STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001133	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN SURGICENTER LLC	320 N SECTION ST , SULLIVAN, Indiana, 47882

(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 federal recertification survey of an Ambulatory Surgery Center. Facility Number: 003633 Survey Dates: 11/14/23, 11/15/23 and 11/21/23 QA: 11/21/2023 & 11/22/2023	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, interview and observation, the facility failed to ensure 9 of 9 battery backup emergency light were tested annually for 90 minutes during the past 12 months to ensure the lights would provide lighting during periods of power outages and a written record of visual inspections and tests was provided, failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3, failed to completely maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5, failed to inspect 15 of 15 portable fire extinguishers each month, failed to ensure documentation was complete for the annual inspection and testing of 6 of 6 stairway fire door assemblies, failed to ensure 1 of 1 emergency generator was provided with a properly operating alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations, and failed to maintain a complete record of monthly generator load testing and routine maintenance during the last 12 months. The cumulative effect of these systemic problems resulted in the facility's inability to ensure the provision of quality health care in a safe environment.	Q0100		01/18/2024

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 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: Findings include; 1. Based on record review on 11/21/23 at 11:13 a.m. with the Director of Nursing, there was documentation to show a 30 second monthly test for nine battery operated emergency light sets during the past twelve months, however, there was no documentation to show the battery operated emergency light sets were tested annually for 90 minutes during the past twelve months. Based on an interview at the time of record review, the Director of Nursing said there was no other documentation available to show the battery operated emergency light sets were tested annually for 90 minutes during the past twelve months. Additionally, during a tour of the facility from 12:55 p.m. and 1:40 p.m., the battery operated emergency light in the kitchen and second floor east stairwell failed to function when the test buttons were pushed several times. Based on interview at the time of observations, the Director of Nursing confirmed the emergency lights failed to function when tested. Based on record review on 11/21/23 between 9:45 a.m. and 12:45 p.m. with the Director of Nursing, the most recent annual fire alarm system inspection dated	Q0100 Q0104		12/29/2023

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Q0104	Continued from page 2 09/14/23 from the facility's vendor listed deficiencies. The inspection report indicated the batteries inside the main Fire Alarm Control Panel (FACP) failed. Additionally, there were nine of 26 ionization detectors that failed to report to the panel and three of 15 manual pull stations that failed to report to the panel. Based on interview at the time of record review, the Director of Nursing confirmed the issues but stated there was no documentation showing repairs have been made or have been scheduled at the time of the survey. Based on observation on 11/21/23 at 1:10 p.m. during a tour of the facility with the Director of Nursing, the two batteries in the main FACP had '9/18' wrote on them in a black marker. Based on record review on 11/21/23 between 9:45 a.m. and 12:45 p.m. with the Director of Nursing, no documentation could be provided regarding a semi-annual visual inspection of the fire alarm system. The most recent two annual fire alarm inspections were performed on 09/14/23 and 09/08/22. There was no semi-annual visual inspection documentation between the two annual inspection dates available for review. Based on interview at the time of record review, the Director of Nursing said that documentation of a visual inspection of the fire alarm system's devices was not available for review at the time of the survey. Based on observation of the fire alarm panel on 11/21/23 at 1:10 p.m., during a tour of the facility with the Director of Nursing, the date and time on the fire alarm panel were incorrect. The display on the main fire alarm control panel indicated the date and time to be 09/19/23 at 12:43 a.m. Based on interview at the time of observation, the Director of Nursing indicated she was unaware off the discrepancy and would contact the fire alarm vendor to have the displayed date and time updated on the fire alarm control panel. 5. Based on record review on 11/21/23 from 9:45 a.m. to 12:55 p.m., the most recent annual sprinkler system inspection was performed 09/14/23. Under the deficiencies section of the first page, it stated 'deficiency found - System is due for 5 year internal pipe inspection'. On the annual sprinkler system inspection dated 09/08/22, the 'system due for 5-year internal' was noted on the report. Documentation of an unsigned proposal for inspection services to conduct a 5-year internal pipe inspection was dated 04/28/23. The report indicated the date of the last 5-year internal pipe inspection was 04/2016. Based on interview at the time of record review, the Director of Nursing confirmed the noted deficiency on the report and stated that the owner was working to get more estimates for	Q0104		

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Q0104	Continued from page 3 the internal pipe inspection, and there was no documentation available for review to show an internal pipe inspection had been conducted or scheduled at the time of the survey. 6. Based on record review on 11/21/23 from 9:45 a.m. to 12:55 p.m., the facility's wet sprinkler system was inspected quarterly on 09/14/23, 06/02/23, 03/14/23 and 10/16/22. Monthly wet sprinkler system gauge and control valve inspection documentation for eight of the past 12 months was not available for review. Based on interview at the time of observation, the Director of Nursing confirmed the sprinkler gauge and valve inspection was not documented on a monthly basis outside of the quarterly sprinkler inspections. Based on observation with the Director of Nursing during a tour of the facility between 12:55 p.m. and 1:40 p.m., the facility had at least one wet pressure gauge at the sprinkler riser. Based on record review on 11/21/23 at 10:35 a.m., the most recent annual sprinkler system inspection dated 09/14/23 stated the gauges are out of date. The report indicated the date of the gauge to be 07/2018. Based on interview at the time of record review, the Director of Nursing stated the gauge had not been replaced to her knowledge. Based on observation with the Director of Nursing during a tour of the facility at 1:15 p.m. the gauge on the sprinkler riser had a date of 07/2018 wrote on the face of the gauge. Based on observations on 11/21/23 between 12:55 p.m. and 1:40 p.m. during a tour of the facility with the Director of Nursing, the annual inspection of all 15 of the fire extinguishers in the facility was performed in May of 2023. None of the 15 fire extinguishers have been inspected monthly since May of 2023 according to the monthly inspection tags on each fire extinguisher. Based on interview at the time of the observations, the Director of Nursing said there was no monthly inspection of fire extinguishers performed. Based on record review on 11/21/23 between 9:45 a.m. and 12:55p.m. with the Director of Nursing, the facility was not able to provide documentation of an annual fire door assembly inspection for 6 stairway fire door assemblies. Based on interview at the time of record review, the Director of Nursing said she was unaware of the requirement and confirmed there was no documentation available for an annual inspection of stairway fire door assemblies during the past 12 months. Based on observations during a tour of the facility with the Director of Nursing between 12:55 p.m. and 1:40 p.m., there were 6 stairway fire door	Q0104		

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Q0104	Continued from page 4 assemblies noted in the facility.	Q0104		
Q0108	BUILDING SAFETY 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: Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was provided with a properly operating alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' stations. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: a. Low lubricating oil pressure.	Q0108		01/18/2024

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Q0108	Continued from page 5 b. Low water temperature. c. Excessive water temperature. d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 6.4.1.1.17(1) and (2) occur but need not display these conditions individually. Based on record review and interview the facility failed to maintain a complete record of monthly generator load testing and routine maintenance during the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. Findings include; Based on observation on 11/21/23 between 12:55 p.m. and 1:40 p.m. during a tour of the facility with the Director of Nursing, the remote generator annunciator panel located in the maintenance building was not in operation. The Director of Nursing said she was not aware the generator annunciator panel was not in operation. Furthermore, the generator annunciator panel	Q0108		

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Q0108	Continued from page 6 was located in the maintenance building that was not occupied by staff at all times. Based on record review on 11/21/23 between 9:45 a.m. and 12:55 p.m. with the Director of Nursing, the Emergency Generator Monthly Load Test form did not indicate the generator was ran under load for at least 30 minutes during the last twelve months. A hash mark was wrote in the column 'running time with load'. Based on interview at the time of record review, the Director of Nursing agreed there was no running time under load documentation provided on the monthly generator load test form during the past 12 months. Based on record review on 11/21/23 between 9:45 a.m. and 12:55 p.m. with the Director of Nursing, documentation for the most recent 12 monthly load tests of the emergency generator did not have a percentage provided to verify the monthly load was meeting or exceeding the thirty percent requirement. There was no documentation of a load bank test available for review during the past 12 months. Based on interview at the time of record review, the Director of Nursing confirmed there was no percentage provided on the monthly testing form and that no load bank test documentation was available for the past 12 month period. Based on record review on 11/21/23 between 9:45 a.m. and 12:55 p.m. with the Director of Nursing, no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Director of Nursing stated the facility does have a diesel generator and there is no annual fuel quality testing documentation available to review. 4. Based on record review on 11/21/23 between 9:45 a.m. and 12:55 p.m. with the Director of Nursing present, there was no documentation available to show that the emergency generator has had routine maintenance during the past 12 months. Based on interview at the time of record review, the Director of Nursing stated she does not deal with the generator, the owner does, and confirmed there was no documentation for routine maintenance on the emergency generator within the past 12 months available for review at the time of the survey. These findings were reviewed with the Director of	Q0108		

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Q0108	Continued from page 7 Nursing at the exit conference.	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 failed to examine a request for clinical privileges, current licensure, training and professional education, documented experience and supporting references for reappointment on 1 of 1 medical doctor (MD) on staff. Findings include: 1. Facility policy titled, Governing Body: Powers and Duties, policy number 1000.02, last reviewed 2/7/2013, indicated the governing body would ensure reappointment was acted upon biennially. 2. Facility policy titled, Credentialing Physician Process, policy number 1000.14, last reviewed 2/7/13, indicated no person (including persons engaged by the Sullivan Surgicenter in administrative positions) should exercise clinical privileges in the surgery center unless and until he/she applied for and received appointment to the medical staff or was granted temporary privileges as set forth in the bylaws of the medial staff by applying to the medical staff for appointment or reappointment. Guidelines for reappointment were listed as follows: a. The application would be reviewed. b. The delineation of privileges would be reviewed for completeness. c. The applicant's Indiana license would be verified with the Health Professional Bureau. d. The applicant's malpractice insurance would be verified with the Indiana Insurance Commission or verified blanket policy in place. e. Primary Source verification of training would be requested.	Q0122		12/15/2023

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Q0122	Continued from page 8 f. At least 2 peer references were required. g. Any facility listed by the applicant would be queried regarding clinical performance. h. The National Practitioner Data Bank would be queried on all applicants, if so desired by the Surgical Review Committee. i. A criminal background check would be completed if applicable and warranted. j. Upon receipt of all information, the application would be deemed complete, then forwarded to the Surgical Review Committee for review, evaluation and verification of the supporting documents. 3. Review of credential file for MD1 (MD and Chief Executive Officer [CEO]) lacked reappointment application with contents as described above, last reappointment application found in credential file was from 2008. 4. In interview on 11/15/23 at approximately 9:40 am, MD1 (MD and CEO) verified he/she did not go through the reappointment process as described above, that he/she is the only MD in the facility, and is the Chief Executive Officer of the facility.	Q0122		
Q0162	FORM AND CONTENT OF RECORD CFR(s): 416.47(b) The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: (1) Patient identification. (2) Significant medical history and results of physical examination (as applicable); (3) Pre-operative diagnostic studies (entered before surgery), if performed. (4) Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. (5) Any allergies and abnormal drug reactions. (6) Entries related to anesthesia administration.	Q0162		12/15/2023

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Q0162	Continued from page 9 (7) Documentation of properly executed informed patient consent. (8) Discharge diagnosis. This STANDARD is NOT MET as evidenced by: Based on document review and interview, facility failed to maintain completed medical records for 4 of 30 medical records reviewed (Patient #26, 27, 28, and 29). Findings include: 1. Facility policy titled "Operative Report and Techniques", Policy Number: 200.42, last reviewed 5/19/2011, indicated an operative report and techniques has to be dictated immediately at the dictation room in the lounge immediately after each surgical procedure. 2. Medical record review on 11/15/2023 indicated 4 of 30 medical records (Patient #26, 27, 28, and 29), lacked documentation of operative report. 3. In interview on 11/15/2023 at approximately 1000 hours with A2 (Business Office Manager), he/she indicated provider had not completed operative report for patient #27 and patient #28 due to being out of the office; he/she also confirmed Patient #26 and patient #29 lacked operative report.	Q0162		
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 document review, observation and interview, the facility failed to maintain the cleanliness of the patient bathroom in 1 of 1 patient preoperative rooms, and 1 of 2 patient waiting areas; nursing personnel failed to perform hand hygiene after removal of gloves for 1 of 1 surgical procedures observed (A3). Finding Include: 1. Facility policy titled "Handwashing after Gloves are Removed", Policy Number: 1400.23, last reviewed 6/4/2020, indicated all personnel providing medical	Q0241		12/14/2023

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Q0241	Continued from page 10 care to patients, must wash his/her hands each time gloves are removed after coming in contact with a patient or performing a medical procedure or assessment. 2. Facility policy titled Renovation and Construction, policy number 1400.08, last reviewed 5/19/11 indicated under construction and renovation areas must be properly separated from other areas in use, and there must be no dust, fumes, nor particles that should gain access to non-construction site. The policy also indicated the contractor will provide barricades to prevent unauthorized entry into construction area. 3. In observation of surgical procedure on 11/14/2023 at approximately 1030 hours, A3 (Registered Nurse, Director of Nursing, Infection Prevention) donned gloves to clean surgical area, after task was completed, nurse removed gloves and proceeded to assist in opening saline bottle and pouring fluid appropriately into container held by surgical technician in the sterile field. 4. On 11/15/23 at approximately 11:40 am, while on tour, this writer observed the following: a. The patient lobby/waiting area by the main entrance had a layer of dust on the surface of the chairs, end tables, television, water cooler, and table the patient/visitor drinking cups were on. Cobwebs observed under the legs of 1 chair and 1 end table. b. The bathroom in patient preoperative room (room 208) was observed to have a black ring inside the toilet bowl. The toilet seat was in an upright position and observed to have a yellow crust with a hair stuck to it. The sink was observed to have an accumulation of dirt on the surface. c. No observations made to indicate a construction project was in progress. 5. In interview on 11/14/2023 at approximately 1100 hours with A3, he/she indicated was busy and must have forgotten to clean hands after removing gloves. 6. In interview on 11/15/23 at approximately 11:40 am, A2 (Business Office Manager) verified the observations as described above. A2 also verified that the dust in the lobby/waiting area by the main door was likely due to a construction project which was in progress. 7. In interview on 11/15/23 at approximately 12:00 pm, MD1 (Medical Doctor [MD] and Chief Executive Officer	Q0241		

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SULLIVAN SURGICENTER LLC	320 N SECTION ST , SULLIVAN, Indiana, 47882

(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
Q0241	Continued from page 11 [CEO]), verified there was a construction project in progress and there were no barricades in place to prevent unauthorized entry into construction area.	Q0241		
Q0243	INFECTION CONTROL PROGRAM - DIRECTION CFR(s): 416.51(b)(1) The program is - Under the direction of a designated and qualified professional who has training in infection control. This STANDARD is NOT MET as evidenced by: Based on document review and interview, facility failed to maintain personnel file documentation of ongoing education, training, and/or certification to oversee the infection control program for 2 of 2 personnel assigned (MD1 & A3). Findings include: 1. Facility policy titled "Infection Control of Outpatient Surgical Services", Policy Number: 1400.01, last reviewed 6/4/2023, indicated 1.2.4 The infection control chair will receive continuing education on infection control annually. 2. Review of personnel file on 11/14/2023 indicated MD1 (Medical Doctor, Chief Executive Officer) and A3 (Registered Nurse, Director of Nursing/Infection Prevention) lacked documentation of ongoing education, training, and/or certification of infection control practices/program. 3. In interview on 11/14/2023 at approximately 1230 hours with A2 (Office Manager) and A3, A3 indicated had not signed up for any courses since he/she has been in the infection control position, has not received training, and has not kept record of articles read on infection control. A2 confirmed lack of documentation on infection prevention/control education completed by MD1 and A3 in personnel file.	Q0243		12/15/2023