STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGAMORE SURGICAL SERVICES INC	2320 CONCORD ROAD, SUITE B , LAFAYETTE, Indiana, 47909

(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 a recertification survey of an Ambulatory Surgery Center and the OMNIBUS (COVID 19) Health care staff Vaccine survey in accordance with QSO-22-09-ALL Memorandum. Facility Number: 006126 Survey Date: 1-4-2023 to 1-5-2023 Sagamore Surgical Services Inc., is in compliance with 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: 01/10/2023	Q0000		
Q0242	INFECTION CONTROL PROGRAM CFR(s): 416.51(b) The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. This STANDARD is NOT MET as evidenced by: Based on document review and interview, the facility failed to ensure Rubeola immunizations in 5 of 10 personnel files (N1, S2, N4, S3 and N8) reviewed. Findings Include: Review of policy titled: Infection Control for Employee Health (Section XIII.A), last approved 01/31/22. indicated a communicable disease history will be taken	Q0242		02/07/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGAMORE SURGICAL SERVICES INC	**2320 CONCORD ROAD, SUITE B , LAFAYETTE, Indiana, 47909**

(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
Q0242	Continued from page 1 to determine documentation or history of immunity to Rubeola. Review of 5 of 10 (N1, S2, N4, S3 and N8) personnel files indicated lack of documentation of Rubeola immunizations. Interview on 01/05/23 with S2 (Director of Nursing) at 10:00 am confirmed that 5 of 10 (N1, S2, N4, S3 and N8) personnel files indicated lack of documentation of Rubeola immunizations.	Q0242		