STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54. Survey Date: 12/15/21 Facility Number: 005406 Provider Number: 15C0001025 AIM Number: 100274380A At this Emergency Preparedness survey, Meridian Plastic Surgery Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54. The facility has 2 certified operating rooms and one procedure room. Quality Review completed on 12/20/21 The requirement at 42 CFR, Subpart 416.54 is NOT MET as evidenced by:	E 000		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 416.54(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop	E 006		

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
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 006	Continued From page 1 and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.	E 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 006	Continued From page 2 *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 416.54(a) (1) and 42 CFR 416.54(a) (2). The plan must be reviewed and updated at least every 2 years. In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Plan for Meridian Plastic Surgery Center and Meridian Plastic	E 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 006	Continued From page 3 Surgeons" documentation dated August 2020 with the Surgery Center Director during record review from 9:35 a.m. to 1:05 p.m. on 12/15/21, the facility-based and community-based risk assessment documentation did not include emerging infectious diseases. No emerging infectious diseases hazard risk assessment was available for review at the time of the survey. Based on interview at the time of record review, the Surgery Center Director stated the facility has developed Covid-19 policies and procedures but agreed the facility-based and community-based risk assessment documentation did not include emerging infectious diseases. This finding was reviewed with the Surgery Center Director during the exit conference.	E 006		
E 013	Development of EP Policies and Procedures CFR(s): 416.54(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and	E 013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 013	Continued From page 4 procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related	E 013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 013	Continued From page 5 emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least every 2 years in accordance with 42 CFR 416.54(b). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Plan for Meridian Plastic Surgery Center and Meridian Plastic Surgeons" documentation dated August 2020 with the Surgery Center Director during record review from 9:35 a.m. to 1:05 p.m. on 12/15/21, the facility-based and community-based risk assessment documentation did not include emerging infectious diseases. No emerging infectious diseases hazard risk assessment was available for review at the time of the survey. As a result, emergency preparedness policies and procedures developed for emerging infectious diseases was not available for review at the time of the survey. Based on interview at the time of record review, the Surgery Center Director stated the facility has developed Covid-19 policies and procedures but agreed policies and procedures for emerging infectious diseases was not available for review at the time of the survey. This finding was reviewed with the Surgery Center Director during the exit conference.	E 013		
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 416.54(b)(2)	E 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 020	Continued From page 6 §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.	E 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 020	Continued From page 7 * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least every 2 years in accordance with 42 CFR 416.54(b). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Plan for Meridian Plastic Surgery Center and Meridian Plastic Surgeons" documentation dated August 2020 with the Surgery Center Director during record review from 9:35 a.m. to 1:05 p.m. on 12/15/21, the facility-based and community-based risk assessment documentation did not include emerging infectious diseases. No emerging infectious diseases hazard risk assessment was available for review at the time of the survey. As a result, emergency preparedness policies and procedures developed for emerging infectious	E 020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 020	Continued From page 8 diseases was not available for review at the time of the survey. Based on interview at the time of record review, the Surgery Center Director stated the facility has developed Covid-19 policies and procedures but agreed policies and procedures for emerging infectious diseases was not available for review at the time of the survey. This finding was reviewed with the Surgery Center Director during the exit conference.	E 020		
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 416.54(b)(5) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 024	Continued From page 9 *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 416.54(b)(5). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Plan for Meridian Plastic Surgery Center and Meridian Plastic Surgeons" documentation dated August 2020 with the Surgery Center Director during record review from 9:35 a.m. to 1:05 p.m. on 12/15/21, emergency preparedness policies and procedures did not include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on interview at the time of	E 024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 024	Continued From page 10 record review, the Surgery Center Director agreed emergency preparedness policies and procedures did not include a policy on volunteers. This finding was reviewed with the Surgery Center Director during the exit conference.	E 024		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 416.54(b)(6) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency	E 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 026	Continued From page 11 management officials. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ASC facility under a waiver declared by the Secretary, in accordance with Section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 416.54(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Plan for Meridian Plastic Surgery Center and Meridian Plastic Surgeons" documentation dated August 2020 with the Surgery Center Director during record review from 9:35 a.m. to 1:05 p.m. on 12/15/21, emergency preparedness policies and procedures did not expressly state the role of the facility under a waiver declared by the Secretary, in accordance with Section 1135 of the Act. Based on interview at the time of record review, the Surgery Center Director agreed the emergency preparedness plan for the facility did not expressly state the role of the facility under a waiver declared by the Secretary. This finding was reviewed with the Surgery Center Director during the exit conference.	E 026		
E 031	Emergency Officials Contact Information CFR(s): 416.54(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2),	E 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 031	Continued From page 12 §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) Other sources of assistance in	E 031		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 031	Continued From page 13 accordance with 42 CFR 416.54(c)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Plan for Meridian Plastic Surgery Center and Meridian Plastic Surgeons" documentation dated August 2020 with the Surgery Center Director during record review from 9:35 a.m. to 1:05 p.m. on 12/15/21, the emergency preparedness communication plan did not include notification of the Indiana Department of Health. Based on interview at the time of record review, the Surgery Center Director agreed the emergency preparedness communication plan did not include notification of the Indiana Department of Health. This finding was reviewed with the Surgery Center Director during the exit conference.	E 031		
E 032	Primary/Alternate Means for Communication CFR(s): 416.54(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:	E 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 032	Continued From page 14 (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) ASC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 416.54(c)(3). This deficient practice could affect all occupants. Findings include: Based on review of "Disaster Plan for Meridian Plastic Surgery Center and Meridian Plastic Surgeons" documentation dated August 2020 with the Surgery Center Director during record review from 9:35 a.m. to 1:05 p.m. on 12/15/21, emergency preparedness policies and procedures did not include alternate means of communication with emergency management agencies. The documentation included the use of cell phones and overhead pagers as the primary means of communication but did not include alternate means of communication with emergency management agencies during an emergency. Based on interview at the time of record review, the Surgery Center Director stated the use of cell phones and overhead paging was	E 032		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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
E 032	Continued From page 15 the primary means of communication but agreed emergency preparedness policies and procedures did not include alternate means of communication with emergency management agencies. This finding was reviewed with the Surgery Center Director during the exit conference.	E 032		
K 000	INITIAL COMMENTS A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 12/15/21 Facility Number: 005406 Provider Number: 15C0001025 AIM Number: 100274380A At this Life Safety Code survey, Meridian Plastic Surgery Center was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. The facility located on the first floor and second floor of a two story building with a basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and hazardous areas. Quality Review completed on 12/20/21	K 000		
K 100	General Requirements - Other	K 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 100	Continued From page 16 CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section, any LSC Section 20.1 and 20.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of over 10 corridor doors would self close and latch into the door frame per LSC 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect 3 patients, staff and visitors. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the following was noted: a. the west door at the bottom of the stairwell on the first floor failed to latch into the door frame when tested to self close multiple times. The latching mechanism failed to protrude into the latching plate on the door frame. The door was equipped with a 1-hour fire resistance rating label affixed to the hinge side of the door. The stairwell was open to the second floor. b. the employee entrance door in the corridor on the second floor by the Doctor's office was equipped with self closing hinges and had a 1-hour fire resistance rating label affixed to the hinge side of the door. The door was equipped with a kick down door stop which would prevent	K 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 100	Continued From page 17 the door from self closing or automatic closing. The latching mechanism on the door failed to latch into the door frame when the door was tested to self close and latch multiple times. c. the corridor door to the spa treatment area on the second floor was self closing and was held in the fully open position with a wall mounted magnetic release device but the door failed to latch into the door frame when tested to close multiple times. The latching mechanism failed to protrude into the latching plate on the door frame. Based on interview at the time of the observations, the Surgical Tech agreed the aforementioned corridor doors did not fully close properly when tested to self close multiple times with a kick down door stop affixed to one of the doors. This finding was reviewed with the Surgery Center Director during the exit conference.	K 100		
K 131	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following: * The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access. * They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating. Ambulatory health care facilities shall be separated from other tenants and occupancies	K 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 131	Continued From page 18 and shall meet all of the following: * Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab. * Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. * Doors are self-closing and are kept in the closed position, except when in use. * Windows in the barriers are of fixed fire window assemblies per 8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain 1 of 1 one fire barriers separating it from an adjoining tenant. This deficient practice could affect all patients, staff and visitors if smoke from a fire were to infiltrate the protective barrier. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, wood was noted as the tenant separation wall above the suspended ceiling in the east wall of the north vestibule. The east wall of the vestibule serves as the tenant separation fire barrier. Brick was noted as the east wall of the tenant separation fire barrier wall below the suspended ceiling. Based on interview at the time of the observations, the Surgery Center Director and the Surgical Tech agreed wood was noted as the tenant separation fire barrier above the suspended ceiling in the east wall of the north	K 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 131	Continued From page 19 vestibule. This finding was reviewed with the Surgery Center Director during the exit conference.	K 131		
K 233	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Doors in the means of egress from diagnostic or treatment areas, such as x-ray, surgical, or physical therapy, shall provide a clear width of not less than 32 inches, unless the doors are existing 34 inch-wide doors. 21.2.3.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 3 stairwell doors provided a clear width of not less than 32 inches. This deficient practice could affect second floor spa visitors and staff on the second floor. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, a door stop was screwed into the floor in the second floor stairwell for the back hallway stairs which prevented the second floor stairwell door from fully opening into the stairwell when tested to swing open. The door stop was in place to prevent the stairwell door from hitting a wall mounted lighting fixture in the stairwell. The clear width of the door swing with the door in the fully opened position with the door stop in place measured 28 and one half inch as measured with a measuring tape. Based on interview at the time	K 233		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 233	Continued From page 20 of the observations, the Surgical Tech agreed the door stop and the lighting fixture prevented the clear width of the door opening to not less than 32 inches. This finding was reviewed with the Surgery Center Director during the exit conference.	K 233		
K 291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 5 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the battery operated emergency lighting system	K 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 291	Continued From page 21 at the top of the stairwell in the Spa waiting area failed to illuminate when its respective test button was pushed multiple times. In addition, the battery operated emergency lighting system located outside the facility near the emergency generator failed to illuminate when its respective button was pushed multiple times. Based on interview at the time of the observations, the Surgical Tech agreed the aforementioned battery operated emergency lighting systems each failed to illuminate when it's respective test button was pushed multiple times. This finding was reviewed with the Surgery Center Director during the exit conference.	K 291		
K 311	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Vertical openings shall be enclosed or protected per 8.6, unless one of the following conditions exist: 1. Unenclosed vertical openings per 8.6.9.1 are permitted. 2. Unenclosed openings which do not serve as a required means of egress are permitted. 3. Exit access stairs may be unenclosed if they meet the following conditions: Two stories or less a. Building is protected throughout by a supervised sprinkler system per 9.7.1.1(1). b. Total travel distance to outside does not exceed 100 feet. Three stories or less a. Occupant load per story does not exceed 15 people. b. Building is sprinkler protected throughout	K 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 311	Continued From page 22 per 9.7.1.1(1). c. Building contains an automatic smoke detection system per 9.6. d. Activation of the sprinkler system or smoke detection system notifies all occupants of the building. e. Total travel distance to outside does not exceed 100 feet. Floors that are below the street level and are used for storage or any use other than a business occupancy, shall not have any unprotected openings to the business occupancy floors. 21.3.1, 39.3.1.1, 39.3.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain protection of 1 of 2 interior stairwell vertical openings. LSC 21.3.1 requires vertical openings shall be protected in accordance with LSC 39.3.1. LSC 39.3.1.1 states vertical openings shall be enclosed or protected in accordance with Section 8.6 unless otherwise permitted by Section 39.3.1.1(1), (2) or (3). LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient practice could affect all patients, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the latching mechanism for the back hallway	K 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 311	Continued From page 23 stairwell door on the second floor was taped over which prevented the latching mechanism from protruding from the door and into the latching mechanism on the door frame which caused the door to not latch into the door frame when tested to close multiple times. When the tape was removed, the latching mechanism in door failed to protrude into the latching plate on the door frame when tested to close multiple times. The stairwell door was equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door. Based on interview at the time of the observations, the Surgical Tech agreed the aforementioned stairwell door did not latch into the door frame when tested to close multiple times and the latching mechanism was taped over which would prevent the door from latching into the door frame. This finding was reviewed with the Surgery Center Director during the exit conference.	K 311		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas must meet one of the following: *Contain 1 hour rated enclosure when non-sprinklered *Sprinkler protected with smoke resistive separation *Severe Hazard locations contain sprinkler protection and 1 hour separation with 3/4 hour rated self-closing doors 20.3.2, 21.3.2, 38.3.2, 38.3.2.2, 39.3.2.1, 39.3.2.2, 8.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 2 hazardous areas in the	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 321	Continued From page 24 basement were protected in accordance with 21.3.2. LSC Section 21.3.2 states see Section 39.3.2 which states hazardous areas including boiler or furnace rooms shall be protected in accordance with Section 8.7. LSC Section 8.7.1.1 states: protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means: (1) Enclosing the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.3 (2) Protecting the area with automatic extinguishing systems in accordance with Section 9.7 (3) Applying both 8.7.1.1(1) and (2) where the hazard is severe or where otherwise specified by Chapters 11 through 43. Section 21.3.2.1 states doors to hazardous areas shall be self-closing or automatic closing in accordance with 21.2.2.4. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the corridor door to the sprinkler riser room in the basement was equipped with a 90-minute fire resistance rating label on the hinge side of the door but the door was not self-closing or automatic closing. The sprinkler riser room contained the two sprinkler system risers for the facility, the main fire alarm control panel, the automatic transfer switch for the facility's emergency generator, the main electrical panels for the facility and one natural gas fired furnace and one natural gas fired water heater. Based on	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 321	Continued From page 25 observation and interview, the Surgical Tech agreed the corridor door to the sprinkler riser room in the basement was not self-closing or automatic closing. This finding was reviewed with the Surgery Center Director during the exit conference.	K 321		
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm Systems - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.3.1 requires unless otherwise permitted by Section 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. Section 14.4.5 requires unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. This deficient practice could affect all occupants.	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 345	Continued From page 26 Findings include: Based on records review and interview with the Surgery Center Director on 12/15/21 between 10:35 a.m. and 1:05 p.m., documentation for the most recent annual inspection and biannual sensitivity test was incomplete. Receipts dated 12/30/20 and 09/27/21 were provided for inspections done by Crossman Fire and Safety but corresponding detailed reports were not available for review at the time of the survey. The Surgery Center Director stated the contractor had been notified reports were needed for review however no reports were made available during the survey. This finding was acknowledged by the Surgery Center Director at the time of observation and again at the exit conference at 4:00 p.m. with the Surgery Center Director present.	K 345		
K 346	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Fire alarms that are out of service for 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in	K 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 346	Continued From page 27 accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review and interview with the Surgery Center Director on 12/15/21 between 10:35 a.m. and 1:05 p.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the Indiana Department of Health when a fire watch was initiated. Provided documentation was conflicting about when IDOH would be notified in the event of a fire watch. Based on an interview at the time of record review, the Surgery Center Director acknowledged the aforementioned discrepancy and stated the policy would need to be modified. This finding was acknowledged by the Surgery Center Director at the time of observation and again at the exit conference at 4:00 p.m. with the Surgery Center Director present.	K 346		
K 351	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation Sprinkler systems (if installed) are installed per NFPA 13. Where more than two sprinklers are installed in a single area for protection, waterflow devices shall be provided to sound the building fire alarm system or to notify a constantly attended location such as a PBX, security office, or emergency room. 20.3.5.1, 20.3.5.2, 21.3.5.1, 21.3.5.2, 9.7.1.2, 9.7, NFPA 13 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 351	Continued From page 28 facility failed to maintain the ceiling construction for 3 of 3 ceiling smoke barriers in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.2 states escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of the listed sprinkler assembly. Section 6.2.7.3 states cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly. This deficient practice could affect staff all patients, staff and visitors. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the following concealed sprinkler locations were each missing its cover plate: a. basement receiving room closet. b. in the PACU Recovery area on the first floor. c. main office area closet on the first floor. d. first floor patient waiting area near the window by the main entrance door. e. second floor closet in the spa treatment area by the restroom. f. second floor alcove containing cabinets. g. second floor closet inside the southwest spa treatment room. Based on interview at the time of the observations, the Surgical Tech agreed the aforementioned concealed sprinkler locations were each missing it's respective cover plate. This finding was reviewed with the Surgery Center Director during the exit conference. 2. Based on observation and interview, the facility failed to ensure that a complete automatic	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 351	Continued From page 29 sprinkler system or documentation of fire retardant material was provided for 3 of 3 exterior canopies. NFPA 13-2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible or limited-combustible, or fire retardant. Textiles such as canvas used as an awning shall meet NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the exterior canopy at the main entrance extended 15 feet from the building, appeared to be of wood construction and was not sprinklered. The exterior canopy at the rear entrance extended 7 feet from the building, appeared to be of wood construction and was not sprinklered. The fabric canopy at the rear of the building extended 8 feet from the building and was not sprinklered. All measurements were made with a measuring tape. Based on interview at the time of the observations, the Surgical Tech did not know if the exterior canopies were fire retardant and agreed each of the three canopies were not sprinklered. This finding was reviewed with the Surgery	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 351	Continued From page 30 Center Director during the exit conference. 3. Based on observation and interview, the facility failed to ensure 1 of over 50 ceiling mounted sprinkler heads in the facility were installed in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition, Section 8.6.4.1.1.1 states under obstructed construction, the distance between the sprinkler deflector and the ceiling shall be a minimum of 1 inch (25.4 mm) and a maximum of 12 inches (305 mm) throughout the area of coverage of the sprinkler. Section 6.4.1.1.2 states the requirements of 8.6.4.1.1.1 shall not apply where ceiling-type sprinklers (concealed, recessed, and flush types) have the operating element above the ceiling and the deflector located nearer to the ceiling where installed in accordance with their listing. This deficient practice could affect over 2 patients and staff in the 14 residents, staff and visitors in the vicinity of the closet in the main office area on the first floor. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the concealed sprinkler in the closet in the main office area had dropped down from its installed position in the suspended ceiling of the closet with its deflector two inches or more below the plane of the suspended ceiling in which it had been mounted in. The concealed sprinkler was also missing its cover plate. Based on interview at the time of the observations, the Surgical Tech agreed the concealed sprinkler was not currently correctly installed.	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 351	Continued From page 31 This finding was reviewed with the Surgery Center Director during the exit conference. 4. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 basement receiving room closets in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect staff only. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, shelve storage of items within three inches of the ceiling in the basement receiving room closet provided obstruction for the concealed sprinkler installed on the ceiling of the closet. Based on interview at the time of the observations, the Surgical Tech agreed the shelf storage of items in the closet would obstruct sprinkler coverage. This finding was reviewed with the Surgery Center Director during the exit conference.	K 351		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 353	Continued From page 32 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 3 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on observations with the Surgery Center	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 353	Continued From page 33 Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the facility has supervised dry and wet sprinkler systems and had a total of three pressure gauges. The manufacture date of 2013 was listed on the face of the wet sprinkler system gauge in the sprinkler riser room in the basement. No recalibration date information was affixed to the sprinkler system gauge. Based on interview at the time of the observations, the Surgical Tech was not aware if the sprinkler system gauge had been recalibrated within the most recent five year period and agreed documentation of sprinkler system gauge replacement or recalibration was not available for review for the one wet sprinkler system pressure gauge which was more than five years old. This finding was reviewed with the Surgery Center Director during the exit conference. 2. Based on observation and interview, the facility failed to ensure the minimum supply of spare sprinklers was maintained on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers in the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. Section 5.4.1.6.1 states a special wrench shall be provided and kept in the cabinet to be used in the removal and installation of	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 353	Continued From page 34 sprinklers. This deficient practice could affect all patients, staff, and visitors in the facility. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, one sidewall sprinkler was observed installed in the main entrance foyer. No sidewall spare sprinklers were noted in the spare sprinkler cabinet in the basement sprinkler riser room. Based on interview at the time of the observations, the Surgical Tech agreed the minimum supply of spare sprinklers of the type installed in the facility was not maintained in the spare sprinkler cabinet. This finding was reviewed with the Surgery Center Director during the exit conference. 3. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Section 5.2.2.2 states sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect all patients, staff, and visitors. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, two electrical cables were affixed to horizontal sprinkler pipes with cable ties near the ceiling in	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 353	Continued From page 35 the basement near the sprinkler system risers. Based on interview at the time of the observations, the Surgical Tech agreed the aforementioned sprinkler pipe location was used to support non-system components. This finding was reviewed with the Surgery Center Director during the exit conference.	K 353		
K 354	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide a 1 of 1 written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine	K 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 354	Continued From page 36 procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Surgery Center Director on 12/15/21 between 10:35 a.m. and 1:05 p.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the Indiana Department of Health when a fire watch was initiated. Provided documentation was conflicting about when IDOH would be notified in the event of a fire watch. Based on an interview at the time of record review, the Surgery Center Director acknowledged the aforementioned discrepancy and stated the policy would need to be modified. This finding was acknowledged by the Surgery Center Director at the time of observation and again at the exit conference at 4:00 p.m. with the Surgery Center Director present.	K 354		
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure all portable fire extinguishers located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 355	Continued From page 37 NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect patients, staff and/or visitors. Findings include: Based on records review and interview with the Surgery Center Director on 12/15/21 between 10:35 a.m. and 1:05 p.m., it was unclear how many ABC type portable fire extinguisher were located in the facility. Documentation provided at the time of the survey was conflicting. The document entitled "Customer Inventory Form" provided by the facilities contractor itemized a total of 15 fire extinguishers. The facilities document entitled "Monthly Fire Extinguisher Inspection Record" which was not itemized, indicated 13 fire extinguishers were inspected on a monthly bases. Based on interview at the time of observation, the Surgery Center Director stated she was unaware of the documentation discrepancy and unsure of the exact number of extinguishers in the building but believed it to be around 14. This finding was acknowledged by the Surgery	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 355	Continued From page 38 Center Director at the time of observation and again at the exit conference at 4:00 p.m. with the Surgery Center Director present.	K 355		
K 372	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2 hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 21.3.7.5, 21.3.7.6, 8.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 3 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. LSC 21.3.7.5 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a wall constructed as a smoke barrier floor/ceiling assembly shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all patients, staff and visitors. Findings include:	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 372	Continued From page 39 Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the following openings were noted ceiling smoke barriers: a. foam was used to firestop two ceiling penetrations in the sprinkler system riser room in the basement above the wall mounted electrical panel identified as "HT Electrical Panel". b. a three in diameter hole was noted in the ceiling above the vacuum pump in the sprinkler system riser room in the basement. c. a flexible red conduit and a flexible blue conduit penetrated the ceiling of the basement sprinkler system riser room near the risers and each penetration was not firestopped. The holes in the ceiling revealed the ceiling was constructed of two layers of 5/8ths inch thick drywall. d. the annular space surrounding a two inch in diameter black pipe which penetrated the ceiling of the elevator machine room in the basement was not firestopped. In addition, three open metal grates were installed on the ceiling of the elevator machine room in the basement which exposed wood joists above the ceiling of the room or were filled with fiberglass insulation. e. one lighting fixture in the ceiling smoke barrier in the outdoor breezeway by the fabric canopy on the first floor had dropped down from its installed position and was not in place which caused a six inch in diameter hole in the ceiling smoke barrier for the breezeway. Based on interview at the time of the observations, the Surgical Tech stated he was not aware of the fire resistance rating of the foam used to firestop the penetrations in the basement sprinkler riser room ceiling and agreed the aforementioned openings in ceiling smoke barriers did not maintain the fire resistance rating	K 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 372	Continued From page 40 of the ceiling smoke barrier. This finding was reviewed with the Surgery Center Director during the exit conference.	K 372		
K 712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 21.7.1.4 through 21.7.1.7 This STANDARD is not met as evidenced by: 1. Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all occupants. Findings include: Based on records review of the "Fire Drill Reports" and interview with the Surgery Center Director on 12/15/21 between 10:35 a.m. and 1:05 p.m., 7 of 8 fire drills were conducted near the same time of the month, on either the 20th or 21st day of the month. These conditions do not allow fire drills to be conducted on unexpected days. This finding was acknowledged by the Surgery Center Director at the time of observation and again at the exit conference at 4:00 p.m. with	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 712	Continued From page 41 the Surgery Center Director present. 2. Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 1 of 4 quarters. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and patients. Findings include: Based on records review of the "Fire Drill Reports" and interview with the Surgery Center Director on 12/15/21 between 10:35 a.m. and 1:05 p.m., the first shift, fourth quarter for calendar years 2020 and 2021 was missing documentation of a completed fire drill or documented orientation training: Based on interview at the time of record review, the Surgery Center Director agreed the fire drill was missing and staff has not been trained in the fire safety procedures for the fourth quarter of 2020 or 2021. This finding was acknowledged by the Surgery Center Director at the time of observation and again at the exit conference at 4:00 p.m. with the Surgery Center Director present.	K 712		
K 901	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories	K 901		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 901	Continued From page 42 Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a documented risk assessment conducted by the facility governing body was available for review. This deficient practice could affect 3 patients. Findings include: Based on record review with the Surgery Center Director from 9:35 a.m. to 1:05 p.m. on 12/15/21, documentation of a risk assessment conducted by the facility's governing body was not available for review. Based on interview at the time of record review, the Surgery Center Director stated documentation of a risk assessment was not available for review. This finding was reviewed with the Surgery Center Director during the exit conference.	K 901		
K 918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 918	Continued From page 43 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 1 automatic transfer switches was maintained in accordance with NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, Section 6.2.16.2 states two pilot lights with identification nameplates or other approved position indicators shall be provided to indicate the switch position. This deficient practice could	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 918	Continued From page 44 affect all patients, staff and visitors. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, neither position indicator for the automatic transfer switch located in the sprinkler riser room in the basement was illuminated to indicate the switch position. One pilot position was listed as "Normal" and the second pilot was listed as "Emergency." When the door to the transfer switch was opened, each indicator position was missing it's light bulb and associated wiring to illuminate the bulb. Based on interview at the time of the observations, the Surgical Tech stated the automatic transfer switch is operable but agreed neither position indicator for the automatic transfer switch was illuminated to indicate the switch position. This finding was reviewed with the Surgery Center Director during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a properly located remote stop in the event the generator caught fire. NFPA 110, Standard for Emergency and Standby Power Systems 2010 Edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. Section 5.6.5.6.1, requires the remote manual stop station to be labeled.	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 918	Continued From page 45 Annex A is not a part of the requirements but is included for informational purposes only. A.5.6.5.6 states for systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the emergency generator for the facility located outside the building on the west side of the property was not equipped with a remote emergency stop. Manufacturer's nameplate documentation affixed to weatherproof shell stated the unit was rated at 25 kW and was manufactured 04/14/09. Based on interview at the time of the observations, the Surgical Tech agreed a remote emergency stop could not be located on the premises. This finding was reviewed with the Surgery Center Director during the exit conference. Surveyor: Hughes, Glenn Based on record review and interview, the facility failed to maintain a complete written record of the monthly load testing for 1 of 1 generators to ensure the requirements of NFPA 110 Chapter 8.4.2, 2010 Edition were met. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 918	Continued From page 46 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. 6.2.10 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Surgery Center Director on 12/15/21 between 10:35 a.m. and 1:05 p.m., there was documentation of some monthly load tests for the Natural Gas-powered generator, but the documentation was incomplete missing reports for the following months in 2021, March, May, July, August, September, October, November and December. Based on an interview at the time of record	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 918	Continued From page 47 review, the Surgery Center Director agreed the monthly load documentation was missing the aforementioned months. This finding was acknowledged by the Surgery Center Director at the time of observation and again at the exit conference at 4:00 p.m. with the Surgery Center Director present.	K 918		
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 920	Continued From page 48 power strips were not used as a substitute for fixed wiring. LSC 19.5.1 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 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 1 patient and staff in the 23 hour PACU recovery room. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, one UL 6060-1 power strip was laying on the floor up against the wall at the head of the patient bed in the 23 hour PACU recovery room. The power	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 920	Continued From page 49 strip was not a component of a movable patient-care-related electrical equipment (PCREE) assembly and it could not be assured the power strip was utilized for non-PCREE in the patient care vicinity. Based on interview at the time of the observations, the Surgery Center Director stated the power strip was used for various equipment and agreed it could not be assured the power strip was utilized for non-PCREE in the patient care vicinity This finding was reviewed with the Surgery Center Director during the exit conference.	K 920		
K 923	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage *Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. *Greater than 300 but less than 3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hour fire protection rating. *Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 923	Continued From page 50 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 piped gas system supply and oxygen storage areas was enclosed with a separation of 1 hour fire resistive construction. NFPA 99, Standard for Health Care Facilities, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 3000 cubic feet shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section 5.1.3.3.2(4) states locations for central supply systems and the storage of positive-pressure gases, if indoors, shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating. This deficient practice could affect two patients. Findings include: Based on observations with the Surgery Center Director and the Surgical Tech during a tour of the facility from 1:05 p.m. to 3:15 p.m. on 12/15/21, the annular space surrounding copper pipes which penetrated the ceiling of the piped gas	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 923	Continued From page 51 system supply room on the first floor were not firestopped. A large hole for two electrical wiring conduits which penetrated the north wall of the room was also not firestopped. The annular space surrounding one PVC pipe which also penetrated the north wall of the room was also not firestopped. Miscellaneous holes in the north wall of the room were also not firestopped. In addition, the annular space surrounding sheet metal ductwork which penetrated the ceiling of the room was also not firestopped. Based on interview at the time of the observations, the Surgery Center Director and the Surgical Tech agreed the penetrations and holes did not ensure the piped gas system supply room was not enclosed with separation of 1 hour fire resistive construction. This finding was reviewed with the Surgery Center Director during the exit conference.	K 923		
K 933	Features of Fire Protection - Fire Loss Preve CFR(s): NFPA 101 Features of Fire Protection - Fire Loss Prevention in Operating Rooms Periodic evaluations are made of hazards that could be encountered during surgical procedures, and fire prevention procedures are established. When flammable germicides or antiseptics are employed during surgeries utilizing electrosurgery, cautery or lasers: * packaging is non-flammable. * applicators are in unit doses. * Preoperative "time-out" is conducted prior the initiation of any surgical procedure to verify: o application site is dry prior to draping and use of surgical equipment. o pooling of solution has not occurred or has	K 933		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 933	Continued From page 52 been corrected. o solution-soaked materials have been removed from the OR prior to draping and use of surgical devices. o policies and procedures are established outlining safety precautions related to the use of flammable germicide or antiseptic use. Procedures are established for operating room emergencies including alarm activation, evacuation, equipment shutdown, and control operations. Emergency procedures include the control of chemical spills, and extinguishment of drapery, clothing and equipment fires. Training is provided to new OR personnel (including surgeons), continuing education is provided, incidents are reviewed monthly, and procedures are reviewed annually. 15.13 (NFPA 99) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a fire loss prevention evaluation in operating rooms had been developed. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 15.13.1.1, states an evaluation shall be made of hazards that could be encountered during surgical procedures. Section 15.13.1.2, states the evaluation shall include hazards associated with the properties of electricity, hazards associated with the operation of surgical equipment, and hazards associated with the nature of the environment. Section 15.13.1.3, states periodic reviews of surgical operations and procedures shall be conducted with special attention given to any change in materials, operations, or personnel. This deficient practice could affect two patients in the event of an emergency in the facility's two operating rooms. Findings include:	K 933		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001025	A. BUILDING **01** B. WING _____	**12/15/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN PLASTIC SURGERY CENTER	**170 W 106TH ST** **INDIANAPOLIS, IN 46290**

(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 933	Continued From page 53 Based on record review with the Surgery Center Director from 9:35 a.m. to 1:05 p.m. on 12/15/21, a fire loss prevention evaluation in operating rooms was not available for review. Based on interview at the time of record review, the Surgery Center Director stated an evaluation for fire loss prevention in operating rooms was not available for review. This finding was reviewed with the Surgery Center Director during the exit conference.	K 933		