STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 0000 Bldg. 00	This visit was for a Recertification survey of an Ambulatory Surgery Center and a Focused Infection Control survey. Facility Number: 005396 Survey Date: 10/26-27/2020 and 11/4/20 QA: 10/29/20 and 11/12/20	Q 0000		
Q 0100 Bldg. 00	416.44 ENVIRONMENT The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. Community Surgery Center South was found not in compliance with 42 CFR 416.44, Environment, Requirements for Ambulatory Surgery Centers. Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire barriers that separate other occupancies were protected to maintain the fire resistance rating of the fire barrier. NFPA 101, 2012 edition, Section 8.3.5.6.1 states membrane penetrations for cables cable trays conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device (see tag K131), to document sprinkler system inspections	O 0100	1. Fire wall has been caulked with fire caulk. Gauges and valves were inspected on November 14, 2020. Internal pipe inspection was performed by Koorsen on November 14, 2020. A live pull fire drill will be conducted on November 23, 202 for the day shift staff. A live pull will be conducted on November 23, 2020 at 7pm to ensure compliance for a live pull for the second shift staff. Tension polarity testing of all electrical outlets in patient rooms was conducted on November 21, 2020 by D.S. Mechanical, an approved contractor. Extension cords were removed and new quad outlets will be installed by D. S. Mechanical.	12/14/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained (see tag K353), to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping (see tag K353), to document activation of the fire alarm system for first shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters (see tag K712), to document annual inspection and testing of all fire door assemblies. LSC 21.7.6 Maintenance and Testing (see tag K761), to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review (see tag K914), and to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring (see tag K920). The cumulative effect of these systemic problems resulted in the facility's inability to ensure that the location from which it provides services are constructed, arranged and maintained to ensure the provision of quality health care in a safe environment.		Installation will occur on the following weekend days- December 5, 12, and 13, as not to disrupt patient care. 2. Future onsite contract work will be supervised by VEI Maintenance to ensure proper work and fire wall remains intact. Gauges and valves will be inspected monthly by VEI Building Maintenance and will be documented in a monthly preventative maintenance log. Internal pipe inspection has been scheduled with Koorsen for every five years. Live pulls will be scheduled out each year at the beginning of the calendar year. Pulls will be scheduled quarterly and for both shifts. Polarity testing only needs to be performed once, or if an outlet is replaced. We will perform the tension polarity test in the future if an outlet is replaced. No extension cords will be allowed at patient bedside. 3. VEI Property Management will be responsible, as well as the Nurse Manager for fire drills. 4. Corrections were made November 4, November 14, November 21, November 23, 2020. Outlets will be installed by December 14, 2020.	
Q 0101 Bldg. 00	416.44(a)(1) PHYSICIAL ENVIRONMENT The ASC must provide a functional and sanitary environment for the provision of surgical services.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area. 1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on record review with the Director of Nursing and the VEI Maintenance Technician from 9:15 a.m. to 2:00 p.m. on 11/04/20, monthly sprinkler system gauge and valve inspection documentation for 8 months of the most recent 12-month period was not available for review. Based on review of the sprinkler system contractor's "Inspection and Test Report" documentation dated 01/21/20, 04/17/20, 08/15/20 and 10/06/20, the sprinkler system contractor	Q 0101	1. Gauges and valves were inspected on November 14, 2020. Internal pipe inspection was performed by Koorsen on November 14, 2020. Fire Door inspection was completed by Central Indiana Hardware, an approved contractor, on November 17, 2020. Tension polarity testing of all electrical outlets in patient rooms was conducted on November 21, 2020, by D.S. Mechanical, an approved contractor. Extension cords were removed and new quad outlets will be installed by D.S. Mechanical, an approved contractor. Installation will occur on the following weekend days- December 5, 12, and 13, as not to disrupt patient care. 2. Gauges and valves will be inspected monthly by VEI Building Maintenance. This will be documented in a monthly preventative maintenance log. Internal pipe inspection has been scheduled with Koorsen for every five years. Fire Door inspection was set-up on a yearly preventative maintenance schedule to ensure compliance. Tension polarity testing is only needs to be performed once, or if an outlet is replaced. We will	12/14/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inspected sprinkler system gauges and valves for 4 months of the most recent 12-month period. Based on interview at the time of record review, the VEI Maintenance Technician stated the facility does not perform and document sprinkler system gauge and valve inspections outside of the contractor's quarterly inspections. Based on observations with the Director of Nursing and the VEI Maintenance Technician during a tour of the facility from 2:00 p.m. to 3:25 p.m. on 11/04/20, the facility has supervised wet sprinkler systems. 2. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, section 14.2.2. This deficient practice affects all patients, staff and visitors. Findings include: Based on record review with the Director of Nursing and the VEI Maintenance Technician from 9:15 a.m. to 2:00 p.m. on 11/04/20, documentation of an internal pipe inspection conducted within the most recent five-year period was not available for review. Based on interview at the time of record review, the Director of Nursing and the VEI Maintenance Technician agreed documentation of an internal pipe inspection was not available for review at the time of the survey. 3. Based on record review, observation and interview; the facility failed to document annual inspection and testing of all fire door assemblies. LSC 21.7.6 Maintenance and Testing states See		perform the tension polarity test in the future if an outlet is replaced. No extension cords will be allowed at patient bedside. 3. VEI Property Management will be responsible. 4. Inspections were completed on November 14, November 17 and November 21, 2020. Outlets will be installed by December 14, 2020.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4.6.12. LSC 4.6.12 states whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review with the Director of Nursing and the VEI Maintenance Technician from 9:15 a.m. to 2:00 p.m. on 11/04/20, annual inspection documentation of fire door assemblies within the facility within the most recent twelve-month period was not available for review. Based on a review of facility floor plan documentation, the facility has three stairwell doors on the first floor. Based on interview at the time of record review, the VEI Maintenance Technician agreed annual inspection documentation of fire door assemblies within the facility within the most recent twelve-month period was not available for review. Based on observations with the Director of Nursing and the VEI Maintenance Technician during a tour of the facility from 2:00 p.m. to 3:25 p.m. on 11/04/20, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	three stairwell doors were all fire door assemblies. 4. Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all patients. Findings include: Based on record review with the Director of Nursing and the VEI Maintenance Technician from 9:15 a.m. to 2:00 p.m. on 11/04/20, documentation of an itemized listing of the inspection and testing electrical outlet receptacles			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at patient bed locations was not available for review. Based on interview at the time of record review, the Director of Nursing and the VEI Maintenance Technician stated hospital grade receptacles are installed at all patient bed locations and agreed receptacle testing documentation was not available for review. The Director of Nursing stated general anesthesia can be used in each of the 7 Operating Rooms. Based on observations with the Director of Nursing and the VEI Maintenance Technician during a tour of the facility from 2:00 p.m. to 3:25 p.m. on 11/04/20, multiple hospital grade electrical receptacles were installed at each patient bed location and hospital grade receptacles were installed in Operating Room 5.			
Q 0104 Bldg. 00	416.44(b)(1)-(3) SAFETY FROM FIRE (b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served, and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4). (2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. Based on record review and interview, the facility failed to document activation of the fire alarm system for first shift fire drills conducted between 6:00 a.m. and 9:00 p.m. for 1 of 4 quarters. LSC 21.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on review of "Fire and Tornado Drill Scenario: Fire" documentation with the Director of Nursing and the VEI Maintenance Technician during record review from 9:15 a.m. to 2:00 p.m. on 11/04/20, the first shift fire drill conducted on 01/21/20 at 1:45 p.m. did not include activation of the fire alarm system and transmission of the fire alarm signal. Documentation for the aforementioned fire drill stated "No" in response to "fire alarm signal received by monitoring company." In addition, "pull box simulation and overhead paging system" was stated in response to "Method of notification." Based on interview at the time of record review, the Director of Nursing stated the facility operates two shifts per day (7:00 a.m. to 6:30 p.m. and 6:00 p.m. to 6:00 a.m.), the facility performs one live pull of fire alarm initiating devices per year for quarterly fire drills per shift and agreed documentation of the activation of the fire alarm system and	Q 0104	1. A live pull will be conducted on November 23, 2020 for the day shift staff. A live pull will be conducted on November 23, 2020 at 7pm to ensure compliance for a live pull for our second shift staff. 2. Live pulls will be scheduled out for each year at the start of the calendar year. They will be scheduled quarterly and for both shifts. 3. The Nurse Manager and VEI Property Management will be responsible. 4. Pull will be conducted on November 23, 2020.	11/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transmission of the fire alarm signal for the 01/21/20 fire drill conducted at 1:45 p.m. was not available for review.			
Q 0108 Bldg. 00	416.44(c) BUILDING SAFETY (c) Standard: Building Safety. Except as otherwise provided in this section, the ASC must meet the applicable provisions and must proceed in accordance with the 2012 edition of the Health Care Facilities Code (NFPA 99, and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to an ASC. (2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the ASC, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. 1. Based on observation and interview, the facility failed to ensure 1 of 1 fire barriers that separate other occupancies were protected to maintain the fire resistance rating of the fire barrier. NFPA 101, 2012 edition, Section 8.3.5.6.1 states membrane penetrations for cables cable trays conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. Section	O 0108	1. Fire wall hole has been caulked with fire caulk. This was completed on November 4, 2020 by VEI Maintenance Technician. Extension cords were removed and new quad outlets will be installed by D.S. Mechanical, an approved contractor. Installations will occur on the following weekend days- December 5, 12, and 13 as not to disrupt patient care. 2. Future on-site contract work will be supervised by VEI	12/14/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	8.3.5.6.2 states the firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Test of Through Penetration Fire stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops. In addition, doors are self-closing and are kept in the closed position, except when in use. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observations with the Director of Nursing and the VEI Maintenance Technician during a tour of the facility from 2:00 p.m. to 3:25 p.m. on 11/04/20, a two inch by one inch hole for the passage of one data cable was noted in the tenant separation wall above the suspended ceiling above the Electrical Room door by the lobby in which the main fire alarm control panel is installed on the first floor. Based on interview at the time of the observations, the VEI Maintenance Technician agreed the aforementioned opening in the fire barrier wall which separates other occupancies did not maintain the fire resistance rating of the fire barrier. 2. Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 21.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved		Maintenance to ensure proper work and fire wall remains intact. No extension cords will be allowed at patient bedside. 3. VEI Property Management will be responsible. 4. Work was completed on November 4, 2020 to repair fire wall. The quad outlet installation will be complete by December 14, 2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect one patient and staff. Findings include: Based on observations with the Director of Nursing and the VEI Maintenance Technician during a tour of the facility from 2:00 p.m. to 3:25 p.m. on 11/04/20, a Venaflow medical device was plugged into a power strip laying on the floor within three feet of the patient bed in Room 23. The UL listing of the power strip was identified as UL 1446. Based on interview at the time of the observations, the Director of Nursing and the VEI Maintenance Technician stated the power strip is normally affixed to the wall and agreed a power strip was being used as a substitute for fixed wiring and in the patient care vicinity in Room 23.			
Q 0181 Bldg. 00	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	acceptable standards of practice. Based on observation and interview, the facility failed to ensure that outdated medications were disposed of in a timely manner. Findings Include: 1. Tour of facility on 10/27/20 with S1 (Director of Nursing) and S3 (Operating Room Manager) at approximately 1:25 pm, this surveyor observed 18/36 vials of Dantrolene (20 milligrams/vial), in the Malignant Hyperthermia cart in Substerile 3, expired on 6/2020. 2. Interview with S1 and S3 on 10/27/20 at 1:40 pm, confirmed that 18/36 vials of Dantrolene (20 milligrams/vial), in the Malignant Hyperthermia cart in Substerile 3, were outdated as of 6/2020.	O 0181	1. Eighteen replacement vials of Dantrolene were ordered on October 27, 2020. The vials were drop shipped and arrived at the facility on October 28, 2020 and placed into the malignant hyperthermia cart. 2. Registered nurses are assigned to check the expiration dates and stock list of the malignant hyperthermia cart each month. The expiration date of the Dantrolene will be placed on the outside of the cart that houses the Dantrolene to ensure visibility. The expiration date will also be placed on the Nurse Manager's calendar as a second step to ensure compliance. 3. The Nurse Manager will be responsible for assigning the nurses each month. 4. Vials were replaced October 28, 2020.	10/28/2020
Q 0242 Bldg. 00	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. Based on document review and interview, the facility failed to follow CDC guidelines in screening visitors/staff for COVID-19 upon entering of facility.	O 0242	1. The Surgery Center screens all patients and visitors upon arrival to the facility. On October 26, 2020 the Director of Nursing reeducated	11/17/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding Include: 1. Review of policy titled: Infection Control Plan: Prevention of Exposures, Identification, surveillance/Investigation of Surgical Site Infections/Communicable Diseases, dated 10/1/13, indicated facility followed CDC (Centers for Disease Control) as a resource for practice guidelines and recommended standards. 2. Review of CDC guidelines, Infection Control Guidance dated 07/15/20 under Screen and Triage, indicated "...screen everyone entering the healthcare facility for symptoms consistent with COVID-19...actively take their temperature and document absence of symptoms consistent with COVID-19". 3. This surveyor was not screened when entering the facility on the first day of survey (10/26/20) with temperature or asking symptomatic questions; day 2 (10/27/20) of survey this surveyor was screened by asking symptom screening questions, but no temperature; answers not documented. 4. Interview on 10/26/20 with S1 (Director of Nursing) at approximately 9:30 am, confirmed: that facility does not obtain temperatures on visitors or staff; staff is to do self monitoring; do not document; and this surveyor should have been asked symptomatic questions upon entering facility.		the front desk staff who perform the screening, the all people entering the facility must be screened, including State Board of Health employees. The next day the front desk staff screened everyone entering the building, including the State Board of Health employees. 2. A screening sign-in sheet was placed at the front desk on November 17, 2020. All visitors will sign their name and date of their screening as documentation the screening was completed. 3. The Nurse Manager will meet daily with the front desk staff to ensure all visitors are being screened and the sign-in sheet is being filled out properly. The Nurse Manager will also check to ensure the front desk staff have no questions or concerns. 4. Sign-in sheet began on November 17, 2020.	
S 0000 Bldg. 00		S 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This visit was for a State Licensure survey of an Ambulatory Surgery Center. Facility Number: 005396 Survey Date: 10/26-27/2020 and 11/4/20 QA: 10/29/20 and 11/12/20			
S 0404 Bldg. 00	410 IAC 15-2.5-1 INFECTION CONTROL PROGRAM 410 IAC 15-2.5-1(b) (b) The center shall maintain a written, active, and effective center-wide infection control program. Included in this program must be a system designed for the identification, surveillance, investigation, control, and prevention of infections and communicable diseases in patients and health care workers. Based on document review and interview, the facility failed to follow CDC guidelines in screening visitors/staff for COVID-19 upon entering of facility. Finding Include: 1. Review of policy titled: Infection Control Plan: Prevention of Exposures, Identification, surveillance/Investigation of Surgical Site Infections/Communicable Diseases, dated 10/1/13, indicated facility followed CDC (Centers for Disease Control) as a resource for practice guidelines and recommended standards. 2. Review of CDC guidelines, Infection Control	S 0404	1. The Surgery Center screens all patients and visitors upon arrival to the facility. On October 26, 2020 the Director of Nursing reeducated the front desk staff who perform the screening, the all people entering the facility must be screened, including State Board of Health employees. The next day the front desk staff screened everyone entering the building, including the State Board of Health employees. 2. A screening sign-in sheet was placed at the front desk on November 17, 2020. All visitors	11/17/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Guidance dated 07/15/20 under Screen and Triage, indicated "...screen everyone entering the healthcare facility for symptoms consistent with COVID-19...actively take their temperature and document absence of symptoms consistent with COVID-19". 3. This surveyor was not screened when entering the facility on the first day of survey (10/26/20) with temperature or asking symptomatic questions; day 2 (10/27/20) of survey this surveyor was screened by asking symptom screening questions, but no temperature; answers not documented. 4. Interview on 10/26/20 with S1 (Director of Nursing) at approximately 9:30 am, confirmed: that facility does not obtain temperatures on visitors or staff; staff is to do self monitoring; do not document; and this surveyor should have been asked symptomatic questions upon entering facility.		will sign their name and date of their screening as documentation the screening was completed. 3. The Nurse Manager will meet daily with the front desk staff to ensure all visitors are being screened and the sign-in sheet is being filled out properly. The Nurse Manager will also check to ensure the front desk staff have no questions or concerns. 4. Sign-in sheet began on November 17, 2020.	
S 1010 Bldg. 00	410 IAC 15-2.5-6 PHARMACEUTICAL SERVICES 410 IAC 15-2.5-6(3)(A) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (A) Drug handling, storing, labeling, and dispensing. Based on observation and interview, the facility failed to ensure that outdated medications were	S 1010	1. Eighteen replacement vials of Dantrolene were ordered on	10/28/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001015	A. BUILDING 00 B. WING	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY SURGERY CENTER SOUTH	1550 E COUNTY LINE RD STE 100 INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	disposed of in a timely manner. Findings Include: 1. Tour of facility on 10/27/20 with S1 (Director of Nursing) and S3 (Operating Room Manager) at approximately 1:25 pm, this surveyor observed 18/36 vials of Dantrolene (20 milligrams/vial), in the Malignant Hyperthermia cart in Substerile 3, expired on 6/2020. 2. Interview with S1 and S3 on 10/27/20 at 1:40 pm, confirmed that 18/36 vials of Dantrolene (20 milligrams/vial), in the Malignant Hyperthermia cart in Substerile 3, were outdated as of 6/2020.		October 27, 2020. The vials were drop shipped and arrived at the facility on October 28, 2020 and placed into the malignant hyperthermia cart. 2. Registered nurses are assigned to check the expiration dates and stock list of the malignant hyperthermia cart each month. The expiration date of the Dantrolene will be placed on the outside of the cart that houses the Dantrolene to ensure visibility. The expiration date will also be placed on the Nurse Manager's calendar as a second step to ensure compliance. 3. The Nurse Manager will be responsible for assigning the nurses each month. 4. Vials were replaced October 28, 2020.	