New Jersey Department of Health

Division of Certificate of Need & Licensing

LICENSE

METROPOLITAN MEDICAL ASSOCIATES

Pursuant to N.J.S.A. 26:2H-1 et seq.,

which is hereby licensed to operate

METROPOLITAN SURGICAL ASSOCIATES

40 ENGLE STREET - ENGLEWOOD, NJ 07631

AMBULATORY CARE FACILITY

Ambulatory Care

4 Operating Room(s)

License #: 10263

Effective: November 1, 2021

Expires: October 31, 2022

Issued: November 23, 2021

THE GREAT SEAL OF THE STATE OF NEW JERSEY

Judith M. Persichilli

Commissioner

MUST BE POSTED IN A CONSPICUOUS PLACE IN THE FACILITY

THIS LICENSE IS NOT TRANSFERABLE, APPLIES ONLY TO THE ABOVE LOCATION, AND TERMINATES ON NOTICE BY THE DEPARTMENT

45

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 358
TRENTON, N.J. 08625-0358
www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

November 23, 2021

Ms. SUSAN MARTINELLI
Metropolitan Surgical Associates
40 ENGLE STREET
ENGLEWOOD,NJ 07631

RE: Facility#: NJ31C0001006/ License#: 10263
License Renewal

Dear Ms. SUSAN MARTINELLI:

Enclosed please find the official license for your health care facility, authorizing continued operation for the next twelve month period. The license must be posted in a conspicuous place in the facility. The license may not be transferred or assigned without the prior approval of the Department.

We appreciate your ongoing efforts to participate as a long term health care provider in NJ. In accordance with N.J.S.A. 26:2H-5, the Department may conduct surveys of the facility to ascertain compliance with all regulatory requirements. The renewal is valid for a one year period, unless revoked or suspended for failure to meet licensure requirements.

Please include the official name of the facility, the license number and contact email(s) on all correspondence if available.

If you have any questions about the license or licensure process, please call this office at (609)292-6552.

Sincerely,

Michael J. Kennedy, J.D.
Executive Director
Certificate of Need and Licensing
New Jersey Department of Health

Facility Data Sheet

Facility Detail

Facility:	Metropolitan Surgical Associates	Facility ID:	NJ31C0001006
Type:	AMBULATORY CARE FACILITY	Tracking:	LR-10263-18946
License#:	10263	License Expires:	10/31/2021 12:00:00 AM

Payment Information

Renewal Fees:	$4,000.00	Inspection Fees:	$2,000.00	Other Fees:	$0.00	Total Due:	$6,000.00

Facility Information

Address:	40 ENGLE STREET, ENGLEWOOD, NJ, 07631	Medicare#:	31C0001006
County:	BERGEN	Medicaid#:	
Telephone:	(201) 567-0522	New Telephone:	
Fax:	(201) 816-9863	New Fax:	
Email:	metmedical@aol.com	New Email:	

AV

Mailing Address

Address:	40 ENGLE STREET	New Address:	
City:	ENGLEWOOD	New City:	
State:		New State:	
Zip:	07631	New Zip:	

Emergency Contact

Name:		New Name:	
Phone:		New Phone:	
Fax:		New Fax:	
Email:		New Email:	

Administrator

Salutation:	Ms	New Salutation:	
First Name:	SUSAN	New First Name:	
Middle Name:		New Middle Name:	
Last Name:	MARTINELLI	New Last Name:	
Title:		New Title:	
Phone Number:		New Phone Number:	
Email:		New Email:	
Current Primary:	Yes	New Current Primary:	
Start Date:		New Start Date:	
End Date:		New End Date:	

Owner Detail

Company Name:	METROPOLITAN MEDICAL ASSOCIATES		
Type:	AMBULATORY SURGICAL CENTER	Business Type:	
Company Tax ID:		Company Tax ID:	
Address:	40 ENGLE STREET	New Address:	
City:	ENGLEWOOD	New City:	
State:	NJ	New State:	
Zip:	07631	New Zip:	
Phone Number:		New Phone Number:	

Fax Number:		New Fax Number:	
Email:		New Email:	

Facility Officers/Principals Name and Ownership Detail

KEITH GRESHAM		50.00%
ORESTIS KOTOPOULOS	CHAIRMAN	50.00%

Bed / Services / Slots	*Facility ID: NJ31C0001006*	*Tracking: LR-10263-18946*

Services & Designations:

	Ambulatory Care
4	Ambulatory Surgery

Related Facilities

Name	License#

Current Accreditation		New Accreditation	
Accrediting Body:	AAAASF	Accrediting Body:	AAAASF
Effective Date:		Effective Date:	
Expiration Date:	04/13/2016	Expiration Date:	4/13/24
Hospital Attestation:	No	Hospital Attestation (Yes/No):	
Hospital Attestation Letter Date:		Hospital Attestation Letter Date:	
Deem:	No	Deem (Yes/No):	

Note: Please include the accreditation certificate(s) and hospital attestation letter, if applicable.

LICENSE RENEWAL QUESTIONNAIRE

AMBULATORY CARE FACILITY

License#: 10263 Expires: NJ31C0001006 Ref#: LR-10263-18946

Please answer the following questions (attach additional sheets if necessary)

1. Have any of the principals of the operating entity ever applied, directly or indirectly, for health care facility approval in New Jersey or any other state, which was denied or revoked ? ______ (Yes/No) If Yes, indicate whom and give details:

2. Do any of the principalsof the operating entity have an ownership, operational or management interest in any other licensed health care facility in New Jersey, or any other state ? ______ (Yes/No) If Yes, explain the nature of the interest and give name and address of each facility :

3. Have any principals of the operating entity ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect ? have any of these ever been indicted for the same charge ? ______ (Yes/No) If Yes, explain in detail:

4. Have any principals of the operating entity ever been indicted for or convicted of a felony crime ? ______ (Yes/No) If Yes, indicate whom and give details

CERTIFICATION

The applicant certifies:
1) that all information contained in this application and attachments is true and correct, to the best of his/her knowledge and belief, and that willful misrepresentation of these facts may make the applicant subject to civil penalties;
2) that the application has been duly authorized by the governing body of the applicant;
3) that the facility has been and will be operated in accordance with applicable licensing requirements;
4) that the facility is not suspended, debarred , or otherwise excluded for any reason from entering into the covered transaction; and
5) that the facility is in compliance with the requirements of Section 6032 of The Federal Deficit Reduction Act.

Name of authorized individual completing form (print or type):

Print Name: SUSAN MARTINELLI Title: 8/20/21

Signature: [signature] Date: 8/20/21

Isabelle Tarikyan <mgmt871@gmail.com>

AUTO GENERATED: DO NOT REPLY - DOH Payment Confirmation

1 message

dohepay.mail@doh.nj.gov <dohepay.mail@doh.nj.gov> Tue, Aug 24, 2021 at 7:20 AM
To: MGMT871@gmail.com

Dear ISABELLE TARIKYAN,

Thank you for using the Department of Health electronic payment system.
Your payment has been processed. Please find a summary of your payment below.

Payment Information:
Application Name: Ambulatory Care Facility - Renewal
Name: METROPOLITAN SURGICAL ASSOCIATES
Confirmation Number: 14280-191332543
Payment Date: 08/24/2021
Application Payment Amount: $6,000.00
Payment Including Service Fee: $6,000.00

Address & Contact Information:
Physical Address Line 1: 40 ENGLE STREET
Physical Address Line 2:
City: ENGLEWOOD
State: NJ
Zip: 07631
Phone Number: 201-567-0522
Email Address: MGMT871@GMAIL.COM

Please print this receipt and keep it on file for your future references.

Visit www.nj.gov/health web site for additional information.

For credit card payment inquires please visit NICUSA support web site ,
https://www.njportal.com/ErrorPages/PaymentHelp.aspx?s=ce

Your Check transaction has been successfully processed. The transaction confirmation number is 14280-191332543. Please print this page for your record.

Check Confirmation

Payer Information

Last Name: Tarikyan

First Name: Isabelle

Electronic Check Payment

E-Check Debit Information

*Bank Routing Number:	[redacted]
*Bank Account Number:	[redacted]
*Account Type:	Checking
*Application Payment Amount:	$6000.00
*Payment Including Service Fee:	$6000.00

Please PRINT this confirmation for your records.
If your registration requires completion of an application please use RETURN button to open the application and follow the instruction.
Otherwise use RETURN button to go back.
Note: Do not click on the back button.

PRINT RETURN

Walker, James [DOH]

From: dohepay.mail@doh.nj.gov
Sent: Tuesday, August 24, 2021 7:20 AM
To: DOH-LTC Payments
Subject: 14280-191332543 & METROPOLITAN SURGICAL ASSOCIATES

Payer Information:

Application Name: Ambulatory Care Facility - Renewal
EFT Code: 14280
Trade or Individual Name: METROPOLITAN SURGICAL ASSOCIATES
Physical Address Line 1: 40 ENGLE STREET
Physical Address Line 2:
City: ENGLEWOOD
State: NJ
Zip: 07631
Phone Number: 201-567-0522
Email Address: MGMT871@GMAIL.COM

Last Name: TARIKYAN
First Name: ISABELLE

Application Type: RENEWAL

Pertinent Number	Expiration Date	Amount
10263	10/31/2021	6000.0

Type of Service: Electronic Check Payment
Application Payment Amount: $6000.00
Payment Including Service Fee: $6000.00
Confidentiality Notice: This e-mail, including any attachments, may include advisory, consultative and/or deliberative material and, as such, would be privileged and/or confidential and not a public document. Any information in this e-mail identifying a client of the Department of Health or including protected health information is confidential. If you received this e-mail in error, you are not authorized to review, transmit, convert to hard copy, copy, or in any way further use or disseminate this e-mail or any attachments to it. You must immediately notify the sender, delete the email/attachment(s), confirm in writing to the sender that you deleted the email/attachment(s) and that you did not/will not further use or disclose the information contained in the email.

State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 358
TRENTON, N.J. 08625-0358

www.nj.gov/health

JON S. CORZINE
Governor

HEATHER HOWARD, J.D.
Commissioner

January 31, 2008

VIA UNITED
PARCEL SERVICE

Susan Martinelli
Administrator
Metropolitan Surgical Associates, Inc.
40 Engle Street
Englewood, New Jersey 07631

Re: Waiver Request
Facility ID # 10263

Dear Ms. Martinelli:

This is in response to your application received on May 1, 2007 requesting a waiver from the American Institute of Architects (AIA) Guidelines for Design and Construction of Hospitals and Health Care Facilities 2001 (Guidelines) Section 9.5.C. This request has been reviewed in consultation with the Department of Health and Senior Services' (Department) staff construction manager.

Section 9.5.C of the AIA Guidelines, entitled "Parking," requires, "Four spaces for each room routinely used for surgical procedures plus one space for each staff member shall be provided. Additional parking spaces convenient to the entrance for pickup of patients after recovery shall be provided."

You state that this waiver is being filed as a result of a citation being issued by the Department for having less then adequate parking space required for an ambulatory care facility. Your waiver request points out that this facility has been operational at the same site since 1982 and is located in an urban area where street parking is available immediately outside the entrance. Furthermore, a municipal parking lot is located within 250 feet from the facility. You also indicate that there is a drop-off area for patients immediately outside the facility at curbside and a handicapped parking space, on the street immediately available.

I am granting this waiver based on the nature of the specialized surgical services provided at this facility and the availability of public transportation for easy access. My decision also takes into consideration that the facility has been at this location since 1982 and has a conveniently located patient drop-off and pickup area at the front entrance, as well as a handicapped parking space. I am satisfied with the operational patterns to access and depart the facility.

Please be advised that this waiver may be rescinded at any time if the waiver results in any negative impact on patient care. Furthermore, this waiver will expire upon any amendments to the rule identified above. At that time, it is incumbent upon the facility to submit a new waiver application for Department review. The aforementioned waiver is for the use of the licensed operator at this location.

If you have any further questions please do not hesitate to contact Mr. Anthony Kobylarz of my staff, at (609) 292-6552.

Sincerely,

John A. Calabria
Director
Certificate of Need and
Healthcare Facility Licensure

c. Ms. Gibson
Mr. Kiani
Mr. Kobylarz
Ms. Diaz
Mr. Spiewak

New Jersey Department of Health and Senior Services
Office of Certificate of Need and Healthcare Facility Licensure
P.O. Box 358
Trenton, NJ 08625-0358

MAY - 1 2007

APPLICATION FOR WAIVER

(Requests for more than one waiver may not be combined. An Application for Waiver form must be completed for each waiver requested).

CN Ref. #	DCA Ref. #	Facility ID # (if currently licensed) **10263 A**
Name and Address of Facility: **METROPOLITAN SURGICAL ASSOCIATES, INC.** **40 ENGLE STREET** **ENGLEWOOD, NJ 07631**		
Name, Address and Telephone Number of Owner, Chief Executive Officer (CEO), Chief Operating Officer (COO), or Administrator of the Existing or Proposed Facility: **SUSAN MARTINELLI** **40 ENGLE STREET** **ENGLEWOOD, NJ 07631** **(201) 567-0522**		
Name, Address and Telephone Number of Architect: **STEVEN B. LAZARUS, A.I.A.** **16 HIGHWOOD AVENUE** **ENGLEWOOD, NJ 07631** **(201) 816-1818**		
The owner, CEO, COO or Administrator of the existing or proposed health care facility hereby applies for a waiver to the following regulation (identify regulation by name, code citation (if applicable) and date (if applicable): **Section 9.5D of the 1987 Edition of the Guidelines for Construction and Equipment of Hospital and Medical Facilities published by the American Institute of Architects**		

CN-28
FEB 07

APPLICATION FOR WAIVER (continued)

A. Provide the following information for each rule or part of rule for which a waiver is being requested. Attach additional sheets as necessary.

1. Restate rule or part of rule for which a waiver is being requested and identify the specific rule citation.

   Four spaces for each room routinely used for surgical procedures plus one space for each staff member shall be provided. Additional parking spaces convenient to the entrace for pickup of patients after recovery shall be provided.

2. Describe the reasons for requesting a waiver, including a statement of the type and degree of hardship that would result upon compliance.

   The facility is located in an urban area and has been in operation since 1982. Complaince with this regulation would be an impossibility at this location since there is no vacant lot adjacent to the facility that could be purchased, rented, or used for parking.

3. Describe an alternative proposal to ensure patient safety.

   The facility is equipped with a patient drop-off/pick-up directly in front of the facility. In addition, a handicapped parking space is located in front of the facility. On-street parking is available in the immediate vicinity of the facility. There is a municipal parking lot located on Bergen Street approximately 250 feet from the facility. The facility is readily accessible via public transportation and many of our patients arrive as pedestrians, via pubic transportation, or medical transport not requiring parking.

4. Is documentation attached to support the waiver request?

   ☒No ☐Yes (Identify):

B. Is the project currently under review by the Department of Community Affairs, Health Care Plan Review?

☒No ☐Yes (Identify DCA Reviewer)

C. Is the request for a waiver based on plan review comments by the Department of Community Affairs.

☒No ☐Yes (Attach Comments)

Name of Owner, CEO, COO or Administrator **SUSAN MARTINELLI**	Title **ADMINISTRATOR**
Signature of Owner, CEO, COO or Administrator Susan Martinelli	Date 4/28/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ______ B. WING ______	C **01/06/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	**40 ENGLE STREET** **ENGLEWOOD, NJ 07631**

(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
Q 000	INITIAL COMMENTS This was a Federal Complaint Survey conducted on 1/6/21. Metropolitan Surgical Associates is in compliance with 42 CFR Part 416, Conditions for Coverage for Ambulatory Care Facilities for this complaint only (C#NJ00141727).	Q 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

New Jersey State Department of Health
Acute Care Survey

COMPLAINT AND SURVEILLANCE REPORT

Facility	Date	Case Number
Metropolitan Surgical Associates	4/24/18	NJ00108847
Administrator/CEO	**Type Facility**	**Time Required to Correct**
	ASC	
Type of Survey	**Matter Under Consideration**	
☐ Revisit ☑ Complaint ☐ Investigation ☐ Surveillance ☐ For Immediate Attention	Alterations to physical plant	

Census/Bed Capacity	Units Toured	Charts Reviewed	Number of Patients Affected

Facility Representatives/Titles	Remarks/Issues
	Valid

When this form is utilized for a survey, the following needs to be addressed:
This survey was reviewed with the Administrator or his/her authorized representative at the conclusion of the survey. He/she was advised of the areas where standards were not met in violation with the rules and regulations promulgated under the authority of N.J.S.A. 26:2H-5(b). He/she was further advised that it was necessary to correct conditions which do not meet the standards and that failure to correct those deficiencies may result in a fine of up to $5,000.00 per violation per day in accordance with N.J.S.A. 26:2H-14 as amended. Refusal to sign does not negate the facility's responsibility to correct deficiencies.

Signature of Responsible Official	Signature of Investigator
[signature]	[signature]

NARRATIVE

A Visit was made to this facility in response to the above referanced complaint. Administrative staff was made aware of the visit and the nature of the complaint.

The investigation included:

✓ Tour.
___Staffing reports.
___Medical record review.
___Staff interviews.
___Patient interviews.
✓ Review of other facility documentation.
___Meal/Medication pass observation.
___Water/Room temperature.

An exit conference was held with administrative staff (discussed findings and concerns).

Comments:

ENTERED ON: 4/26/19
BY: [initials]

AAS-29
JUL 12

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

SHEREEF M. ELNAHAL, MD, MBA
Commissioner

June 14, 2018

Susan Martinelli
Administrator
Metropolitan Surgical Associates
40 Engle Street
Englewood, NJ 07631

Re: Complaint #NJ 00108847

COPY
COPY

Dear Ms. Martinelli:

Thank you for your courtesy and cooperation extended during the Complaint Survey conducted on April 24, 2018 by a surveyor from the New Jersey Department of Health.

Enclosed is the statement of deficiencies; please reply to each deficiency on an item-by-item basis with your Plan of Correction (PoC).

The PoC must include:

1. How you will correct the specific findings cited for each deficiency.
2. What systemic changes will be implemented to ensure that each deficient practice does not recur.
3. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. The plan must identify the individual responsible for monitoring, how and when the monitoring will be conducted, how long and how often monitoring will take place, what the goal is for compliance, and to whom the results will be reported.
4. The date on which each item addressed on the PoC will be corrected.
5. Do not reference and/or include attachments with your PoC.

6. Do not include names of individuals in the PoC. Use of titles is acceptable, such as, Administrator, Director of Nursing, Infection Control Practitioner, etc.

Please be advised that the PoC will not be accepted for review by this office and will be returned to you if it contains reference to and/or attachments and/or names of individuals.

All responses should be numbered to correspond with the number of your deficiency statements. Please sign and date the first page of the deficiency statement with your plan of correction. Return these forms to this office within ten (10) business days of receipt of this letter, to my attention. Any delay or lack of response may jeopardize the licensure of your facility.

Please be advised that some or all of the deficiencies cited in the enclosed survey report may be referred to the Office of Program Compliance ("OPC") for imposition of enforcement remedies, including civil penalties. OPC will advise you, at a later date and under separate cover, of any enforcement actions and your appeal rights.

Please do not hesitate to contact me, if you have any questions regarding the deficiencies at (609) 292-9900.

Sincerely,

Eric DeCicco/SP

Eric DeCicco, CFI
Surveyor Physical Plant/Life Safety
Survey and Certification

Encl.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10263	A. BUILDING: ______ B. WING ______	C 04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATES	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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) COMPLETE DATE
A 000	INITIAL COMMENTS The facility is not in compliance with N.J.A.C. Title 8 Chapter 43A-Standards for Licensure of Ambulatory Care Facilities for this complaint only (C# NJ00108847).	A 000		
A5016	8:43A-19.3(a) PHYSICAL PLANT: PLAN REVIEW FEES Prior to any construction, plans shall be submitted for review and approval, in accordance with the provisions of this chapter, to the Healthcare Plan Review Unit. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to ensure that prior to any construction, plans were submitted for review to the Healthcare Plan Review Unit of the Department of Community Affairs. Findings include: 1. During a tour of the facility on 4/24/18, this surveyor observed new construction, at the top of the stairs, to the main stairwell. The main stairwell was enclosed with a set of double doors which was not enclosed during the previous survey. Staff #1 was unable to provide plans for this new construction that was submitted and approved by the New Jersey Department of Community Affairs Plan Review Unit. a. Staff #1 confirmed plans were not submitted to the New Jersey Department of Community Affairs, Healthcare Plan Review Unit.	A5016	COPY	

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

A5016 8:43A-19.3(a) PHYSICAL PLANT: PLAN REVIEW FEES

Plans for construction shall be submitted to the New Jersey Department of Community Affairs Plan Review Unit no later than June 29, 2018.

The Board of Directors and Chairman of the Board are aware that prior to any construction/renovations at the facility, plans must be submitted and approved by the Healthcare Plan Review Unit of the Department of Community Affairs. No other construction/renovation is planned and no future construction/renovation will be scheduled without first submitting plans to the Healthcare Plan Review Unit.

No new construction/renovation will be commenced without the prior written approval of the Board of Directors at a regularly scheduled or Special meeting of the Board. If any new construction/renovation is contemplated, it will be the responsibility of the Chairman of the Board to ensure that prior to any work being completed, plans will first be submitted and approved by the New Jersey Department of Community Affairs Plan Review Unit.

Plans for the construction at the top of the stairs to the main stairwell shall be submitted no later than June 29, 2018. The facility will follow the Procedures for Submission and inform the corresponding contact at the Department of Health when the Department of Community Affairs Plan Review Unit either approves and/or responds to the application.

4/25/19

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0360

www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

SHEREEF M. ELNAHAL, MD, MBA
Commissioner

April 23, 2019

Susan Martinelli
Administrator
Metropolitan Surgical Associates
40 Engle Street
Englewood, NJ 07631

Re: Complaint # NJ00108847

Dear Ms. Martinelli:

Thank you for providing the Survey and Certification Program with a Plan of Correction (PoC) for the deficiency found during the Complaint Survey at your facility on April 24, 2018.

Your Plan of Correction has been reviewed, found to be complete and approved by this office. Enclosed is a form indicating that all deficiencies have been corrected. Continued compliance with State Licensure Regulations will be required by your facility.

You are advised that this letter does not preclude a revisit from Assessment and Survey staff at a later date, to ensure that all elements of the PoC have been implemented.

Should you have further concerns regarding this investigation, please direct them to me at (609) 292-9900.

Sincerely,

Eric DeCicco, CFI
Surveyor Physical Plant/Life Safety
Survey and Certification

Transaction Report

For: METROPOLITAN SURGICAL ASSOCIATION - NJ31C0001006

Certification ID: RL8Z **Provider #:** 31C0001006 **Survey Date:** 01/25/2011

Printed: 09/16/2011

Transaction Number: 310003852383 **On:** 06/10/2011 **By:** STESKA, LOUISE A.
Tran Type: 03 - ADD **Status:** -1 - Failed Prevalidation in ASPEN

Message Detail:
2101-2786E: CMS-2786E STATUS COMPL (K9) MUST BE A OR B.
<0172R-1539: CMS-1539 THE DETERMINATION APPROVAL DATE (L33) IS REQUIRED.>
0257-2567: CMS-2567 ADM SIGNOFF DATE (X6) IS REQUIRED WHEN DEFICIENCIES ARE PRESENT ON THE LSC SURVEY

Transaction Number: 310003888211 **On:** 07/12/2011 **By:**
Tran Type: 03 - ADD **Status:** 10 - Successful Load into ODIE

Message Detail:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RL8Z

Facility ID: NJ31C0001006

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) 31C0001006

2. STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) METROPOLITAN SURGICAL ASSOCIATION
(L4) 40 ENGLE STREET
(L5) ENGLEWOOD, NJ (L6) 07631

4. TYPE OF ACTION: 2 (L8)
1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 01/25/2011 (L34)

8. ACCREDITATION STATUS: 0 (L10)
0 UNACCREDITED
1 TJC
2 AAAHC
3 AAAASF

7. PROVIDER/SUPPLIER CATEGORY 15 (L7)
01 Hospital
02 SNF/NF/Dual
03 SNF/NF/Distinct
04 SNF
05 HHA
06 PRTF
07 X-Ray
08 OPT/SP
09 ESRD
10 NF
11 IMR
12 RHC
13 PTIP
14 CORF
15 ASC
16 HOSPICE
22 CLIA

FISCAL YEAR ENDING DATE: (L35)
06/30

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE
L Steska
Date: 06/10/2011 (L19)

18. STATE SURVEY AGENCY APPROVAL
L Steska
Date: 06/10/2011 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/29/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00805
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
06/10/2011
(L32)

32. DETERMINATION OF APPROVAL DATE
07/12/2011
(L33)

DETERMINATION APPROVAL

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RL8Z

Facility ID: NJ31C000100

C&T REMARKS - CMS 1539 FORM

On 1/25/11, a federal recertification survey took place that resulted in a condition level deficiency. The Patient Rights condition was found to be out of compliance.

On 6/9/11, a federal revisit was conducted. The Patient Rights condition was found to be back in compliance.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0266

AMBULATORY SURGICAL CENTER REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Please see statement on reverse and read the following instructions before completing this form)

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions of Coverage are met. Assistance in completing the form is available from the State agency.

Answer all questions as of the currrent date. Return the original and first two copies to the State agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Medicare Supplier Number - Insert the facility's six-digit supplier number. Leave blank on initial requests for certification.

Related Provider Number - Complete this block when a facility is participating under more than one provider number, such as a facility also participating as a hospital. The number in this block for each related provider will be the provider number of the highest level of care.

NOTE: If an ASC is operated by a hospital, has a Distinct Part SNF, ICF and ICF/MR, the related provided number field on the application for each provider (including the hospital) will have the hospital provider number.

State/County and State Region Codes - Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.

Item III - If a service is provided directly by the facility, place a '1' in the appropriate block. If a service is provided through an outside source (i.e., by contract or referral), place a '2' in the appropriate block.

Item IV - 'X' the appropriate blocks representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties).

I IDENTIFYING INFORMATION

- Medicare Supplier Number (AS1): 305445
- Related Provider Number (AS2): 2979802
- State/County Code (AS3): 015/002
- State Region Code (AS4):
- Fiscal Year Ending Date (AS5): 06/30
- Name of Facility: METROPOLITAN SURGICAL ASSOC
- Street Address: 40 ENGLE ST
- City, County, and State: ENGLEWOOD, N.J
- Zip Code: 07631
- Telephone No. (Include Area Code): (201) 567-0522

II TYPE OF CONTROL (x one box) (AS6)

1. ☐ Proprietary CORP. (SUB-S)
2. ☐ Non-Profit
3. ☐ Government

III ANCILLARY SERVICES (Place '1' or '2' in blocks) (AS7)

1. 2 Laboratory
2. 2 Radiology
3. 2 EKG
4. 2 Pharmacy

IV SURGICAL SPECIALTIES (X appropriate blocks) (AS8)

1. ☐ Cardiovascular
2. ☐ Foot
3. ☐ General
4. ☐ Neurological
5. ☒ Obstetrics/Gynecology
6. ☐ Ophthalmology
7. ☐ Oral
8. ☐ Orthopedic
9. ☐ Otolaryngology
10. ☐ Plastic
11. ☐ Thoracic
12. ☐ Urology
13. ☐ Other (Specify) ______

V FACILITY CHARACTERISTICS (AS9)

1. Number of Operating Rooms: 4 (AS10)
2. Date Center Began Providing Services: 5/5/80 (AS11)

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR A REQUEST TO PARTICIPATE OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Signature of Authorized Official (sign in ink)	Title	Date
[signature]	Chairman of Board	01-20-2011

AS12

Form CMS-377 (01/97) EF (10/2004)

Metropolitan Medical Associates

Fax

OCT 5 - 2016

Janet Diaz

From: Susan Marinelli

Fax: 609-826-3745

Date: 10/5/16

0000000

Phone:

Pages:2

Re:

Urgent ☐ **For Review**

The document in this facsimile transmission may contain confidential health information that is privileged and legally protected from disclosure by law, the Health Insurance Portability and Accountability Act (HIPAA). You are hereby notified that reading, disseminating, disclosing, distributing, copying, acting upon or otherwise using the information contained in this facsimile is strictly prohibited. If you have received this information in error, please notify the sender immediately at Metropolitan Surgical Associates and destroy this facsimile.

Subject/Notes:

__Re: AAAASF

License 10263

American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

presents this certificate to

Metropolitan Surgical Associates, Inc.

for having met the standards of a CLASS C–M ambulatory surgery facility in which minor or major surgical procedures are performed under intravenous or parenteral sedation (including Propofol), analgesia, or dissociative drugs.

AAAASF President
Foad Nahai, MD

Secretary/Treasurer
Lawrence S. Reed, MD

Certified from 4/13/2016 to 4/13/2017

Certification Number 4303

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

June 10, 2011

Susan Martinelli
Administrator
Metropolitan Surgical Association
40 Engle Street
Englewood, NJ 07631

Dear Ms. Martinelli:

Thank you for the courtesy and cooperation extended during the Federal revisit survey of your facility on June 9, 2011 by surveyors from the Department of Health and Senior Services.

Enclosed is the CMS-2567B form which indicates that the Federal deficiencies, identified during the survey of January 25, 2011 were corrected.

Should you have questions, please do not hesitate to contact Christine Muszynski, Supervisor of Inspections, at (609) 292-9900.

Sincerely,

Louise A. Steska

Louise A. Steska, MSN, RN
Health Care Services Evaluator/Nurse
Assessment and Survey

Encl.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of informat including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperv Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
31C0001006	A. Building B. Wing	6/9/2011

Name of Facility	Street Address, City, State, Zip Code
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Q0103 Reg. # 416.44(a)(3) LSC	Correction Completed 06/09/2011	ID Prefix Q0104 Reg. # 416.44(b) LSC	Correction Completed 06/09/2011	ID Prefix Q0105 Reg. # 416.44(c) LSC	Correction Completed 06/09/2011
ID Prefix Q0162 Reg. # 416.47(b) LSC	Correction Completed 06/09/2011	ID Prefix Q0181 Reg. # 416.48(a) LSC	Correction Completed 06/09/2011	ID Prefix Q0220 Reg. # 416.50 LSC	Correction Completed 06/09/2011
ID Prefix Q0221 Reg. # 416.50(a)(1) LSC	Correction Completed 06/09/2011	ID Prefix Q0223 Reg. # 416.50(a)(1)(ii) LSC	Correction Completed 06/09/2011	ID Prefix Q0224 Reg. # 416.50(a)(2) LSC	Correction Completed 06/09/2011
ID Prefix Q0229 Reg. # 416.50(b)(1)(iii) LSC	Correction Completed 06/09/2011	ID Prefix Q0232 Reg. # 416.50(c)(2) LSC	Correction Completed 06/09/2011	ID Prefix Q0242 Reg. # 416.51(b) LSC	Correction Completed 06/09/2011
ID Prefix Q0261 Reg. # 416.52(a)(1) LSC	Correction Completed 06/09/2011	ID Prefix Q0267 Reg. # 416.52(c)(3) LSC	Correction Completed 06/09/2011	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Louise A. Steska	Date: 6/10/11
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/25/2011

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES (NO)

Form CMS - 2567B (9-92)

Event ID: RL8Z12

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
31C0001006	A. Building B. Wing 01 - MAIN BUILDING 01	6/9/2011

Name of Facility	Street Address, City, State, Zip Code
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # 416.44(b)(1) LSC K0029	Correction Completed 06/09/2011	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Louise A Stoska	Date: 6/10/11
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/20/2011		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?		YES (NO)

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

CONSENT FOR OBSERVATION IN THE AMBULATORY SURGERY CENTER

BENEFICIARY NAME: Eltaneilya George

ADDRESS: 243 18th Avenue Paterson, NJ 07504

By this document, I hereby consent to have State/Federal health survey personnel observe care provided me at the ASC to ensure that the Federal requirements are met and to assist in evaluating the effectiveness and quality of care that I receive from the

____
(Name of Ambulatory Surgery Center)

I understand that consent for this visit is voluntary and none of my rights to confidentiality or privacy are waived by my consent. I have been told and I understand that refusal to consent will have no effect on the level or nature of Health Insurance benefits to which I am entitled.

[signature]
BENEFICIARY OR REPRESENTATIVE OF THE BENEFICIARY SIGNATURE

6/9/11
DATE

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

POONAM ALAIGH, MD, MSHCPM, FACP
Commissioner

February 14, 2011

Susan Martinelli
Administrator
Metropolitan Surgical Association
40 Engle Street
Englewood, NJ 07631

Dear Ms. Martinelli:

Thank you for the courtesy and cooperation extended during the Federal Health Survey of your facility on January 20 , 2011 and January 25, 2011 by surveyors from the Department of Health and Senior Services.

As a result of observation and evaluation certain Federal deficiencies were evident. The deficiencies identified during this visit have resulted in the determination that your facility is not in compliance with the following Medicare Condition for Coverage:

416.50 Patient Rights.

A complete listing of the specific deficiencies identified by the surveyors is enclosed. These Federal deficiencies were discussed with you and/or your staff during the visit and are listed on the left side of the enclosed CMS-2567 form. Please reply to each deficiency, on an item by item basis, with your Plan of Correction (PoC) and the date you expect the correction to be completed.

The PoC should address the systemic problem that resulted in the deficiency. Please number your responses to correspond with the number of each deficiency statement.

The PoC must include:

1. How the corrective action will be accomplished for those patients found to have been affected by the deficient practice.

2. How the facility will identify other patients having the potential to be affected by the same deficient practice.

3. What measures or systemic changes will be instituted to ensure that the deficient practice will not recur.

4. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systemic changes.

   The plan must identify the individual responsible for monitoring, how and when the monioring will be conducted, and to whom the results will be reported.

5. The date on which each item addressed on the PoC will be corrected.

Please submit the PoC to the Department of Health and Senior Services Health Facilities Evaluation and Licensing, 120 South Stockton Street, Trenton, NJ 08611.

Sign and date the first page of the CMS-2567 form and return the form with your PoC to the attention of Christine Muszynski, Supervisor of Inspections. Please retain a copy of each page for your records. All responses must be returned within 10 calendar days of receipt of this letter.

It is important to return the completed forms promptly. Any delay or lack of response may jeopardize the certification status of your facility. If you have any questions concerning this report, please contact Christine Muszynski at (609) 292-9900.

Sincerely,

Christine Muszynski BSN, RN for

Louise A. Steska, MSN, RN
Health Care Services Evaluator/Nurse
Assessment and Survey

Encl.

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

PRINTED: 02/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ______ B. WING ______	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 000	INITIAL COMMENTS This is a federal recertification survey. Medical records reviewed: 20 Staff interviews / staff files reviewed: 17	Q 000		
Q 103	416.44(a)(3) IDENTIFICATION, PREVENTION, AND MAINTENANCE [The ASC must provide a functional and sanitary environment for the provision of surgical services.] The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities. This STANDARD is not met as evidenced by: Based on staff interview and a review of documents on 1/20/11, it was determined that the facility failed to follow up on each patient after discharge, in order to identify and track infections associated with the patient's stay in the ASC. Findings include: 1. When asked on 1/20/11 at 11:08 AM, about how the facility monitors and tracks patient infections, Staff #8 stated the following: "Not all of the patients have primary physicians, but if the patient returns to the facility for their two week follow up visit, the facility staff will complete an infection control survey form. If the patient has a primary physician, a letter is sent to the physician asking about infections. A general letter (but not a list of patients seen) is also sent to Planned Parenthood every six months."	Q 103		

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/28/11

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ______ B. WING ______	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 104	Continued From page 3 (2) 0.5 gallons (2.0 liters) for dispensers in suites of rooms (C) The dispensers shall have a minimum horizontal spacing of 4 feet (1.2m) from each other; (D) Not more than an aggregate of 10 gallons (37.8 liters) of ABHR solution shall be in use in a single smoke compartment outside of a storage cabinet; (E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code; (F) The dispensers shall not be installed over or directly adjacent to an ignition source; (G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments; and (v) The dispensers are maintained in accordance with dispenser manufacturer guidelines. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to meet the provisions of the Life Safety Code concerning Alcohol Based Hand Rub dispenser (ABHR) locations above ignition sources. Findings include: 1. On 1/20/11, at 11:15 AM, in the presence of Staff #9, in the pre-op nurse station and PACU	Q 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ______ B. WING ______	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 104	Continued From page 4 bay #11, ABHRs were located above electrical boxes, which can be an ignition source.	Q 104		
Q 105	416.44(c) EMERGENCY EQUIPMENT Emergency equipment available to the operating rooms must include at least the following: (1) Emergency call system. (2) Oxygen. (3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. (4) Cardiac defibrillator. (5) Cardiac monitoring equipment. (6) Tracheostomy set. (7) Laryngoscopes and endotracheal tubes. (8) Suction equipment. (9) Emergency medical equipment and supplies specified by the medical staff. This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 1/20/11, it was determined that the facility failed to ensure that there was emergency suction equipment available to the operating rooms. Findings include: 1. Upon interview at 11:00 AM on 1/20/11, Staff #1 stated that the only suction equipment available were the suction machines in each operating room. This suction equipment is used during the procedure and is not available as emergency suction equipment.	Q 105		
Q 162	416.47(b) FORM AND CONTENT OF RECORD The ASC must maintain a medical record for	Q 162		

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

PRINTED: 02/14/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ______ B. WING ______	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 162	Continued From page 5 each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination. (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration. (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. This STANDARD is not met as evidenced by: A. Based on a review of the medical records of three patients (#1, #2, and #19) who underwent a surgical procedure at the facility it was determined that a properly executed informed patient consent was not obtained prior to the performance of the surgery. Findings include: 1. Review of an INFORMED CONSENT FOR CERVICAL DILATORS (SAME DAY) form dated [redacted] in the medical record of Patient #2 indicated that the 'Patient signature' section did not contain the signature of the patient. The form did not have a section to indicate the name or signature of the physican who obtained the informed consent. The only other signature line	Q 162		

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

PRINTED: 02/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ________ B. WING ________	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 162	Continued From page 6 on the form is for 'Witness signature." A dilator was used on the patient even though there was no documentation that she consented. 2. Review of INFORMED CONSENT FOR CERVICAL DILATORS (SAME DAY) forms in the medical records of Patient #1 and #19 did not indicate that a physician obtained informed consent. 3. Administrator #1, on the morning of January 20, 2011, stated that consent should have been obtained by the facility counselor. She further indicated that the counselor was not a physican. The 'counselor' was not qualified to obtain informed consent for use of a medical device. B. Based on a review of the medical records of five patients it was determined that not all medical records included patient identification. Findings include: 1. Review of two ENGLEWOOD PHYSICAN'S GROUP assessment forms, one dated [redacted] and one dated [redacted], in the medical record of Patient #19 did not include the name of the patient on the form. The 'NAME (Patient's)' section at the top of the form did not indicate an entry. Additionally, an INFORMED CONSENT FOR CERVICAL DILATORS (SAME DAY) form dated [redacted] did not contain the name of the patient. 2. Review of the medical records of Patients #1, #15, #16, and #19 indicated 'Size Check Sheets.' None of the completed forms indicated the names of the patients.	Q 162		

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Q 162	Continued From page 7 3. Not all of the pages in each medical record indicated at least one patient identifyer on each page. If a sheet without a patient identifyer were to become seperated from the medical record cover, it would be difficult, if not impossible, to determine which patient's medical record it belonged in. C. Based on observation on [redacted] a review of documents, and medical record review of #20, it was determined that the facility failed to ensure an accurate medical record. Findings include: Reference: The facility policy titled, "Informed Consent Policy," states "...The evaluating physician, treating physician and counselor together shall obtain appropriate informed consent from patients...before starting any treatment or activity that presents a risk to the patient's health or safety...Treatments and activities requiring informed consent include...Anesthesia...All operative procedures...Non-surgical Abortion..." 1. On [redacted], this surveyor followed Patient #20 throughout her stay at the ASC. a. Medical record #20 contains a document titled, "Counseling," which contains check marks in boxes next to the words, "The available methods anesthesia (sic) and their risks and benefits have been reviewed," and "Birth Control Methods have been reviewed". This document is signed by Staff #12.	Q 162		

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Q 162	Continued From page 8 (i) On [redacted] Patient #20 met with Staff #12, the facility counselor. During this meeting, Staff #12 gave Patient #20 the facility "Consent for Termination of Pregnancy and Anesthesia" to sign. This consent includes risks of anesthesia and the procedure. However, Staff #12 failed to review the available methods of anesthesia and their risks and benefits and failed to review birth control methods with Patient #20. b. The "Consent for Termination of Pregnancy and Anesthesia" in medical record #20 dated [redacted] contains signatures on the lines titled, "Evaluating Physician," and "Treating Physician." However, the evaluating physician and the treating physician failed to inform Patient #20 of the anesthesia risks and benefits or the risks and benefits of the surgical procedure, prior to the procedure on 1/20/11 at 1:30 PM.	Q 162		
Q 181	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on a review of medical records and staff interview, it was determined that the facility failed to ensure that a physician order was in place to discontinue the intravenous solution and/or the hep lock from the patient. Findings include: 1. In 20 of 20 medical records reviewed on	Q 181		

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Q 181	Continued From page 9 1/20/11 and 1/25/11, there was no evidence that a physician order was written to discontinue the intravenous and / or hep lock from the patient. 2. This was confirmed by Staff #9 and Staff #15.	Q 181		
Q 220	416.50 PATIENT RIGHTS The ASC must inform the patient or the patient's representative of the patient's rights, and must protect and promote the exercise of such rights. This CONDITION is not met as evidenced by: Based on observation, document review, patient interview and medical record review, it was determined that the facility failed to promote and exercise patient rights. Findings include: 1. The facility failed to provide patients with verbal and written notice of the facility's patient rights, in advance of the date of the procedure. (Cross refer Q221). 2. The facility failed to provide patients with disclosure of information in writing regarding physician financial interests or ownership in the ASC, in advance of the date of the procedure. (Cross refer Q223). 3. The facility failed to provide patients with information concerning its policies on advance directives, including a description of applicable State health and safety laws, in advance of the date of the procedure. (Cross refer Q224). 4. The facility failed to fully inform patients about treatment options and failed to ensure that	Q 220		

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Q 220	Continued From page 10 patients are given the information needed in order to make an informed decision regarding care. (Cross refer Q229). 5. The facility failed to ensure that patients are treated with respect and dignity. (Cross refer Q232).	Q 220		
Q 221	416.50(a)(1) NOTICE OF RIGHTS The ASC must provide the patient or the patient's representative with verbal and written notice of the patient's rights in advance of the date of the procedure, in a language and manner that the patient or the patient's representative understands. This STANDARD is not met as evidenced by: Based on observation, patient interview and medical record review on 1/20/11, it was determined that the facility failed to provide patients with verbal and written notice of the facility's patient rights, in advance of the date of the procedure. Finding include: 1. On [redacted], Patient #20 stated that she was not informed of nor did she receive a copy of the facility's patient rights prior to [redacted] 2. Medical Record #1 contained documentation that Patient #1, whose procedure was on [redacted], signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted], rather than in advance of the date of the procedure.	Q 221		

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Q 221	Continued From page 11 3. Medical Record #3 contained documentation that Patient #3, whose procedure was on [redacted] signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted] rather than in advance of the date of the procedure. 4. Medical Record #4 contained documentation that Patient #4, whose procedure was on [redacted] signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted] rather than in advance of the date of the procedure. 5. Medical Record #6 contained documentation that Patient #6, whose procedure was on [redacted] signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted] rather than in advance of the date of the procedure. 6. Medical Record #8 contained documentation that Patient #8, whose procedure was on [redacted] signed a document attesting to the fact that she received a copy of the facility's patient rights on [redacted], rather than in advance of the date of the procedure.	Q 221		
Q 223	416.50(a)(1)(ii) NOTICE - PHYSICIAN OWNERSHIP The ASC must also disclose, where applicable, physician financial interests or ownership in the ASC facility in accordance with the intent of Part 420 of this subchapter. Disclosure of information must be in writing and furnished to the patient in advance of the date of the procedure. This STANDARD is not met as evidenced by:	Q 223		

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Q 223	Continued From page 12 A. Based on observation and patient interview on [redacted] it was determined that the facility failed to provide Patient #20 with disclosure of information in writing regarding physician financial interests or ownership in the ASC, in advance of the date of the procedure. Findings include: On [redacted], Patient #20 stated that she did not receive a copy of the facility's disclosure of information in writing regarding physician financial interests or ownership in the ASC prior to the visit scheduled for [redacted]. While the facility counselor, Staff #12 interviewed Patient #20 on [redacted], Staff #12 advised Patient #20 of the physician ownership of the ASC, just prior to Patient #20's procedure on [redacted], rather than in advance of the date of the procedure. B. Based on medical record review and staff interview, it was determined that the facility failed to provide the patients with disclosure of information in writing regarding physician financial interests or ownership in the ASC, in advance of the date of the procedure. Findings include: 1. On 1/20/11 and 1/25/11, during a review of medical records #1 through #19, the facility was unable to provide evidence that the patients received disclosure of information in writing regarding physician financial interests or ownership in the ASC, in advance of the date of the procedure. 2. This was confirmed by Staff #15.	Q 223		

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Q 224	416.50(a)(2) ADVANCE DIRECTIVES The ASC must comply with the following requirements: (i) Provide the patient or, as appropriate, the patient's representative in advance of the date of the procedure, with information concerning its policies on advance directives, including a description of applicable State health and safety laws, and, if requested, official State advance directive forms. (ii) Inform the patient or, as appropriate, the patient's representative of the patient's rights to make informed decisions regarding the patient's care. (iii) Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. This STANDARD is not met as evidenced by: A. Based on observation and patient interview on [redacted] it was determined that the facility failed to provide Patient #20 with information concerning its policies on advance directives, including a description of applicable State health and safety laws, in advance of the date of the procedure. Findings include: On [redacted] Patient #20 stated that she did not receive information about the facility's policies on advance directives prior to the visit scheduled for [redacted]. While the facility counselor, Staff #12 interviewed Patient #20 on [redacted], Staff #12 asked Patient #20 about a "Living Will" just prior to Patient #20's procedure on [redacted] rather than in advance of the date of the procedure.	Q 224		

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Q 224	Continued From page 14 B. Based on medical record review and staff interview, it was determined that the facility failed to provide the patients with information concerning its policies on advance directives, including a description of applicable State health and safety laws, in advance of the date of the procedure. Findings include: 1. On 1/20/11 and 1/25/11, in a review of medical records #1 through #19, the facility was unable to provide evidence that the patients received information concerning its policies on advance directives, including a description of applicable State health and safety laws, in advance of the date of the procedure. 2. This was confirmed by Staff #15.	Q 224		
Q 229	416.50(b)(1)(iii) EXERCISE OF RIGHTS - INFORMED CONSENT [The patient has the right to -] Be fully informed about a treatment or procedure and the expected outcome before it is performed. This STANDARD is not met as evidenced by: Based on document review and observation on [redacted], it was determined that the facility failed to fully inform Patient #20 about her treatment options, failed to ensure that Patient #20 was given the information needed in order to make an informed decision regarding her care and failed to follow the facility policy titled "Informed Consent Policy" prior to Patient #20's anesthesia and procedure.	Q 229		

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Q 229	Continued From page 15 Findings include: Reference: The facility policy titled "Informed Consent Policy" states "...The evaluating physician, treating physician and counselor together shall obtain appropriate informed consent from patients...before starting any treatment or activity that presents a risk to the patient's health or safety...Treatments and activities requiring informed consent include...Anesthesia...All operative procedures...Non-surgical Abortion..." 1. On [redacted] this surveyor followed Patient #20 throughout her stay at the ASC. a. On [redacted] Patient #20 stated to Staff #12, a counselor [redacted] Staff #12 stated to Patient #20 "[redacted] Staff #12 is not a health care professional, but a counselor. Staff #12 failed to direct Patient #20's question about "[redacted]" to a member of the facility medical staff. b. On [redacted], Staff #12, counselor, gave Patient #20 the surgical consent to sign. The evaluating physician and the treating physician failed to inform Patient #20 of the anesthesia risks and benefits or the risks and benefits of the surgical procedure prior to the procedure on [redacted]	Q 229		
Q 232	416.50(c)(2) SAFETY [The patient has the right to -] Receive care in a safe setting This STANDARD is not met as evidenced by:	Q 232		

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Q 232	Continued From page 16 Based on document review and observation on [redacted] it was determined that Patient #20 did not receive care in a safe setting. Findings include: Reference: The facility, "Protocol for Stocking of OR/PACU Supply Storage Closets," states, ". . .Medical assistants are responsible for maintaining adequate stock in the supply storage closets. . .After restocking, the medical assistant will sign and date the supply storage sheet (see attached). . . ." 1. On [redacted] Patient #20, while in the facility recovery room, stated to Staff #13 that she was "feeling sick." Staff #13 gave Patient #20 a garbage can, that was sitting on the floor next to the stretcher, to use as an emesis basin. There were no emesis basins available in the recovery room area on [redacted]. Providing a trash can rather than an emesis basin did not provide for the patient's emotional health and safety, of which respect and dignity are components. 2. The supply storage sheet, mentioned in the Referece above, failed to contain emesis basins, which Patient #20 required, as a supply to keep in the Supply Storage Closet.	Q 232		
Q 242	416.51(b) INFECTION CONTROL PROGRAM The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.	Q 242		

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Q 242	Continued From page 17 nationally recognized infection control guidelines. This STANDARD is not met as evidenced by: A. Based on observation, staff interview and a review of documents on 1/20/11, it was determined that the facility failed to implement infection control policies and failed to maintain an infection control program that follows up on each patient after discharge, in order to identify and investigate infections associated with the patient's stay in the ASC. Findings include: 1. Staff #8 stated on 1/20/11 that the facility follows CDC (Centers for Disease Control) for infection control policies. Reference #1: The CDC "MMWR October 25, 2002 Guideline for Hand Hygiene in Health-Care Settings" states "...When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers..." Reference #2: The facility policy titled, "Bloodborne Pathogen Exposure Control Plan," states "...All personnel participating in direct patient care practices must wash hands for 10 seconds before and after patient contact regardless of the use of gloves..." Reference #3: The facility policy titled, "Hand Hygiene," states "...Wash hands thoroughly and effectively with running water and soap...Using	Q 242		

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Q 242	Continued From page 18 friction on front and back of hands and between fingers scrub for 10-15 seconds...Wash hands with soap and water...When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other bodily fluids..." 1. The facility policies in References #2 and #3 above fail to follow the CDC recommendation of washing hands for 15 seconds with soap and water. 2. On [redacted], Staff #10, while wearing gloves, was observed in the facility examination room, performing a vaginal examination of Patient #20. After removing his/her gloves, Staff #10 did not wash his/her hands and, then, without donning gloves, utilized the facility ultrasound machine to perform a uterine ultrasound. Staff #10 typed information into the ultra sound computer system and proceeded to document on Patient #20's paper medical record with a pen. Staff #10 then removed his/her gloves and washed his/her hands with hand gel, rather than soap and water, prior to leaving the examination room. Staff failed to comply with facility policy in Reference #2, above. Reference #4: The facility policy titled, "Surveillance for Health Care Associated Infections," states, "...Data Collecting...Patients will be encouraged to return to center two weeks post procedure for examination and investigation of any complications including symptoms of infection. Patients will be provided verbal and written instructions on discharge which includes information on symptoms of infection and a mail in card to complete as to whether or not there	Q 242		

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Q 242	Continued From page 19 was any evidence of this...Report of Infection Investigation will be completed for each suspected infection...Infections will be reported on Monthly Report of Infections...Reports will be reviewed monthly by Infection Control Committee...Data on percent of mail in cards returned will be reported..." 1. When asked on 1/20/11 at 11:08 AM, about how the facility monitors and tracks patient infections, Staff #8 stated, "Not all of the patients have primary physicians, but if the patient returns to the facility for their two week follow up visit, the facility staff will complete an infection control survey form. If the patient has a primary physician, a letter is sent to the physician asking about infections. A general letter (but not a list of patients seen) is also sent to Planned Parenthood every six months." a. Upon request on 1/20/11, Staff #8 could not provide evidence of how patients who do not return to the facility for the follow up visit or who do not have a primary physician are followed or tracked for evidence of infections. Staff #8 stated, "If we don't see them here, and we don't know the identity of the primary physician, we don't do anything." (about following up on possible infections) b. Documentation provided by Staff #8 of the facility "Infection Control Committee" meetings failed to include data regarding infections reported on the "mail in cards" or data regarding the percentage of "mail in cards" completed and returned by patients. c. The facility failed to comply with its policy, Reference #4.	Q 242		

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Q 242	Continued From page 20	Q 242		

B. Based on a review of the facility infection control plan, a review of the personnel files of four Employees (#1, #2, #4, and #5) and interview with administrative staff it was determined that the facility did not implement a policy regarding the rubella and rubeola status of employees.

Findings include:

1. The EMPLOYEE HEALTH section of the facility 'Infection Prevention and Control Organizational Plan Metropolitan Medical Associates' stated: "NJDHSS (New Jersey Department of Health and Senior Services), OSHA (Occupational Safety and Health Administration), and CDC (Centers for Disease Control) standards are followed. ..... All employees born after 1957 are screened for rubeola. All employees are screened for rubella. ....."

2. Review of the personnel files of Employees #1 and #5 lacked evidence that the employees were screened for rubella or rubeola status.

3. Administrator #2, at 1:15pm on January 20,. 2011, confirmed the findings.

C. Based on a review of the facility infection control plan, a review of the personnel files of four Employees (#1, #2, #4, and #5) and interview with administrative staff it was determined that the facility did not implement a policy regarding physical examinations of employees.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ______ B. WING ______	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 242	Continued From page 21 1. The EMPLOYEE HEALTH section of the facility 'Infection Prevention and Control Organizational Plan Metropolitan Medical Associates' stated: "NJDHSS (New Jersey Department of Health and Senior Services), OSHA (Occupational Safety and Health Administration), and CDC (Centers for Disease Control) standards are followed. ..... Physical examinations are required on employment. ....." 2. The personnel file of Employee #4 lacked evidence of a physical examination prior to, or subsequent to, his/her employment. 3. Administrator #2, at 1:15pm on January 20, 2011, confirmed the findings.	Q 242		
Q 261	416.52(a)(1) ADMISSION ASSESSMENT Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards or practice, and ASC policy. This STANDARD is not met as evidenced by: Based on a review of medical records and staff interview, it was determined that the facility failed to ensure that each patient had a comprehensive medical history and physical assessment completed by a physician not more than 30 days before the date of the scheduled surgery. Findings include: 1. 20 of 20 medical records reviewed on 1/20/11 and 1/25/11 lacked evidence of a comprehensive	Q 261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ______ B. WING ______	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 261	Continued From page 22 medical history and physical assessment. a. In 20 of 20 medical records, a "Physical Examination" was documented with the following areas checked off: "Abdomen, Extremities, Adnexae, External Genitalia, Vagina / Cervix and Uterus week size." b. This was confirmed by Staff #9 and Staff #15.	Q 261		
Q 267	416.52(c)(3) DISCHARGE WITH RESPONSIBLE ADULT [The ASC must -] Ensure all patients are discharged in the company of a responsible adult except those patients exempted by the attending physician. This STANDARD is not met as evidenced by: Based on a review of the medical records of five patients who underwent surgical procedures, a review of facility policy and procedure, and interview with administrative staff it was determined that patients needn't be discharged in the company of a responsible adult except if exempted by the attending physician. Findings include: Reference: The DISCHARGE CRITERIA section of an untitled facility policy and procedure stated: ". . ."It is the policy that all MSA (Medical Surgical Associates) patients receiving conscious or deep sedation have made arrangements for transportation that does not include operation of a motor vehicle themselves. They also must be accompanied by another person who accepts responsibility for the patient. This information is verified by the administrative staff as well as the	Q 267		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ______ B. WING ______	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 267	Continued From page 23 surgery. In extenuating circumstances, (patient's ride leaves, patient has privacy issues), the patient's transportation must be arranged by our counseling staff or the patient herself if she prefers. Every effort must be made to find another escort. If one is not available, a taxi or medical transportation will be called." 1. The above referenced policy indicated that only patients who receive conscious sedation or deep sedation must be discharged in the company of a responsible adult. Exemptions must be specific to the individual patient. Blanket exemptions to entire classes of patients are not permitted. Additionally, the policy allows patients who have undergone conscious or deep sedation to be discharged without the company of a responsible adult if the facility fails to find one for the patient. 2. Staff #3, on the afternoon of January 20, 2011, stated that patients who not receive conscious or deep sedation are not required to be discharged in the company of a responsible adult, nor does the attending physician write an order that the patient may be discharged without a responsible adult in instances when the patient does not receive conscious or deep sedation.	Q 267		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
K 029	416.44(b)(1) LIFE SAFETY CODE STANDARD Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems 38.3.2, 39.3.2 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to separate hazardous areas from other parts of the building with self closing doors. Findings include: 1. On 1/20/11, at 11:50 AM, in the presence of Staff #9, the door to the furnace room could not latch due to the door strike not being in place.	K 029		

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

)eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 'ing 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ______ B. WING ______	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 103	Continued From page 1 a. Upon request on 1/20/11, Staff #8 could not provide evidence of how patients who do not return to the facility for the follow up visit, or who do not have a primary physician, are followed or tracked for evidence of infections, and stated "If we don't see them here, and we don't know the identity of the primary physician, we don't do anything" about following up on possible infections.	Q 103		
Q 104	416.44(b) SAFETY FROM FIRE (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served. The Director of the Office of the Federal Register has approved the NFPA 101® 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to http://www.archives.gov/federalregister/code_of_federal-regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods	Q 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31C0001006	A. BUILDING ____ B. WING ____	01/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLITAN SURGICAL ASSOCIATION	40 ENGLE STREET ENGLEWOOD, NJ 07631

(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
Q 104	Continued From page 2 deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. (4) An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006. (5) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if: (i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities; (ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; (iii) The dispensers are installed in a manner that adequately protects against inappropriate access; and (iv) The dispensers are installed in accordance with the following provisions: (A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m); (B) The maximum individual dispenser fluid capacity shall be: (1) 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors	Q 104		

PoC Addendum#2

METROPOLITAN SURGICAL ASSOCIATES

40 Engle Street
Englewood, NJ 07631
Tel: (201) 567-0522 Fax: (201) 816-9863
Email: metmedical@aol.com

May 25, 2011

Department of Health and Senior Services
Attn: Louise A. Steska, MSN, RN
PO Box 367
Trenton NJ, 08625-0367

RE: Metropolitan Surgical Associates
Addendum to Plan of Correction

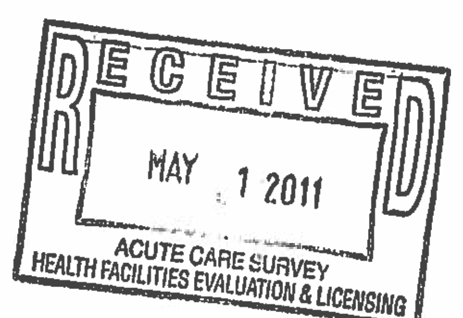
Dear Ms. Steska:

Enclosed please find an addendum to our Plan of Correction for the cited deficiencies as a result of the Health Survey conducted on January 20, 2011 and January 25, 2011 by the surveyors from the Department of Health and Senior Services. Should you have any additional questions or concerns please do not hesitate to contact us for immediate assistance.

We kindly thank you in advanced for your time and courtesies with regards to this matter.

Sincerely,

Susan Martinelli
Administrator



ADDENDUM TO FEEDERAL PLAN OF CORRECTION

ok 6/2/11 [illegible]

Q103

3. The Facility Administrator will be responsible for monitoring compliance and will report to the Infection Control Committee.

May 25, 2011

5/23/11 Q 103 not covered AF

ADDENDUM TO FEDERAL PLAN OF CORRECTION

Q162

PoC Addendum #1

3. The cited deficiencies of practice relating to CFR 416.47(b) are to be addressed as follows:

OK 5/23/11 AF

(i) and (ii): The Consent for Cervical Dilators was incorporated into the main Consent form so that Doctors are now required to sign the Cervical Dilator Consent. Both the Evaluating and Operating Physician are required to sign the Consent Form in order for a patient to receive care. Monthly Chart reviews are conducted by the director of nursing in order to monitor completeness of all charts. Her report is submitted to the facility administrator on a monthly basis and reported to the Quality Assurance Committee.

(iii): A separate Anesthesia Consent form has now been introduced into the patient's file. Consent is now obtained separately by the Anesthesiologist. Monthly Chart reviews are conducted by the director of nursing in order to monitor completeness of all charts. Her report is submitted to the facility administrator on a monthly basis and reported to the Quality Assurance Committee.

Q220

4. The Facility Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness on a weekly basis; the findings will be reported to the Quality Assurance Committee. The administrator is also observing staff making appointments on a weekly basis in order to ensure all requirements are being met; her findings will be reported to the Quality Assurance Committee.

Q221 OK 5/23/11 AF

4. The Facility Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness on a weekly basis; the findings will be reported to the Quality Assurance Committee. The administrator is also observing staff making appointments on a weekly basis in order to ensure all requirements are being met; her findings will be reported to the Quality Assurance Committee.

Q223 ok 5/23/11 [illegible]

4. The Facility Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness on a weekly basis; the findings will be reported to the Quality Assurance Committee. The administrator is also observing staff making appointments on a weekly basis in order to ensure all requirements are being met; her findings will be reported to the Quality Assurance Committee.

Q224 ok 5/23/11 [illegible]

4. The Facility Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness on a weekly basis; the findings will be reported to the Quality Assurance Committee. The administrator is also observing staff making appointments on a weekly basis in order to ensure all requirements are being met; her findings will be reported to the Quality Assurance Committee.

Q229 ok 5/23/11/[illegible]

4. To monitor this corrective action the Evaluating Physicians will attend one session with each of the counselors on a weekly basis for a period of two months to assure that they are not exceeding the scope of their practice. They will report findings to the Medical Director and the Quality Assurance Committee.

5. April 1, 2011 – May 31, 2011

PoC

FEDERAL

Q103

1. The plan of correction will be implemented to survey potential patients starting from the beginning of the year.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The facility will expand its efforts to track infections and has updated the Surveillance for Health Care Associated Infections policy in an effort to systematically address the need to maintain a proper environment for surgical procedures, as well as, identify and prevent infections. These efforts will include the tracking of patients returning to the facility for follow up, the provision of information relating to possible post operative infection and self reporting data cards, the serial contact of both private and institutional referrers regarding possible complications experienced by their patients, as well as, contact patients directly to as about possible post-op complication.

3/31/11

Who QA / will #3 that is being done? AL

4. As with current practice, each response that indicates a potential infection will be brought to the attention of the Infection Control Designee (ICD). An Infection Investigation will promptly ensue and the results reviewed by the Medical Director and the Infection Control Committee. The Infection Control Committee will monitor these ongoing efforts on a regular ongoing basis.

5. This Plan of Correction should be effective by 3/31/2011

Q104

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The ABHRs in the pre-op nurse station and the PACU have been moved and are no longer located above electrical boxes.

4. The facility's Fire/Disaster Plan Coordinator, the Medical Director and the Chairman of the Board have conducted an inspection of the premises to ensure that the facility meets the provisions applicable to the Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association. Potential non-conforming conditions will be rectified so as to ensure this deficient practice will not recur. The results of the inspection will be reported at the ensuing Quality Assurance Meeting and to the facility's Fire Prevention Consultant.

5. The corrective action has been completed as of 2/8/2011

OK SS 3/29/11

Q105

OK H4 4/13/11

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. As a result of the cited deficiency, the Medical Director and the Senior Staff Anesthesiologist reviewed CFR 416.44(c). A list of the necessary medical equipment was placed in Anesthesia Policy and Procedure Manual for reference.

4. This equipment is expected by 2/25/11, the Medical Director will then report to the Quality Assurance Committee of the completion of this corrective action. Going forward, the Senior Staff Anesthesiologist will be charged with assuring that the facility possesses all requisite equipment.

5. The corrective action has been completed as of 2/25/2011

Q162

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The cited deficiencies of practice relating to CFR 416.47(b) are to be addressed as follows:

   a. The "Consent for Cervical Dilators" form will be amended by 2/25/11 to include a section for the signature of the physician obtaining patient consent.

   b. On 2/22/11 forms which may be part of the medical record will be reviewed, any that do not provide a section for patient identification will be amended to do so by 3/25/11.

   c. By 2/23/11 the Facility Administrator and the Medical Director will issue to the counselor and physician staffs a memorandum pertaining to these cited deficiencies. The memorandum will review:

      i. That all patient sheets must be labeled so as to be properly identifiable.

      ii. That it is the duty of the Physician prior to the start of any procedure to assure that proper informed consent has been obtained and so documented.

      iii. That the operating physician and the Anesthesiologist together again obtain consent before performing a proposed procedure.

PoC ok 3/31/11

3/31/11 Deficiency was based on observation — QA does not include observation AK

iv. That the medical record must be accurate as to the treatment and management plans actually discussed.

4. Measures to assure the proper implementation of this plan of correction will include:

   a. A mandatory meeting of the Physician and Counseling staffs no later than 3/11/11 to review potential concerns and address questions relating to the corrective actions.

   b. The Director of Nursing will review, as part of the monthly Chart Audits, the medical records for proper documentation and report to the Quality Assurance Committee on a continuing basis.

   c. The importance of maintaining accurate and complete records, as well as, the proper obtainment of informed consent will be reviewed as part of the orientation of new staff.

   d. Identified lapses will be addressed via the Quality Assurance Committee.

5. Dates for implementation are as delineated above.

Q181

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. This deficiency of practice will be addressed in 2 parts.

   a. A memorandum was issued to all physicians on 2/23/11 informing them of this identified deficiency and reminding them that acceptable standards of practice require an order, both for the administration and discontinuance of medications, as well as, IV locks.

   b. Secondly, to help provide a systemic correction, the orders section of the chart will be amended to allow for better clarity and ease in adhering to this policy. The Medical Director will draft these changes and submit them to the Quality Assurance Committee for approval. This will be done by 3/14/11.

4. This plan of correction will be monitored for compliance by incorporating its review into the monthly Chart Audit process. Follow up and remedial action for identified deficient physicians will rest with the Quality Assurance Committee.

5. The final parts of plan of correction should be complete by 3/14/11.

OK 3/28/11

Q220

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. Upon the scheduling of appointments, phone operators will ask each patient how they would like to receive necessary documents that the patient must review prior to their visit; including the "Patient Rights" form, the "Ownership Disclosure" form and the "Advance Directives" form. The operator will document whether the patient requested the documents via fax, mail or whether the patient will download the forms from our website. Thus all documents are made available to patients in writing prior to their visit to the facility eliminating the possibility of the deficient practice to recur.

4. The Faculty Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness; the findings will be reported to the Quality Assurance Committee

5. The corrective action has been completed as of 2/15/2011

Not accepted how often? 3/28/11

Q221

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. Upon the scheduling of appointments, phone operators will ask each patient how they would like to receive the "Patient Rights" form. The operator will document whether the patient requested the document via fax, mail or whether the patient will download the forms from our website. Thus this document is made available to patients in writing prior to their visit to the facility, eliminating the possibility of the deficient practice to recur.

4. ~~The Faculty~~ Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness; the findings will be reported to the Quality Assurance Committee

5. The corrective action has been completed as of 2/15/2011

3/31/11 when how?

Q223

1. The cited deficiency that may affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. Upon the scheduling of appointments, phone operators will ask each patient how they would like to receive the "Ownership Disclosure" form. The operator will document whether the patient requested the document via fax, mail or whether the patient will download the forms from our website. Thus, this document is made available to patients in writing prior to their visit to the facility, eliminating the possibility of the deficient practice to recur.

3/31/11 how? when AF

4. The Faculty Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness; the findings will be reported to the Quality Assurance Committee.

5. The corrective action has been completed as of 2/15/2011

Q224

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. Upon the scheduling of appointments, phone operators will ask each patient how they would like to receive the "Advance Directives" notification. The operator will document whether the patient requested the document via fax, mail or whether the patient will download the forms from our website. Thus, this document is made available to patients in writing prior to their visit to the facility, eliminating the possibility of the deficient practice to recur.

3/31/11 how? when AF

4. The Faculty Administrator will monitor the scheduling of appointments and review this new form of documentation for completeness; the findings will be reported to the Quality Assurance Committee.

5. The corrective action has been completed as of 2/23/2011

Q229

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The plan of correction focuses on the proper implementation of the "Informed Consent Policy". A memorandum will be drafted by 2/24/11, and issued by the Facility Administrator and the Medical Director to all Medical and Counseling staff members. It will emphasize the requirement that physicians adequately review proposed procedures with patients as part of

3/31/11 deficiency based on observation. QA does not include observation AF

the informed consent process. It will also discuss the Counseling Service, provided by the facility over and above the current standard regulations, which amongst other things, provides a public service to help educate the patients and prevent future unwanted pregnancies.

A mandatory meeting of the Physician and Counseling staffs, chaired by the Medical Director and the Facility Administrator will be held no later than 3/11/11. The meeting will review the scope of practice, as well as, the responsibilities of each staff.

4. To monitor this corrective action the Evaluating Physicians will attend sessions with each of the counselors to assure that they are not exceeding the scope of their practice. They will report findings to the Medical Director and the Quality Assurance Committee.
5. The plan of correction has been completed as of 3/11/2011

Q232

OK 3/31/11 AK

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.
2. The corrective action systematically addresses this cited concern so that future patients will not be affected.
3. Emesis basins have been added to the "Supply Storage Sheet" so that there is a daily restocking of this supply for the PACU. The Head Nurse shall conduct several spot inspections to ensure that there are an adequate number of emesis basins in the PACU.
4. By being placed on the "Supply Storage Sheet" and monitored for proper stocking, there should be no further shortage of readily accessible emesis basins in the PACU. The Head Nurse will be responsible for it's monitoring its adequate availability and report to the Quality Assurance Committee that this practice deficiency has been corrected or any shortcomings in the plan of correction.
5. This Plan of Correction has been put into effect as of 2/23/2011

Q242A

A OK 3/31/11 AK

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.
2. The corrective action systematically addresses this cited concern so that future patients will not be affected.
3. On 2/22/2011 the Infection Control Committee approved revisions to the Bloodbourne Pathogen Exposure Control Plan and the Hand Hygiene policy to more accurately reflect the CDC "MMWR October 25, 2002 Guidelines for Hand Hygiene in Health-Care Settings". Also a hand washing in-service will be conducted for applicable staff members to assure the systematic adoption of this practice. The Surveillance for Health Care Associated Infections policy has been updated to include monitoring of patients via telephone. The Infection

Control Committee minutes will further reflect the ongoing review of Health Care Associated Infections, including follow up on data cards returned by patients.

4. As part of the monitoring of this plan of correction, the facility's Infection Control Specialist shall add to her quarterly review a hand-washing monitoring review to make sure that all staff and employees are remaining consistent with the updated Policy. Any employee or staff member deviating from the hand washing policy shall immediately be corrected and receive a personal hand washing in-service. The Infection Control Committee will oversee the monitoring and investigation of health care related infection in its monthly meetings.

5. This corrective action has been completed as of 2/22/2011

Q242B

OK 3/31/11 AF

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. As of 2/18/2011 all staff members have documentation of Rubella/Rubeola status per the Infection Prevention and Control Organizational Plan Metropolitan Medical Associates. All employees must produce evidence of Rubella immune status, and those born after 1957 must produce evidence of Rubeola immune status or be screened prior to start of employment.

4. The Administrator will ensure that proper documentation is present in the personnel file prior to start of employment.

5. This corrective action has been completed as of 2/22/2011

Q242C

OK 3/31/11 AF

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The facility will require that a physical exam has been performed and documented in the personnel files per the Infection Prevention and Control Organizational Plan Metropolitan Medical Associates prior to the start of a staff member's employment thus ensuring the cited deficiency will not recur.

4. The Administrator will ensure that proper documentation is present in the personnel file prior to the start of employment.

5. This corrective action has been completed as of 2/22/2011

Q261

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The patient medical chart will be revised to comply with the 416.52(a)(1) statutory definition of a comprehensive History and Physical.

4. The completeness of the History and Physical will be assessed by incorporating its review into the monthly Chart Audit conducted by the Director of Nursing. It's successful implementation, or shortcomings will be reported to the Quality Assurance Committee.

5. Revised documents will be drafted by the Medical Director and submitted to the Quality Assurance Committee for review by 3/4/11 and will be used thereafter.

Q267

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The Quality Assurance Committee convened for a meeting on 2/24/2011 and updated the facility's "Discharge Criteria" so as to eliminate blanket exemptions to entire classes of patients.

4. The Quality Assurance Committee conducted a review of its "Discharge Criteria" and concluded that upon discharge, patients must be accompanied by another person that accepts responsibility for that patient. If extenuating circumstances exist and a patient cannot arrange for an escort, it will be the responsibility of the operating physician to approve an alternate discharge plan. Thus, discharge plans that fall outside of the facility's discharge parameters must be determined on an individualized basis and be based upon the judgment of the patient's attending physician.

5. This corrective action has been completed as of 2/24/2011

K029

1. The cited deficiency that may have affected patients has been addressed and a corrective action has been accomplished.

2. The corrective action systematically addresses this cited concern so that future patients will not be affected.

3. The door strike to the door of the furnace room has been replaced and the door can now latch properly.

4. The Housekeeping Sanitary and Safety Consultant shall conduct routine and regular inspections of the facility to ensure that all furnishings shall be in good working order and that broken or worn items shall be repaired, replaced or removed promptly. The Housekeeping Sanitary and Safety Consultant shall report his findings to the Facility Administrator should any furnishing need broken or worn and need to be repaired, replaced or promptly removed. The Facility Administrator shall report any such incidents to the Quality Assurance Committee and the ensuing Quality Assurance meeting.

5. This corrective action has been completed as of 2/8/2011

OK
SS
3/25/11