

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001069	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/26/2011
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NAME OF PROVIDER OR SUPPLIER SURGICARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 MCINTIRE DR STE C BLOOMINGTON, IN47403
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(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
K0000	<p>A Life Safety Code Validation Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 09/26/11</p> <p>Facility Number: 009971 Provider Number: 15C0001069 AIM Number: 200145120A</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Surgicare LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>This facility was located on the first floor of a two story building and was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detectors in the corridors and common areas.</p>	K0000		

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.

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K0050	<p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/30/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. 20.7.1.2, 21.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure a fire alarm transmission signal was included during fire drills for the past 4 of 4 quarters. This deficient practice could affect all occupants, visitors and staff in the event of a fire emergency.</p> <p>Findings include:</p> <p>Based on fire drill record review on 09/26/11 at 2:53 p.m. with the Charge Nurse it was revealed the facility only conducts simulated fire alarm tests and no audible signals are heard within the facility and no signal is transmitted to the monitoring station. Based on interview on 09/26/11 with the Charge Nurse it was acknowledged the facility only performs mock fire alarm drills which do not</p>	K0050	The transmission signal will be sounded and verified through our Security Monitor System, CSC, and documented that the signal was received on the current Fire Drill Log. Responsibility: Executive Director Completed date 10/27/2011	10/27/2011

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	include activating the fire alarm system.				