STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001024	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLOOMINGTON SURGERY CENTER	**1011 W SECOND ST , BLOOMINGTON, Indiana, 47403**

(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
Q0000	INITIAL COMMENTS This visit was for recertification survey of an ambulatory surgery center and the OMNIBUS [COVID-19] Health Care Staff Vaccination survey in accordance with QSO-22-09-All Memorandum. Survey Dates: 7/18/22, 7/19/22 and 8/1/22 Facility Number: 005405 The OMNIBUS [COVID-19] Health Care Staff Vaccination survey in accordance with QSO-22-09-All Memorandum. The Indiana Department of Health has evaluated this facility and determined that it is in compliance with federal certification requirements. QA: 8/9/2022	Q0000		
Q0100	ENVIRONMENT CFR(s): 416.44 The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. This CONDITION is NOT MET as evidenced by: Based on record review, observation and interview; the facility failed to ensure 1 of 2 fire barriers that separate other occupancies were protected to maintain the fire resistance rating of the fire barrier (see tag K131), failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 3 smoke compartments (see tag K351) failed to completely maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained (see tag K353) and failed to ensure the supply of spare sprinklers maintained on the premises corresponded to the types and temperature ratings of the sprinklers in the property (see tag	Q0100		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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Q0100	Continued from page 1 K353). The cumulative effect of these systemic problems resulted in the facility's inability to ensure it had implemented a systemic plan of correction to prevent recurrence, therefore failing to ensure the provision of quality health care in a safe environment.	Q0100		
Q0104	SAFETY FROM FIRE CFR(s): 416.44(b)(1)-(3) (b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served, and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4). (2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC. This STANDARD is NOT MET as evidenced by: 1. Based on record review, observation and interview; the facility failed to ensure 1 of 2 fire barriers that separate other occupancies were protected to maintain the fire resistance rating of the fire barrier. NFPA 101, 2012 edition, Section 8.3.5.6.1 states membrane penetrations for cables cable trays conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. Section 8.3.5.6.2 states the firestop	Q0104		

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Q0104	Continued from page 2 system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Test of Through Penetration Fire stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops. In addition, doors are self-closing and are kept in the closed position, except when in use. This deficient practice could affect all patients, staff and visitors. 2. Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 3 smoke compartments. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect up to 10 patients and staff in main reception. Findings include: Based on observations with the Director of Surgical Services and the Building Grounds Coordinator during a tour of the facility from 12:15 p.m. to 1:08 p.m. on 08/01/22, two, three inch diameter holes were was noted above the suspended ceiling in the tenant separation fire wall on the east side of the facility in the lunch room/office above the door to the corridor. Based on interview at the time of the observation, the Building Grounds Coordinator agreed the aforementioned holes in the east tenant separation fire wall did not maintain the fire resistance rating of the tenant separation fire barrier. This finding was reviewed with the Director of Surgical Services at the time of exit. Based on observation during a tour of the facility with the Director of Surgical Services and Building Grounds Coordinator on 08/01/22 between 12:15 p.m. and 1:08 p.m., one quick response sprinkler head was installed in the southwest corner of the main reception area. The other sprinkler heads in main reception, approximately 10, were standard response sprinkler heads. Based on an interview at the time of observations, the Building Grounds Coordinator agreed the main reception area has a mix of sprinkler response types.	Q0104		
Q0108	BUILDING SAFETY	Q0108		

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Q0108	Continued from page 3 CFR(s): 416.44(c) (c) Standard: Building Safety. Except as otherwise provided in this section, the ASC must meet the applicable provisions and must proceed in accordance with the 2012 edition of the Health Care Facilities Code (NFPA 99, and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5 and TIA 12-6). (1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to an ASC. (2) If application of the Health Care Facilities Code required under paragraph (c) of this section would result in unreasonable hardship for the ASC, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients. This STANDARD is NOT MET as evidenced by: 1. Based on record review and interview, the facility failed to completely maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test, and maintenance required by this standard. This deficient practice could affect all occupants. 2. Based on observation and interview, the facility failed to ensure the supply of spare sprinklers maintained on the premises corresponded to the types and temperature ratings of the sprinklers in the property. 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	Q0108		

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Q0108	Continued from page 4 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. This deficient practice could affect all patients, staff, and visitors in the facility. Findings include: Based on observations with the Director of Surgical Services and the Building Grounds Coordinator during a tour of the facility from 12:15 p.m. to 1:08 p.m. on 08/01/22, two, three inch diameter holes were was noted above the suspended ceiling in the tenant separation fire wall on the east side of the facility in the lunch room/office above the door to the corridor. Based on interview at the time of the observation, the Building Grounds Coordinator agreed the aforementioned holes in the east tenant separation fire wall did not maintain the fire resistance rating of the tenant separation fire barrier. This finding was reviewed with the Director of Surgical Services at the time of exit. Based on observation during a tour of the facility with the Director of Surgical Services and Building Grounds Coordinator on 08/01/22 between 12:15 p.m. and 1:08 p.m., one quick response sprinkler head was installed in the southwest corner of the main reception area. The other sprinkler heads in main reception, approximately 10, were standard response sprinkler heads. Based on an interview at the time of observations, the Building Grounds Coordinator agreed the main reception area has a mix of sprinkler response types.	Q0108		
Q0122	REAPPRAISALS CFR(s): 416.45(b) Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. This STANDARD is NOT MET as evidenced by: Based on document review and interview, the medical staff (MS) failed to conduct periodic reappraisals that included evidence of data on the practitioner's practice within the center for outcome-oriented performance evaluations on 7 of 7 reappointed MS members (MD1, MD3, MD5, MD6, MD7, MD8 and MD9).	Q0122		

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Q0122	Continued from page 5 Findings include: Review of the MS Bylaws, approved 12/14/21, indicated the following:Membership of the MS is a privilege which shall be extended only to those physicians who have demonstrated professional competence and who meet the qualifications. All appointees and reappointees will undergo an annual review during the twelve (12) month anniversary dates of appointment/reappointment. Review of MS credential files and the annual evaluations for reappointed members MD1, MD3, MD5, MD6, MD7, MD8 and MD9 lacked evidence of the evaluations having been outcome-oriented for demonstrated competence and lacked evidence of data on the practitioner's practice within the center. On 7/19/22 at approximately 12:15 p.m. , A5, RN (Registered Nurse)/Director of Surgical Services, verified their appraisal system lacked procedures for evaluation of competence that was outcome-oriented.	Q0122		
Q0241	SANITARY ENVIRONMENT CFR(s): 416.51(a) The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the center failed to ensure 2 of 2 mechanical rooms (the air handler room and medical gas storage room) were kept clean, orderly, and safe in one facility. Findings include: On 7/19/22, beginning at approximately 2:30 PM, it was observed in the air handler mechanical room a bowl overflowing with water was observed sitting underneath a backflow prevention device which appeared to be leaking. In the bowl blackish particles were noted and the floor was wet in approximately a 2-3 foot radius around the bowl. In the mechanical room with the air handlers was a	Q0241		

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Q0241	Continued from page 6 large, unused piece of equipment (indicated as out of service), on top was a stack of loose towel papers and miscellaneous items. On the floor against a wall was a metal door panel. On the floor near air handler #1 was an old appearing disconnected part. On the wall, approximately 2' (two feet) in front of air handler #1 was an uncovered service panel with lit lights, spliced wires joined by wire nuts, and areas indicated as "A/C Lockout" (not all inclusive). In the medical gas storage/mechanical room were two large unsecured and unlocked biohazardous waste boxes. The top box contained what appeared to be full sharps containers. The door to the room did not indicated this to be a biohazardous waste storage area. On 7/19/22, the following was indicated in interview:Beginning at approximately 2:30 PM, A5, Director of Surgical Services, verified the contents of the biohazardous waste box and that the door to the room was not marked for biohazardous waste. A5 indicated this was not their usual storage area for biohazardous waste, but was sometimes used for overflow. Beginning at approximately 3:00 PM, Building and Grounds Coordinator P5 indicated the items on top of the out of service equipment were things he/she used when needed. P5 indicated the part to the air handler that was on the ground was one that had been replaced and was to fixed in case it was later needed as a replacement part. P5 indicated he/she did not know the purpose of the exposed panel near air handler #1. P5 indicated the panel was non-functioning. P5 further indicated the panel did not need to be covered.	Q0241		