STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001095	A. BUILDING 00 B. WING	03/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KLEINERT KUTZ SURGERY CENTER IN AFFILIATION W/ FLO	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S 0000 Bldg. 00	This visit was for a State licensure survey. Dates: 3/13/17 to 3/14/17 Facility #002524 QA: 5/9/17 LH	S 0000		
S 0104 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(a)(2) The governing body shall do the following: (2) Adopt bylaws and function accordingly. Based on document review and interview the governing body (GB) failed to adopt bylaws. Findings include: 1. Review of facility documents lacked evidence of GB Bylaws or documentation of requirements for authority and responsibility of the GB in determining, implementing, and monitoring policies governing the center's operation and for ensuring that policies are followed so as to provide quality health care in a safe	S 0104	- 1.Kleinert Kutz Surgery Center severed the part-ownership agreement with Floyd Memorial Hospital as Floyd was acquired by Baptist Health in Mid 2016. Until this transfer was complete the Board of Governors did not meet in the last half of 2016 due to uncertainty of Floyd members. The remaining Governing Board members are also members of the Medical Staff which did meet quarterly in 2016 and monitored	05/24/2017

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

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	environment. 2. On 3/14/17 at 3:00 PM, A1, Director of Surgery, indicated the GB had not adopted bylaws.		the operation of the Center. 2.Kleinert Kutz and Associates, owner of the Surgery Center, is a partnership. The Operating Agreement and Bylaws were updated and signed on May 24th, 2017and will be reviewed triennially, mandated by the Governing Board.	
S 0110 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (a)(5) The governing body shall do the following: (5) Review, at least quarterly, reports of management operations, including, but not limited to, quality assessment and improvement program, patient services provided, results attained, recommendations made, actions taken, and follow-up. Based on document review and interview, the governing body (GB) failed to at least quarterly review reports of management operations, including, but not limited to, the quality assessment and improvement program and patient services for the past 4 quarters.	S 0110	1.The Medical Staff did review the QAPI program and patient services quarterly. The Governing Board reviewed the operations, medical staff minutes, in the first and second quarters, and the Medical Staff reviewed in the 3rd, 4th quarters of 2016 and first quarter 2017.	05/11/2017

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	Findings include: 1. Review of 4 quarters of GB meeting minutes lacked documentation of the GB have met or reviewed reports at least quarterly since 7/21/16. Meeting minute dates for 2016 to present were 4/21/16 and 7/21/16. 2. On 3/14/17 at 3:00 PM, A1, Director of Surgery, verified that the GB had only 2 meetings in 2016 and none to present in 2017.		2.Now that the ownership transition is complete the Governing Board met on 5-11-17 and reviewed and approved the 3rd and 4th quarter 2016 committee reports and minutes. The 1st Quarter 2017 minutes will be submitted for approval by the Medical Staff at the 2nd Quarter Medical Staff Meeting July 2017. 3.Responsibility: Chairman of the Governing Board of Managers monitored by quarterly meeting schedule.	
S 0122 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1 (b)(3) The governing body shall do the following: (3) Ensure that the medical staff has approved bylaws and rules, and that the bylaws and rules are reviewed and approved at least triennially by the governing body. Based on document review and interview, the governing body (GB) failed to triennially review and approve medical staff (MS) bylaws and rules. Findings include: 1. Review of GB meeting minutes dated	S 0122	1.Triennially review of the Medical Staff by-laws was done on 7-11-16. The Governing Board reviewed and approved the changes on 5-11-17. 2.Responsibility: Administrator/Director schedules quarterly Medical Staff and Governing Board meetings. Monitoring: Ongoing.	05/11/2017

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	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.			
S 0216 Bldg. 00	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 center-wide quality assessment and	S 0216	1.Safety, Infection, Tissue, Medical Records, Patient Satisfaction Surveys, Problems	05/11/2017

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	performance improvement (QAPI) program for 2016 or 2017 to date. Findings include: 1. Review of the document titled Quality Assessment and Performance Improvement - Committee Meeting Agenda, Reviewed 2/15, indicated items to be reviewed at each QAPI committee meeting (Safety, Infection, Tissue, Medical Records, Patient Satisfaction Surveys, Problems Requiring Committee Attention). 2. Review of Medical Staff (MS) Bylaws, last adopted 7/11/16, indicated in X.2.2 that the Quality Improvement Committee shall...(a) Adopt and submit approval of the governing body a Quality Improvement Plan that provides for specific programs and procedures for reviewing, evaluating, and maintaining the quality and efficiency of patient care within the Center. 3. Review of GB meeting minutes dated 10/14/15, 4/21/16 and 7/21/16 lacked documentation of GB review or approval of a center QAPI plan. 4. On 3/14/17 at 10:30 AM, A1, Director of Surgery, indicated that the document titled Quality Assessment and		requiring committee attention have been reviewed at each quarterly medical staff meeting. The Governing Board reviewed and approved these on 5-11-17. There is Center-wide participation by, and documentation of, employees in collection of data and reviewing results. 2.Specific programs described above in number 1 are in place for reviewing, evaluating and maintaining quality and efficient patient care. 3.Future Governing Board minutes will document QAPI plan and approval thereof. 4.Responsibility: Administrator/Director. Monitoring: Ongoing.	

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	Performance Improvement - Committee Meeting Agenda, was the QAPI Plan. A1 verified that the last review date was 2/15 and that the GB had not reviewed or approved a QAPI plan for 2016 or 2017 to date.			
S 0224 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 410 IAC 15-2.4-1(e)(2) 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: (2) Ensure that the services performed under a contract are provided in a safe and effective manner and are included in the center's quality assessment and improvement program. Based on document review and interview, the governing body (GB) failed to ensure that services performed under contract were included in the center's quality assessment and performance improvement program (QAPI) in 2016 or 2017 to date. Findings include: 1. Review of the document titled Quality Assessment and Performance	S 0224	1.Contracted services evaluations have been incorporated within the QAPI report each quarter. In the first quarter 2017 separate evaluation sheets for each vendor have been put in use and same is documented in medical staff meeting minutes which were approved by the Governing Board 5-11-17. 2.The By-laws Article X.2.2 will be revised to include evaluation of contracted services quarterly or annually. 3.Contracted services	05/11/2017

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	Improvement - Committee Meeting Agenda, Reviewed 2/15, indicated items to be reviewed at each QAPI committee meeting (Safety, Infection, Tissue, Medical Records, Patient Satisfaction Surveys, Problems Requiring Committee Attention). The document lacked documentation of contracted services to be included in QAPI review or evaluation 2. Review of Medical Staff (MS) Bylaws, last adopted 7/11/16, indicated in X.2.2 that the Quality Improvement Committee shall...(a) Adopt and submit approval of the governing body a Quality Improvement Plan that provides for specific programs and procedures for reviewing, evaluating, and maintaining the quality and efficiency of patient care within the Center. The document lacked documentation of a QAPI plan to review or evaluate contracted services. 3. Review of contracted services included the following, but was not limited to: biomedical engineering, biohazardous waste hauler, housekeeping, laboratory services, laundry, maintenance, medical records review service and radiology. 4. Review of 2016 and 2017 quality reports and meeting minutes titled QA - PI Committee Meeting dated 12/2/16		evaluations have been implemented and reviewed by the Governing Board on 5-11-17. 4.Contracted services evaluations have been implemented and reviewed by the Governing Board on 5-11-17. 5.Responsibility: Administrator/Director. Monitoring: Ongoing.	

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	lacked documentation of review or evaluation of contracted services.			
S 0230 Bldg. 00	410 IAC 15-2.4-1 GOVERNING BODY; POWERS AND DUTIES 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. Based on document review and interview, the governing body (GB) failed to provide for periodic review of the center and its operation in accordance with the Center's medical staff Bylaws or by a utilization review (UR) or other committee composed of 3 or more physicians having no financial interest in the facility for the past 4 quarters. Findings include: 1. Review of Medical Staff (MS) Bylaws, last adopted 7/11/16, indicated	S 0230	1.a. Utilization Review committee was restructured to include three physicians with no financial interest in the Center. b. Appropriateness of admission, diagnosis, pathology, ancillary has been reviewed each quarter by the Utilization Review Committee. 2. Committee makeup has been changed as of 5-11-17 to reflect By-laws with three physicians with no financial interest in the Center.	05/11/2017

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	in X.2.3. Utilization Review Committee the following: a. The Utilization Review Committee shall consist of a chairperson and at least two (2) members, none of whom have a financial interest in the Center as well as the following ex-officio members: the Administrator and Director of Nursing. The committee shall meet quarterly. b. The duties of the UR Committee shall be to: a) Review the appropriateness of admission b) Review the consistency of the diagnosis, procedure and pathology c) Review the appropriateness of the ancillary services utilized. 2. Review of the document titled Committees, dated January 11, 2017, subsection titled Utilization and Peer Review, indicated only 2 physicians (MDA and MDB) were on the committee for UR. 3. Review of facility documents and meeting minutes titled Utilization and Peer Review Committee Minutes dated 4/18/16, 7/11/16, 10/17/16 and 1/23/17 indicated the following: a. On 4/18/16 lacked documentation of MDA or MDB having participated in the meeting. b. On 7/11/16 lacked		3. a, b. MD participation was omitted from the reports but will be included in the future reports. c, d. Future meeting minutes 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.	

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	documentation of MDA or MDB having participated in the meeting. The minutes lacked documentation of any attendees present or absent and lacked documentation of review of the appropriateness of admission, review of the consistency of the diagnosis, procedure and pathology or review of the appropriateness of the ancillary services utilized. c. On 10/17/16 the minutes indicated MDA reviewed charts for peer-review on 10/10/16. The minutes lacked documentation of any attendees present or absent and lacked documentation of review of the appropriateness of admission, review of the consistency of the diagnosis, procedure and pathology 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 1/3/17. The minutes lacked documentation of any attendees present or absent and lacked documentation of review of the appropriateness of admission, review of the consistency of the diagnosis, procedure and pathology or review of the appropriateness of the ancillary services utilized. 4. On 3/14/17 at 12:15 PM, A1, Director			

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	of Surgery, verified that the Center's UR committee was not composed of 3 or more physicians having no financial interest in the facility and that meeting minutes, as indicated above, did not show attendees or UR as per MS Bylaws.			
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 develop, implement and maintain an effective, organized, center-wide, comprehensive quality assessment and performance improvement (QAPI) program for 2016	S 0300	1.The services listed will be incorporated into regular evaluation with approval of Governing Board - Safety, Infection control, Tissue, Medical Records, patient surveys,	05/11/2017

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	or 2017 to present by not including 9 services (biomedical engineering, biohazardous waste hauler, housekeeping, laboratory, laundry, maintenance, nursing, contracted radiology, or security) in its plan, review or evaluation, by not following medical staff (MS) bylaws for the Quality Improvement Committee and by failing to ensure the GB approved the QAPI plan for 2016 or 2017. Findings include: 1. Review of the document titled Quality Assessment and Performance Improvement - Committee Meeting Agenda, Reviewed 2/15, indicated items to be reviewed at each QAPI committee meeting (Safety, Infection, Tissue, Medical Records, Patient Satisfaction Surveys, Problems Requiring Committee Attention). The document lacked documentation of being center-wide or comprehensive in which all areas of the center were to participate. 2. Review of Medical Staff (MS) Bylaws, last adopted 7/11/16, indicated in X.2.2 the following: a. The Quality Improvement Committee shall consist of a chairperson and two members who shall be appointed from the MS. This committee shall also		problems are reviewed quarterly as part of the QAPI and presented at staff meeting. All areas of the center are informed of outcomes, all areas contribute to informing of any problems. 1.a. The QAPI committee was restructured as of 5-11-17 to consist of three staff MDs and Director of Center. b. Committee meets quarterly. c. Will be done with center-wide input and documented. 1.Correction accomplished with revised committee list. 2.Evaluation of services will be 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 medical staff members. 5.Responsibility: Administrator/Director. Monitoring: Reported quarterly to Medical Staff and Governing Board meetings and is ongoing.	

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	have as members the following non-medical staff members: the Administrator and the Director of Nursing. b. The Committee shall meet quarterly. c. The Quality Improvement Committee shall be responsible for conducting, coordinating and reviewing the quality of patient care on an ongoing basis and monitoring the various quality assurance programs and shall: (a) Adopt and submit approval of the governing body a Quality Improvement Plan that provides for specific programs and procedures for reviewing, evaluating, and maintaining the quality and efficiency of patient care within the Center. 3. Review of the document titled Committees, dated January 11, 2017, subsection titled QAPI lacked documentation of 2 MS members on the committee. 4. Review of 2016 and 2017 to present QAPI meeting minutes (only 1 provided) dated 12/2/2016 lacked documentation of center-wide monitors or comprehensive review or evaluation of center services for biomedical engineering, biohazardous waste hauler, housekeeping, laboratory, laundry, maintenance, medical records review services, nursing, pharmacy,			

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	internal radiology, contracted radiology, security, transcription, discharge, transfer, infection control, medication errors, response to patient emergencies or reportable events. The minutes lacked documentation of a chairperson and lacked documentation of 2 MS members present. 5. Review of MS meeting minutes dated 4/18/16, 7/11/16, 10/17/16 and 1/23/17 and attached quality reports indicated the MS had reviewed reports for medical records, pharmacy checks, infection control, medication errors, internal radiology, transcription, discharge, transfer, response to patient emergencies and reportable events. The minutes and reports lacked documentation of review or evaluation for the services of biomedical engineering, biohazardous waste hauler, housekeeping, laboratory, laundry, maintenance, nursing, contracted radiology, or security. The minutes lacked documentation of MS members having been appointed to the QAPI Committee. 6. On 3/14/17 at 10:30 AM, A1, Director of Surgery, indicated that the document titled Quality Assessment and Performance Improvement - Committee Meeting Agenda, was the QAPI Plan for 2017. A1 verified that the last review			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KLEINERT KUTZ SURGERY CENTER IN AFFILIATION W/ FLO	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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.			