STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001157	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATE STREET SURGERY CENTER LLC	1801 N SENATE BLVD MPC2 - D1450, INDIANAPOLIS, Indiana, 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
Q0000	INITIAL COMMENTS This visit was for a recertification survey of an Ambulatory Surgery Center. Facility Number: 006622 Survey Date: 1-9-2023 to 1-10-2023 and 1/18/2023 QA: 1/12/2023 and 1/24/2023	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 maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5 (see tag K353), failed to have documentation available and ensure that a 5-year internal pipe inspection had been done (see tag K353), failed to ensure 1 of 1 fire damper systems in the facility were inspected and provided necessary maintenance at least every four years (see tag K521), failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 1 of 4 quarters (see tag 712), failed to ensure 2 of 7 Operating Rooms (OR) used flexible cords power strips powering medical equipment that met the required UL rating (see tag K920) and failed to ensure power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw (see tag K920). The cumulative effect of these systemic problems resulted in the facility's inability to ensure that all locations from which it provides services are	Q0100		02/17/2023

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 constructed, arranged and maintained 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: Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. Which 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, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. 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	Q0104		02/17/2023

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Q0104	Continued from page 2 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. Based on record review, observation, and interview; the facility failed to ensure 1 of 1 fire damper systems in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all occupants. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 1 of 4 quarters. This deficient practice could affect all patients, staff and visitors in the facility. Based on observation and interview, the facility failed to ensure 2 of 7 Operating Rooms (OR) used flexible cords power strips powering medical equipment that met the required UL rating of 1363A or 60601-1. This deficient practice could affect 2 patient in the OR's. Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect only staff.	Q0104		

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Q0104	Continued from page 3 Findings include: 1. Based on records review and interviews with the ASE Director, Admissions Assistant, two Clinical Managers and Shift Coordinator and a visit to the main facility records storage room and facility maintenance personnel from 8:45 a.m. to 11:45 a.m. on 01/18/23, there was no monthly inspection of the wet pipe sprinkler system's gauges and valves available for review. This finding was acknowledged at the time of discovery by the ASE Director and again at the exit conference with the ASE Director and other the facility representatives present. 2. Based on records review and interviews with the ASE Director, Admissions Assistant, two Clinical Managers and Shift Coordinator and a visit to the main facility records storage room and facility maintenance personnel from 8:45 a.m. to 11:45 a.m. on 01/18/23, no documentation was available showing an internal inspection of piping had been done. The facility representatives stated that they had previously been unaware of the requirement and that to his knowledge, no 5-year internal pipe inspection had been done. This finding was acknowledged at the time of discovery by the ASE Director and again at the exit conference with the ASE Director and other the facility representatives present. 3. Based on records review and interviews with the ASE Director, Admissions Assistant, two Clinical Managers and Shift Coordinator from 8:45 a.m. to 11:45 a.m. on 01/18/23, no documentation was available reflecting fire and smoke damper testing. The facility representative stated that those records might be stored in a central location. A visit and interview with the facility's overall maintenance and support persons did not produce documentation of fire and smoke damper testing. Based on interview at the time of records review and observation, the Facility's support personnel agreed there are fire/smoke dampers in the facility, but it was unknown how many dampers were in the facility and stated no damper inspection could be found. This finding was acknowledged at the time of discovery by the ASE Director and again at the exit conference	Q0104		

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Q0104	Continued from page 4 with the ASE Director and other the facility representatives present. 4. Based on review of "Fire Drill Evaluation Report-Team Member" documentation with the ASE Director, Admissions Assistant, two Clinical Managers and Shift Coordinator during record review from 8:45 a.m. to 11:45 a.m. on 01/18/23, documentation for a fire drill during the second quarter of 2022 was not provided. Based on interview at the time of record review, the facility representatives stated the facility operates one shift per day from 7:00 a.m. to 5:30 p.m. and agreed the aforementioned first shift fire drill documentation was not available. This finding was acknowledged at the time of discovery and again at the exit conference by the facility representatives present. 5. Based on interviews and a facility tour with the ASE Director on 01/18/22 between 11:45 a.m. and 1:45 p.m., the following locations had power strips that did not meet 1363A or 60601-1. 1. OR # 6 used to power computer equipment. 2. OR # 3 affixed to wall used to power computer equipment. This finding was acknowledged at the time of discovery by the ASE Director and again at the exit conference with the ASE Director and other the facility representatives present. 6. Based on interviews and a facility tour with the ASE Director on 01/18/22 between 11:45 a.m. and 1:45 p.m., in the Pain Center Office a power strip was being used to power a dorm style mini-refrigerator (high power draw equipment). This finding was acknowledged at the time of discovery by the ASE Director and again at the exit conference with the ASE Director and other the facility representatives present.	Q0104		