

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2022
NAME OF PROVIDER OR SUPPLIER BALL OUTPATIENT SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2401 W UNIVERSITY AVE STE 200 OMP , MUNCIE, Indiana, 47303	
(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	<p>INITIAL COMMENTS</p> <p>This visit was for a 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.</p> <p>Facility Number: 012159</p> <p>Survey Dates: 12-07-2022 to 12-08-2022 and 12/19/2022</p> <p>Ball Outpatient Surgery Center is in compliance with 42 CFR 416.40 through 416.52, Requirements for Ambulatory Surgery Centers.</p> <p>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.</p> <p>QA: 12/13/2022 and 12/27/2022</p>	Q0000		
Q0100	<p>ENVIRONMENT</p> <p>CFR(s): 416.44</p> <p>The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.</p> <p>This CONDITION is NOT MET as evidenced by:</p> <p>Based on record review, interview and observation, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition (see tag K353), failed to maintain the ceiling construction in 2 of 2 Electrical rooms (see tag K353), and failed to ensure 1 of 1 oxygen storage location was secured against unauthorized entry per NFPA 99 11.3.2.1 (see tag K923).</p> <p>The cumulative effect of these systemic problems resulted in the facility's inability to ensure it had</p>	Q0100		01/18/2023

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 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	<p>SAFETY FROM FIRE</p> <p>CFR(s): 416.44(b)(1)-(3)</p> <p>(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).</p> <p>(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.</p> <p>(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.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants.</p> <p>2. Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of 2 Electrical rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of</p>	Q0104		01/18/2023

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Q0104	<p>Continued from page 2 construction. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>1. Based on record review and interviews with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative on 12/19/22 between 9:45 a.m. and 1:15 p.m., no documentation was available showing an internal inspection of piping had been done. The Director of Facilities stated that they had just recently been made aware of the requirement and that to his knowledge, no 5-year internal pipe inspection had ever been done. Additionally, the facility stated that they are in communication with the contractor, but no 5-year internal pipe inspection had been scheduled.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative all present.</p> <p>2. Based on a facility tour and interviews with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative on 12/19/22 between 1:15 p.m. and 3:20 p.m., the following locations were missing ceiling tiles which would resist the passage of smoke;</p> <p>A. The electrical room #2635A was missing ceiling tile.</p> <p>B. The electrical/telephone closet near the elevator was missing all ceiling tile. The facility representative believed that was due to work done recently on the elevator.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative all present.</p>	Q0104		
Q0108	<p>BUILDING SAFETY</p> <p>CFR(s): 416.44(c)</p> <p>(c) Standard: Building Safety. Except as otherwise</p>	Q0108		01/18/2023

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Q0108	<p>Continued from page 3 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).</p> <p>(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to an ASC.</p> <p>(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.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage location was secured against unauthorized entry per NFPA 99 11.3.2.1. This deficient practice could affect 3 staff.</p> <p>Findings include:</p> <p>Based on record review and interviews with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative on 12/19/22 between 9:45 a.m. and 1:15 p.m., the oxygen storage room, containing approximately 14 cylinders, had a corridor door which did not have a lock and was not secure from unauthorized entry.</p> <p>This finding was acknowledged at the time of discovery and again at the exit conference with the Clinical Manager, Director of Facilities, Center Director, Life Safety Consultant, EPP and EOC Safety and Security Representative all present.</p>	Q0108		