXT KUTZ SURGERY CENTER IN AFFILIATION W/ FLOOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10/14/15, 4/21/16 and 7/21/16 lacked documentation of GB review of the MS Bylaws or Rules. 2. On 3/14/17 at 11:00 AM, A1, Director of Surgery, indicated the GB had two meetings in 2016 and those meetings did not have documentation of GB review or approval of MS Bylaws or Rules. At 3:00 PM, A1 verified that the center did not have documentation of GB review of the MS Bylaws within the past 3 years. 410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(d)(4) In accordance with center policy, the governing body shall do the	TROUDER OR SUPPLIER TO KUTZ SURGERY CENTER IN AFFILIATION W/ FLO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 10/14/15, 4/21/16 and 7/21/16 lacked documentation of GB review of the MS Bylaws or Rules. 2. On 3/14/17 at 11:00 AM, A1, Director of Surgery, indicated the GB had two meetings in 2016 and those meetings did not have documentation of GB review or approval of MS Bylaws or Rules. At 3:00 PM, A1 verified that the center did not have documentation of GB review of the MS Bylaws within the past 3 years. 410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(d)(4) In accordance with center policy, the governing body shall do the following: (4) Ensure that there is a center-wide, quality assessment and improvement program that evaluates the provision of patient care and outcome. Based on document review and interview, the governing body (GB) failed to ensure that there was a	ROVIDER OR SUPPLIER TO KUTZ SURGERY CENTER IN AFFILIATION W/FLO SUMMARY STATEMENT OF DEFICIENCY BENEFIC (EACH DEFICIENCY MUST BE PRECEDED BY PULL. REGULATORY OR LSC IDENTIFYING INSPORMATION) 10/14/15, 4/21/16 and 7/21/16 lacked documentation of GB review of the MS Bylaws or Rules. 2. On 3/14/17 at 11:00 AM, A1, Director of Surgery, indicated the GB had two meetings in 2016 and those meetings did not have documentation of GB review or approval of MS Bylaws or Rules. At 3:00 PM, A1 verified that the center did not have documentation of GB review of the MS Bylaws within the past 3 years. 410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(d)(4) In accordance with center policy, the governing body shall do the following: (4) Ensure that there is a center-wide, quality assessment and improvement program that evaluates the provision of patient care and outcome. Based on document review and interview, the governing body (GB) failed to ensure that there was a	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		15C0001095	B. W	ING		03/14/	2017
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SULLEE			3605 N	ORTHGATE CT, STE 101		
KLEINEF	RT KUTZ SURGER`	Y CENTER IN AFFILIATION W/ FI	-0	NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 -	provement (QAPI)			requiring committee attention		
	program for 2016 or 2017 to date.				have been reviewed at each quarterly medical staff meeting	1	
					The Governing Board reviewe	•	
	Findings include:				and approved these on 5-11-1		
					There is Center-wide participa	tion	
	1. Review of the	e document titled Quality			by, and documentation of, employees in collection of data		
	Assessment and	Performance			and reviewing results.	a .	
	Improvement - 0	Committee Meeting			2.Specific programs describe	ed	
	Agenda, Review	ved 2/15, indicated items			above in number 1 are in place	е	
	to be reviewed a	t each QAPI committee			for reviewing, evaluating and	-1	
	meeting (Safety, Infection, Tissue, Medical Records, Patient Satisfaction				maintaining quality and efficier patient care.	π	
					3.Future Governing Board		
	Surveys, Problems Requiring Committee				minutes will document QAPI p	lan	
	Attention).				and approval thereof.		
					4.Responsibility: Administrator/Director.		
	2. Review of M	edical Staff (MS)			Monitoring: Ongoing.		
		opted 7/11/16, indicated					
	1 -	Quality Improvement					
		l(a) Adopt and submit					
		governing body a Quality					
	1 ^ ^	an that provides for					
		ns and procedures for					
		nating, and maintaining					
	U ,	efficiency of patient care					
	within the Cente	• •					
	3. Review of Gl	B meeting minutes dated					
		6 and 7/21/16 lacked					
	· ·	of GB review or approval					
	of a center QAP						
		1					
	4. On 3/14/17 a	t 10:30 AM, A1, Director					
		cated that the document					
	titled Quality As						
	1		1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001095		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 03/14/2017	
	PROVIDER OR SUPPLIER	CENTER IN AFFILIATION W/ FL	360	EET ADDRESS, CITY, STATE, ZIP CODE 5 NORTHGATE CT, STE 101 W ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
S 0224	Meeting Agenda verified that the and that the GB	provement - Committee I, was the QAPI Plan. A1 last review date was 2/15 had not reviewed or II plan for 2016 or 2017			
Bldg. 00	GOVERNING BOIDUTIES 410 IAC 15-2.4-1(The governing bor responsible for set the center whether delivered under conforming body should be a contract at the safe and effective included in the center assessment and in	dy is rvices delivered in r or not they are ontracts. The nall do the following: e services performed are provided in a manner and are nter's quality mprovement program.			
	failed to ensure tunder contract we center's quality a performance imp (QAPI) in 2016.	everning body (GB) chat services performed rere included in the assessment and brovement program or 2017 to date.	S 0224	1.Contracted services evaluations have been incorporated within the QAPI report each quarter. In the firs quarter 2017 separate evaluar sheets for each vendor have been put in use and same is documented in medical staff meeting minutes which were approved by the Governing Bo 5-11-17. 2.The By-laws Article X.2.2 be revised to include evaluation of contracted services quarter annually. 3.Contracted services	pard will on

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15C0001095	B. Wl	ing		03/14/	2017
NAME OF F	PROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP CODE		
			_		ORTHGATE CT, STE 101		
KLEINEF	RT KUTZ SURGER	Y CENTER IN AFFILIATION W/ FL	0	NEW AL	LBANY, IN 47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	Committee Meeting			evaluations have been implemented and reviewed by	the	
	• '	ved 2/15, indicated items			Governing Board on 5-11-17.	uic	
	to be reviewed at each QAPI committee				4.Contracted services		
		, Infection, Tissue,	evaluations have been				
	Medical Records, Patient Satisfaction Surveys, Problems Requiring Committee				implemented and reviewed by	the	
					Governing Board on 5-11-17. 5.Responsibility:		
	· /	e document lacked			Administrator/Director.		
		of contracted services to			Monitoring: Ongoing.		
	be included in Q	API review or evaluation					
	2 Review of M	edical Staff (MS)					
	2. Review of Medical Staff (MS) Bylaws, last adopted 7/11/16, indicated in X.2.2 that the Quality Improvement						
		l(a) Adopt and submit					
	^^	governing body a Quality					
	_	an that provides for					
		ns and procedures for					
		nating, and maintaining					
		efficiency of patient care					
		er. The document lacked					
		of a QAPI plan to review					
	or evaluate contr	racted services.					
	3. Review of co	entracted services					
	included the foll	owing, but was not					
		nedical engineering,					
	biohazardous wa						
		aboratory services,					
	1 0	nance, medical records					
	review service a						
		<i>U</i> ,					
	4. Review of 20	016 and 2017 quality					
	reports and meet	ting minutes titled QA -					
	PI Committee M	feeting dated 12/2/16					

State Form Event ID: XR1011 Facility ID: 002524 If continuation sheet Page 7 of 15

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15C0001095		l í	JILDING	00	COMPL 03/14/	ETED	
	SUMMARY ST (EACH DEFICIEN REGULATORY OR	CENTER IN AFFILIATION W/ FI CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	_0	3605 N	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE CT, STE 101 LBANY, IN 47150 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
S 0230 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BOD DUTIES 410 IAC 15-2.4-1(c) The governing body responsible for ser the center whether delivered under corresponsible for a procenter and its oper utilization review of composed of three licensed physician financial interest in the center and its with the Center's by a utilization recommittee composed of three facility for the facility for the facility for the center and its with the Center's by a utilization recommittee composed for the facility for the facility for the facility for the facility for the center and its with the facility for the facility for the facility for the facility for the center and its with the facility for the facility for the facility for the facility for the center and its with the facility for the facility for the facility for the facility for the center and its with the facility for the facility for the facility for the center and its with the facility for the facility for the facility for the center and its with the facility for the facility for the facility for the facility for the center and its with the facility for	DY; POWERS AND e)(5) dy is vices delivered in r or not they are intracts. The all do the following: eriodic review of the ration by a r other committee e (3) or more duly s having no in the facility. ent review and verning body (GB) for periodic review of operation in accordance medical staff Bylaws or eview (UR) or other osed of 3 or more g no financial interest in e past 4 quarters.	S 02	230	1.a. Utilization Review committee was restructured to include three physicians with r financial interest in the Center b. Appropriateness of admiss diagnosis, pathology, ancillary has been reviewed each quart by the Utilization Review Committee. 2. Committee makeup has be changed as of 5-11-17 to refle By-laws with three physicians	no ion, ter een ect with	05/11/2017
	1. Review of Me Bylaws, last adop	edical Staff (MS) oted 7/11/16, indicated			no financial interest in the Cer	IICI.	

State Form Event ID: XR1011 Facility ID: 002524 If continuation sheet Page 8 of 15

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15C0001095	B. WI	ING		03/14/	2017
KLEINEF (X4) ID	SUMMARY S	CENTER IN AFFILIATION W/ FLO	D .	3605 NO NEW AL	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE CT, STE 101 LBANY, IN 47150 PROVIDER'S PLAN OF CORRECTION (TACH CORRECTION SHOULD BE		(X5)
PREFIX	` `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	in X.2.3. Utilizathe following: a. The U Committee shall and at least two whom have a fin Center as well as members: the A Director of Nurs shall meet quarte b. The d Committee shall appropriateness the consistency of procedure and participated. 2. Review of the Committees, dat subsection titled Review, indicate (MDA and MDE for UR. 3. Review of face meeting minutes Peer Review Conducted the following and the following participated in the committee of the committees of the	ing. The committee erly. Juties of the UR be to: a) Review the of admission b) Review of the diagnosis, athology c) Review the of the ancillary services de document titled ed January 11, 2017, Utilization and Peer ed only 2 physicians B) were on the committee cility documents and titled Utilization and mmittee Minutes dated 10/17/16 and 1/23/17 llowing: 18/16 lacked of MDA or MDB having		TAG	3. a, b. MD participation was omitted from the reports but w be included in the future report c, d. Future meeting minur will list all members present and document in-depth review and documentation of records to include diagnosis, procedure, pathology, ancillary services. 4. Future minutes will list all attendees. 5. Responsibility: Administrator/Director. Monitoring: Ongoing.	ill ts. tes nd	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15C0001095	B. W	ING		03/14/	2017
NAME OF I	DROVIDED OD GUDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF			3605 NO	ORTHGATE CT, STE 101		
		Y CENTER IN AFFILIATION W/ FL	.0	NEW AI	LBANY, IN 47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		,		TAG	BEI ICIENCT)		DATE
		of MDA or MDB having					
		ne meeting. The minutes					
		tation of any attendees					
	present or absen						
	documentation of						
		of admission, review of					
	the consistency						
		athology or review of the					
		of the ancillary services					
	utilized.						
		0/17/16 the minutes					
		reviewed charts for					
	peer-review on 1	10/10/16. The minutes					
	lacked documen	tation of any attendees					
	present or absen	t and lacked					
	documentation of	of review of the					
	appropriateness	of admission, review of					
	the consistency	of the diagnosis,					
	procedure and pa	athology or review of the					
	appropriateness	of the ancillary services					
	utilized.						
	d. On 1/	23/17 the minutes					
	indicated MDB	reviewed charts for					
	peer-review on 1	1/3/17. The minutes					
	lacked documen	tation of any attendees					
	present or absen	-					
	documentation of						
	appropriateness	of admission, review of					
	the consistency						
	1	athology or review of the					
		of the ancillary services					
	utilized.	or the unemary services					
	dillizod.						
	4. On 3/14/17 a	t 12:15 PM, A1, Director					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001095	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/14/2017
	ROVIDER OR SUPPLIER	CENTER IN AFFILIATION W/ FL	3605 N	ADDRESS, CITY, STATE, ZIP CODE IORTHGATE CT, STE 101 ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
S 0300	committee was n more physicians interest in the fac minutes, as indic	ied that the Center's UR not composed of 3 or having no financial cility and that meeting rated above, did not show as per MS Bylaws.			
Bidg. 00	QUALITY ASSESSIMPROVEMENT 410 IAC 15-2.4-2((a) The center musimplement, and morganized, centerquality assessment program in which a center participate. be ongoing and has	a) st develop, aintain an effective, wide, comprehensive at and improvement all areas of the The program shall ave a written plan of at evaluates, but is following:	S 0300		05/11/2017
	interview, the Ce implement and n organized, center quality assessme	enter failed to develop, naintain an effective, r-wide, comprehensive nt and performance API) program for 2016	5 0500	1.The services listed will be incorporated into regular evaluation with approval of Governing Board - Safety, Infection control, Tissue, Medi Records, patient surveys,	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		15C0001095	B. WI	NG		03/14/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	2			ORTHGATE CT, STE 101		
KLEINER	T KUTZ SURGER	Y CENTER IN AFFILIATION W/ FLO	O		LBANY, IN 47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	or 2017 to presen	nt by not including 9			problems are reviewed quarter	Тy	
	services (biomed	lical engineering,			as part of the QAPI and		
	biohazardous wa	aste hauler,			presented at staff meeting. All areas of the center are informed		
	housekeeping, laboratory, laundry,				of outcomes, all areas contribu		
	maintenance, nursing, contracted				to informing of any problems.		
	· ·	curity) in its plan, review					
					1.a. The QAPI committee w	as	
	or evaluation, by not following medical staff (MS) bylaws for the Quality Improvement Committee and by failing				restructured as of 5-11-17 to		
					consist of three staff MDs and		
					Director of Center.		
		approved the QAPI plan			b. Committee meets quarterly		
	for 2016 or 2017	7.				•	
	Findings include:				c. Will be done with center-wide input and documented.	de	
	Assessment and Improvement - C Agenda, Review to be reviewed a meeting (Safety, Medical Records Surveys, Problem Attention). The documentation of	Committee Meeting red 2/15, indicated items t each QAPI committee Infection, Tissue, s, Patient Satisfaction ms Requiring Committee document lacked of being center-wide or n which all areas of the			1.Correction accomplished we revised committee list. 2.Evaluation of services will documented with 2 staff members present. 3.Documentation of evaluation will be kept on requested services. 4.The QAPI committee has been revised to include 3 med staff members. 5.Responsibility: Administrator/Director. Monitoring: Reported quarterly Medical Staff and Governing Board meetings and is ongoing	be on ical	
	Bylaws, last ado in X.2.2 the follo a. The Q Committee shall and two member	edical Staff (MS) pted 7/11/16, indicated owing: Quality Improvement consist of a chairperson rs who shall be appointed his committee shall also					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15C0001095		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/14/2017			
NAME OF PROVIDER OR SUPPLIER KLEINERT KUTZ SURGERY CENTER IN AFFILIATION W/ FLO		STREET ADDRESS, CITY, STATE, ZIP CODE 3605 NORTHGATE CT, STE 101 NEW ALBANY, IN 47150					
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Nursing. b. The C quarterly. c. The C Committee shall conducting, coording, coording the quality of paths basis and monitor assurance program and submit appropriate for specific procedures for remaintaining the patient care with the Committees, dat subsection titled documentation of committee. 4. Review of 20 QAPI meeting in dated 12/2/2016 center-wide more review or evaluate for biomedical elements.	Ef members: the and the Director of Committee shall meet Quality Improvement be responsible for redinating and reviewing tient care on an ongoing bring the various quality ams and shall: (a) Adopt oval of the governing mprovement Plan that cific programs and eviewing, evaluating, and quality and efficiency of ain the Center.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2017 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15C0001095				COMPLETED 03/14/2017		
NAME OF PROVIDER OR SUPPLIER KLEINERT KUTZ SURGERY CENTER IN AFFILIATION W/ FLO			STREET ADDRESS, CITY, STATE, ZIP CODE 3605 NORTHGATE CT, STE 101 NEW ALBANY, IN 47150					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		(X5) COMPLETION DATE		
	security, transcriptransfer, infection errors, response to reportable events documentation of lacked document present. 5. Review of MS	y, contracted radiology, ption, discharge, n control, medication to patient emergencies or s. The minutes lacked f a chairperson and ration of 2 MS members S meeting minutes dated 10/17/16 and 1/23/17						
	and attached qua MS had reviewed records, pharmac control, medicati radiology, transc transfer, response and reportable ex reports lacked do or evaluation for biomedical engir waste hauler, hou laundry, mainten radiology, or sec lacked document	lity reports indicated the d reports for medical by checks, infection on errors, internal ription, discharge, to patient emergencies wents. The minutes and ocumentation of review						
	of Surgery, indic titled Quality As Performance Imp Meeting Agenda	10:30 AM, A1, Director ated that the document sessment and provement - Committee, was the QAPI Plan for ad that the last review						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/14/2017		
NAME OF PROVIDER OR SUPPLIER KLEINERT KUTZ SURGERY CENTER IN AFFILIATION W/ FLO			STREET ADDRESS, CITY, STATE, ZIP CODE 3605 NORTHGATE CT, STE 101 NEW ALBANY, IN 47150					
KLEINERT KUTZ SURGERY CENTER IN AFFILIATION W/ FLO (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) date was 2/15 and that the GB had not reviewed or approved a QAPI plan for 2016 or 2017 to date. A1 also verified that no set written monitors or measurable standards were included in the plan and that none had been documented or established by the QAPI program. A1 verified that the QAPI Committee did not have 2 appointed MS members. At 12:00 PM, A1 verified that the QAPI Committee had only 1 member of the MS.			F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	

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