

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15C0001133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - SULLIVAN SURGIC..</b> B. WING	(X3) DATE SURVEY COMPLETED <b>11/21/2023</b>
NAME OF PROVIDER OR SUPPLIER <b>SULLIVAN SURGICENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 N SECTION ST , SULLIVAN, Indiana, 47882</b>	
(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
K0000	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 11/21/23</p> <p>Facility Number: 003633</p> <p>Provider Number: 15C0001133</p> <p>AIM Number: 200503030A</p> <p>At this Life Safety Code Survey, Sullivan Surgicenter LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>This three story facility was determined to be of Type I (332) construction and partially sprinklered. The facility has a fire alarm system with smoke detection in corridors, some areas open to the corridors, and hazardous areas. Sprinklers were located in the laundry, maintenance shop, and rooms 101 and 309.</p> <p>Quality Review completed on 11/27/23</p>	K0000		
K0291	<p><b>Emergency Lighting</b></p> <p>CFR(s): NFPA 101</p> <p><b>Emergency Lighting</b></p> <p>Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9.</p> <p>20.2.9.1, 21.2.9.1, 7.9</p>	K0291		

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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K0291	<p>Continued from page 1 This STANDARD is NOT MET as evidenced by:</p> <p>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. LSC Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>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.</p> <p>These findings were reviewed with the Director of Nursing at the exit conference.</p>	K0291		
K0345	<p>Fire Alarm System - Testing and Maintenance</p> <p>CFR(s): NFPA 101</p> <p>Fire Alarm Systems - Testing and Maintenance</p> <p>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and</p>	K0345		

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K0345	<p>Continued from page 2 NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants.</p> <p>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 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.</p> <p>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.</p> <p>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</p>	K0345		

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K0345	Continued from page 3 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. These findings were reviewed with the Director of Nursing at the exit conference.	K0345		
K0353	<p>Sprinkler System - Maintenance and Testing</p> <p>CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing</p> <p>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>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, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 11/21/23 from 9:45 a.m. to 12:55 p.m., the most recent annual sprinkler system</p>	K0353		

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K0353	<p>Continued from page 4 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 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.</p> <p>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.</p> <p>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.</p> <p>These findings were reviewed with the Director of Nursing at the exit conference.</p>	K0353		
K0355	<p>Portable Fire Extinguishers</p> <p>CFR(s): NFPA 101</p> <p>Portable Fire Extinguishers</p>	K0355		

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K0355	<p>Continued from page 5</p> <p>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</p> <p>20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to inspect 15 of 15 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device/system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items:</p> <ol style="list-style-type: none"> <li>(1) Location in designated place</li> <li>(2) No obstruction to access or visibility</li> <li>(3) Pressure gauge reading or indicator in the operable range or position</li> <li>(4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks</li> <li>(5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers</li> <li>(6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators.</li> </ol> <p>Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all occupants in the facility.</p>	K0355		

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K0355	Continued from page 6 Findings include:  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.  This finding was reviewed with the Director of Nursing at the exit conference.	K0355		
K0761	Maintenance, Inspection & Testing - Doors  CFR(s): NFPA 101  This STANDARD is NOT MET as evidenced by:  Based on observation, record review, and interview; the facility failed to ensure documentation was complete for the annual inspection and testing of 6 of 6 stairway fire door assemblies. LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.  NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:  (1) No open holes or breaks exist in surfaces of either the door or frame.  (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.  (3) The door, frame, hinges, hardware, and	K0761		

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K0761	<p>Continued from page 7 noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.</p> <p>(4) No parts are missing or broken.</p> <p>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.</p> <p>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.</p> <p>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.</p> <p>(8) Latching hardware operates and secures the door when it is in the closed position.</p> <p>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.</p> <p>(10) No field modifications to the door assembly have been performed that void the label.</p> <p>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.</p> <p>This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>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 assemblies noted in the facility.</p> <p>This finding was reviewed with the Director of Nursing at the exit conference.</p>	K0761		
K0916	<p>Electrical Systems - Essential Electric Syste</p> <p>CFR(s): NFPA 101</p>	K0916		

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K0916	<p>Continued from page 8</p> <p>Electrical Systems - Essential Electric System Alarm Annunciator</p> <p>A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.</p> <p>6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)</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 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:</p> <p>(1) Individual visual signals shall indicate:</p> <p>a. When the emergency or auxiliary power source is operating to supply power to load.</p> <p>b. When the battery charger is malfunctioning.</p> <p>(2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <p>a. Low lubricating oil pressure.</p> <p>b. Low water temperature.</p> <p>c. Excessive water temperature.</p> <p>d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply.</p> <p>e. Overcrank (failed to start).</p> <p>f. Overspeed.</p>	K0916		

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K0916	Continued from page 9 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. This deficient practice could affect all occupants in the facility.  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 was located in the maintenance building that was not occupied by staff at all times.  This finding was reviewed with the Director of Nursing at the exit conference.	K0916		
K0918 Bldg. 01	Electrical Systems - Essential Electric Syste  CFR(s): NFPA 101  Electrical Systems - Essential Electric System Maintenance and Testing  The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.  Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K0918		

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NAME OF PROVIDER OR SUPPLIER <b>SULLIVAN SURGICENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 N SECTION ST , SULLIVAN, Indiana, 47882</b>	
(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
K0918  Bldg. 01	<p>Continued from page 10 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>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.</p> <p>Findings include:</p> <p>1. 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.</p> <p>2. 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</p>	K0918		

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K0918 Bldg. 01	<p>Continued from page 11 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.</p> <p>3. 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.</p> <p>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.</p> <p>These finding were reviewed with the Director of Nursing at the exit conference.</p>	K0918		

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E0000	Initial Comments  An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.54.  Survey Date: 11/21/23  Facility Number: 003633  Provider Number: 15C0001133  AIM Number: 200503030A  At this Emergency Preparedness survey, Sullivan Surgicenter LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54  Quality Review completed on 11/27/23	E0000		
E0004	Develop EP Plan, Review and Update Annually  CFR(s): 416.54(a)  §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).  The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:  (a) Emergency Plan. The [facility] must develop and	E0004		

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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E0004	<p>Continued from page 1 maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least every two years in accordance with 42 CFR 416.54. This deficient practice could affect all patients in the facility.</p> <p>Findings include:</p> <p>Based on interview at the time of review of the Disaster Preparedness Plan on 11/21/23 between 9:45 a.m. and 12:55 p.m., the Director of Nursing said the facility has not had its Disaster Preparedness Plan reviewed within the most recent two year period. The most recent date of review and update was 03/03/2020.</p> <p>This finding was reviewed with the Director of Nursing at the exit conference.</p>	E0004		
E0013	<p>Development of EP Policies and Procedures</p> <p>CFR(s): 416.54(b)</p>	E0013		

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E0013	<p>Continued from page 2</p> <p>§403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and</p>	E0013		

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E0013	<p>Continued from page 3 procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to review and update the facility's Disaster Preparedness Plan's policies and procedures at least every two years in accordance with 42 CFR 416.54(b). This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on interview at the time of review of the Disaster Preparedness Plan on 11/21/23 between 9:45 a.m. and 12:55 p.m., the Director of Nursing said the facility's Disaster Preparedness Plan's policies and procedures have not been reviewed and updated during the past two years. The most recent date of review and update was 03/03/2020.</p> <p>This finding was reviewed with the Director of Nursing at the exit conference.</p>	E0013		
E0029	<p>Development of Communication Plan</p> <p>CFR(s): 416.54(c)</p> <p>§403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).</p> <p>(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure the communication plan that complies with Federal, State, and local laws was reviewed and updated at least every two years in accordance with 42</p>	E0029		

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E0029	Continued from page 4 CFR 416.54(c). This deficient practice could affect all occupants in the facility.  Findings include:  Based on interview at the time of review of the Disaster Preparedness Plan on 11/21/23 between 9:45 a.m. and 12:55 p.m., the Director of Nursing said the communication plan that complies with Federal, State, and local laws has not been reviewed and updated during the past two years. The most recent date of review and update was 03/03/2020.  This finding was reviewed with the Director of Nursing at the exit conference.	E0029		
E0036	EP Training and Testing  CFR(s): 416.54(d)  §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).  *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.  *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section.	E0036		

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E0036	<p>Continued from page 5 The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least every two years in accordance with 42 CFR 416.54(d). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on interview at the time of review of the Disaster Preparedness Plan on 11/21/23 between 9:45 a.m. and 12:55 p.m., there was no documentation available to show the facility had reviewed and updated the emergency preparedness training and testing program within the last two years. Based on interview at the time of record review, the Director of Nursing confirmed the training and testing program for staff had not been updated within the last two years. The most recent date of review and update was 03/03/2020.</p> <p>This finding was reviewed with the Director of Nursing</p>	E0036		

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E0036	Continued from page 6 at the exit conference.	E0036		
E0037	<p>EP Training Program</p> <p>CFR(s): 416.54(d)(1)</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least</p>	E0037		

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E0037	<p>Continued from page 7 every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency</p>	E0037		

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NAME OF PROVIDER OR SUPPLIER <b>SULLIVAN SURGICENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 N SECTION ST , SULLIVAN, Indiana, 47882</b>	
(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
E0037	<p>Continued from page 8 procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and</p>	E0037		

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(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
E0037	<p>Continued from page 9 procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure staff were trained on the emergency preparedness program annually. The ASC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every 2 years; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 416.54(d)(1). This deficient</p>	E0037		

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15C0001133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/21/2023</b>
NAME OF PROVIDER OR SUPPLIER <b>SULLIVAN SURGICENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 N SECTION ST , SULLIVAN, Indiana, 47882</b>	
(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
E0037	Continued from page 10 practice could affect all occupants in the facility.  Findings include:  Based on review of the Disaster Preparedness Plan on 11/21/23 between 9:45 a.m. and 12:45 p.m. with the Director of Nursing, there was no documentation available to indicate facility staff were trained on the Disaster Preparedness Plan during the past twelve months. Based on an interview at the time of record review, the Director of Nursing said the facility has not documented staff training on the Disaster Preparedness Plan during the past 24 months. The most recent staff training on the Disaster Preparedness Plan available for review was dated 02/24/2021.  This finding was reviewed with the Director of Nursing at the exit conference.	E0037		
E0039	EP Testing Requirements  CFR(s): 416.54(d)(2)  §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).  *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:  (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:  (i) Participate in a full-scale exercise that is community-based every 2 years; or  (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or  (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual,	E0039		

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NAME OF PROVIDER OR SUPPLIER <b>SULLIVAN SURGICENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 N SECTION ST , SULLIVAN, Indiana, 47882</b>	
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E0039	<p>Continued from page 11 facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p>	E0039		

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15C0001133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/21/2023</b>
NAME OF PROVIDER OR SUPPLIER <b>SULLIVAN SURGICENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 N SECTION ST , SULLIVAN, Indiana, 47882</b>	
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E0039	<p>Continued from page 12</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p>	E0039		

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NAME OF PROVIDER OR SUPPLIER <b>SULLIVAN SURGICENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 N SECTION ST , SULLIVAN, Indiana, 47882</b>	
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E0039	<p>Continued from page 13</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible,</p>	E0039		

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NAME OF PROVIDER OR SUPPLIER <b>SULLIVAN SURGICENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 N SECTION ST , SULLIVAN, Indiana, 47882</b>	
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E0039	<p>Continued from page 14 conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based</p>	E0039		

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15C0001133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>11/21/2023</b>
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E0039	<p>Continued from page 15 functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p>	E0039		

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E0039	<p>Continued from page 16</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at</p> <p>least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and</p>	E0039		

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E0039	<p>Continued from page 17 emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[ RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually. The ASC facility must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or</p>	E0039		

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NAME OF PROVIDER OR SUPPLIER <b>SULLIVAN SURGICENTER LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 N SECTION ST , SULLIVAN, Indiana, 47882</b>	
(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
E0039	<p>Continued from page 18</p> <p>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or</p> <p>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.;</p> <p>(iii) analyze the ASC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ASC facility's emergency plan, as needed in accordance with 42 CFR 416.54(d)(2). This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of the Disaster Preparedness Plan on 11/21/23 between 9:45 a.m. to 12:55 p.m. with the Director of Nursing, there was no documentation available to show the facility conducted exercises involving the Disaster Preparedness Plan during the past 24 months. This was confirmed by the Director of Nursing at the time of record review.</p> <p>This finding was reviewed with the Director of Nursing at the exit conference.</p>	E0039		