DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BLDG B. WING	(X3) DATE SURVEY COMPLETED 08/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURGICAL CARE CENTER INC	9202 N MERIDIAN STREET SUITE 150 , INDIANAPOLIS, Indiana, 46260

(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	INITIAL COMMENTS A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 08/05/24 Facility Number: 005392 Provider Number: 15C0001011 AIM Number: 100274160A At this Life Safety Code survey, Surgery Care Center Inc. 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 20, New Ambulatory Health Care Occupancies. This facility, located on the first floor of a two-story building with a basement, was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the support rooms and has duct detectors installed in the HVAC system. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:	K0000		
K0131	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following:	K0131		09/06/2024

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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K0131	Continued from page 1 * The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access. * They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating. Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: * Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab. * Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches. * Doors are self-closing and are kept in the closed position, except when in use. * Windows in the barriers are of fixed fire window assemblies per 8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain 1 of 1 one fire barriers separating it from an adjoining tenant. This deficient practice could affect all patients, staff and visitors if smoke from a fire were to infiltrate the protective barrier. Findings include: Based on observations with the Director of Nursing (DON) and the Maintenance Technician for CBRE Property Management during a tour of the facility from 1:05 p.m. to 2:20 p.m. on 08/05/24, the door set serving as the entrance to the waiting area from the main entrance lobby for the building were not in the latched position. The latching mechanisms were in the "dogged down" position and could be released and locked from the lobby side of the door with an electronic access card. Based on interview at the time of the observations, the DON stated the doors are locked at night and even if the doors are locked you can exit the waiting area without the need of the electronic access card.	K0131		

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K0131	Continued from page 2 These findings were reviewed with the DON and the Maintenance Technician for CBRE Property Management during the exit conference.	K0131		
K0291	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 20.2.9.1, 21.2.9.1, 7.9 This STANDARD is NOT MET as evidenced by: Based on record review, observation and interview, the facility failed to ensure 6 of 6 battery powered emergency lights were maintained in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) 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, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (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 patients and staff. Findings include: Based on review of "Battery Powered Emergency Light/Exit Light/Exit Sign Test-Monthly" documentation with the Director of Nursing (DON) and the Maintenance	K0291		08/30/2024

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K0291	Continued from page 3 Technician for CBRE Property Management during record review from 10:00 a.m. to 1:05 p.m. on 08/05/24, the following was noted: A) Dates of monthly and annual testing were not included. B) Locations of each battery-operated light was not itemized by location. The aforementioned documentation stated "see attached checklist and floor plans for locations" but a floor plan with the locations was not available for review. In addition, the aforementioned documentation did not include the date of monthly testing and also did not include annual 90 minute testing documentation. Based on interview at the time of record review, the Maintenance Technician for CBRE Property Management stated a floor plan for battery light locations in the facility was not available for review and agreed additional monthly and annual battery back up light testing documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the DON stated the facility has four operating rooms and two procedure rooms. The DON stated the facility does not perform procedures which require general anesthesia or deep sedation. Based on observations with the DON and the Maintenance Technician for CBRE Property Management during a tour of the facility from 1:05 p.m. to 2:20 p.m. on 08/05/24, battery back up lights were installed in each operating and procedure room. The battery back up lights in OR1, OR3 and OR6 were available to be tested and each light illuminated when its respective test button was pushed. These findings were reviewed with the DON and the Maintenance Technician for CBRE Property Management during the exit conference.	K0291		
K0345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm Systems - Testing and Maintenance 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 NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K0345		08/30/2024

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K0345	Continued from page 4 This STANDARD is NOT MET as evidenced by: Based on record review and interview, it could not be assured the facility's fire alarm system was visually inspected semi-annually. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice would affect all patients, staff and visitors. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Inspection Report" documentation dated 02/16/24 with the Director of Nursing (DON) and the Maintenance Technician for CBRE Property Management during record review from 10:00 a.m. to 1:05 p.m. on 08/05/24, semi-annual fire alarm system inspection documentation six months prior to 02/16/24 was not available for review. Based on interview at the time of record review, the Maintenance Technician for CBRE Property Management stated he does not conduct any semi-annual fire alarm system inspections and agreed additional fire alarm inspection documentation for the most recent twelve month period was not available for review. These findings were reviewed with the DON and the Maintenance Technician for CBRE Property Management during the exit conference.	K0345		
K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K0353		08/23/2024

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K0353	Continued from page 5 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. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 8 of 12 months. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. In addition, the facility failed to maintain the ceiling construction in 1 of 1 telephone rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all patients, staff, and visitors.	K0353		

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K0353	Continued from page 6 Findings include: Based on review of "Monthly Task: Fire Control Post Indicator Valve" check documentation with the Director of Nursing (DON) and the Maintenance Technician for CBRE Property Management during record review from 10:00 a.m. to 1:05 p.m. on 08/05/24, monthly sprinkler system valve inspections conducted by the facility only document Post Indicator Valve (PIV) inspections. No additional monthly sprinkler system gauge or valve inspection documentation for inspections conducted by the facility was available for review. The sprinkler system inspection contractor documented quarterly inspections for sprinkler system gauges and valves were documented on 09/18/23, 11/28/23, 02/13/24 and 06/12/24. Based on interview at the time of record review, the Maintenance Technician for CBRE Property Management agreed additional monthly gauge and valve inspection documentation for the most recent twelve month period was not available for review. Based on observations with the DON and the Maintenance Technician for CBRE Property Management during a tour of the facility from 1:05 p.m. to 2:20 p.m. on 08/05/24, the facility has a supervised wet sprinkler system. In addition, two open ended metal conduits which penetrated the suspended ceiling of the telephone room by Bay 6 were not firestopped. These findings were reviewed with the Director during the exit conference.	K0353		
K0712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 21.7.1.4 through 21.7.1.7 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected	K0712		08/23/2024

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K0712	Continued from page 7 times under varying conditions on the first for 3 of 4 quarters. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on review of "Natural Disaster and Fire Drills" and "Fire Drill Evaluation" documentation with the Director of Nursing (DON) and the Maintenance Technician for CBRE Property Management during record review from 10:00 a.m. to 1:05 p.m. on 08/05/24, three of four fire drills conducted within the most recent twelve month period were not conducted under varied conditions. The fire drills conducted on 09/01/23, 03/06/24 and on 06/12/24 were conducted at, respectively, 6:00 a.m., 6:00 a.m. and 6:15 a.m. Based on interview at the time of record review, the DON stated the facility operates one shift per day and tried to vary fire drills conducted over the last year by conducting the 12/08/23 fire drill at 4:07 p.m. but agreed the aforementioned three fire drills were not conducted at a varied time of day. These findings were reviewed with the DON and the Maintenance Technician for CBRE Property Management during the exit conference.	K0712		
K0761	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 This STANDARD is NOT MET as evidenced by: Based on record review, observation, and interview; the facility failed to document annual inspection and testing of all fire door assemblies. LSC 20.7.6 Maintenance and Testing states See 4.6.12. LSC 4.6.12 states whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. LSC 8.3.3.1 states 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	K0761		08/30/2024

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K0761	Continued from page 8 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 noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all patients, staff, and visitors. Based on record review with the Director of Nursing (DON) and the Maintenance Technician for CBRE Property Management from 10:00 a.m. to 1:05 p.m. on 08/05/24, documentation of annual fire door inspections within	K0761		

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K0761	Continued from page 9 the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Technician for CBRE Property Management agreed documentation for current annual fire door inspections was not available for review. Based on observations with the DON and the Maintenance Technician for CBRE Property Management, the door serving as the entrance to the Clean Assembly Workroom had a 45 minute fire resistance rating label affixed to the door and the stairwell door in the operating room area had a 90 minute fire resistance rating label affixed to the door. Each door had a sticker on the door stating a fire door inspection was performed on the door on 02/11/20. These findings were reviewed with the DON and the Maintenance Technician for CBRE Property Management during the exit conference.	K0761		
K0907	Gas and Vacuum Piped Systems - Maintenance Pr CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to maintain the facility's piped gas and vacuum systems in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition. This deficient practice could affect all patients. Findings include: Based on review of the piped gas system inspection contractor's "Annual Medical Gas Inspection Report" dated 08/05/24 with the Director of Nursing (DON) and the Maintenance Technician for CBRE Property Management	K0907		08/08/2024

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K0907	Continued from page 10 during record review from 10:00 a.m. to 1:05 p.m. on 08/05/24, deficiencies were noted during the inspection of the facility's piped gas system. Six of fourteen zones valves were listed as failing inspection. No corrective action documentation was provided. Based on interview at the time of record review, the DON stated the 08/05/24 documentation shows the contractor did the inspections on 05/29/24, she tried to get the inspection report repeatedly following that date but the contractor never forwarded the report to the facility until she inquired about it again at the time of the survey. The DON stated no corrections have been made because they never got the report until the time of the survey. These findings were reviewed with the DON and the Maintenance Technician for CBRE Property Management during the exit conference.	K0907		
K0914	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For, LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing and Line Isolation Monitor (LIM) testing was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code,	K0914		08/31/2024

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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
K0914	Continued from page 11 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. LIM testing shall be conducted monthly or every 12 months as required by Section 6.3.4.1.4. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on record review with the Director of Nursing (DON) and the Maintenance Technician for CBRE Property Management from 10:00 a.m. to 1:05 p.m. on 08/05/24, patient bay electrical receptacle testing documentation was not available for review. Based on interview at the time of record review, the DON stated the facility opened in 2018, all electrical receptacle locations in patient care areas are hospital-grade receptacles and neither initial installation testing documentation nor subsequent interval testing documentation was available for review. Based on observations with the DON and the Maintenance Technician for CBRE Property Management during a tour of the facility from 1:05 p.m. to 2:20 p.m. on 08/05/24, the facility has 12 patient bays. All electrical receptacles in the patient care vicinity in the patient bays were hospital grade. In addition, the facility has four operating rooms and two procedure rooms. Each of the six rooms has a LIM system for a total of six LIM's in the facility. It could not be determined if any LIM had automated self-test and self-calibration capabilities. Based on interview at the time of the observations, the DON stated LIM testing documentation for the most recent twelve month period was not available for review. These findings were reviewed with the DON and the Maintenance Technician for CBRE Property Management during the exit conference.	K0914		
K0918	Electrical Systems - Essential Electric Syste	K0918		09/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001011	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BLDG B. WING	(X3) DATE SURVEY COMPLETED 08/05/2024

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K0918 Bldg. 01	Continued from page 12 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 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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record review, observation and interview; the facility failed to ensure 1 of 1 emergency generators: a. had documented weekly inspections for 47 weeks of the most recent 52 week period. b. had the transfer time, load percent achieved and cool down time documented for monthly load tests for twelve months of the most recent twelve month period. c. had annual diesel fuel sampling and analysis documented for the most recent twelve month period. d. had a remote emergency stop installed. e. had a battery backup light installed for generators installed in an enclosure.	K0918		

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K0918 Bldg. 01	Continued from page 13 NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.4.1.1.1 states the generator set or other alternate power source and associated equipment, including all appurtenance parts shall be so maintained as to be capable of supplying service within the shortest time frame practicable an within the 10 second interval specified in 6.4.1.1.10 and 6.4.3.1. NFPA 99, 6.4.4.2 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, 2010 Edition, at 6.2.10 Time Delay on Engine Shutdown requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown to allow for engine cool down. 6.2.10.1 states the minimum 5-minute delay shall not be required on small (15 kW or less) air-cooled prime movers. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.4.4.1.1.3 states for Type 1 EES (Essential	K0918		

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K0918 Bldg. 01	Continued from page 14 Electrical System) generator sets, maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. NFPA 110, Standard for Emergency and Standby Power Systems 2010 Edition, Section 5.6.5.6, requires all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. Section 5.6.5.6.1, requires the remote manual stop station to be labeled. Annex A is not a part of the requirements but is included for informational purposes only. A.5.6.5.6 states for systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. NFPA 99, 2012 Edition, Health Care Facilities Code Section 6.4.1.1.6.1. Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 7.3.1 states the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. NFPA 110 7.3.2 states the emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. This deficient practice could affect all patients, staff and visitors. Based on review of "Weekly Generator 10 Min Run" documentation with the Director of Nursing (DON) and the Maintenance Technician for CBRE Property Management during record review from 10:00 a.m. to 1:05 p.m. on 08/05/24, weekly generator inspection documentation for 47 weeks of the most recent 52 week period was not available for review. Based on interview at the time of record review, the Maintenance Technician stated he takes a picture of the emergency generator control panel on weekly inspections now but agreed the picture	K0918		

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K0918 Bldg. 01	Continued from page 15 does not include a visual inspection of the starting batteries. In addition, review of "Monthly Load Checklist" and "Monthly Generator Load Test" documentation for the most recent twelve month period indicated transfer time, load percent achieved (or exhaust temperature) and cool down time is not documented. Diesel fuel sampling and analysis documentation for the most recent twelve month period was also not available for review. Based on interview at the time of record review, the Maintenance Technician for CBRE Property Management agreed transfer time, cool down time and the load percent achieved is not documented on monthly load testing and fuel sampling and analysis documentation for the facility's one diesel fuel fired emergency generator was not available for review. Based on observations with the DON and the Maintenance Technician for CBRE Property Management, the facility has one diesel fuel fired emergency generator located outside of the building inside a weatherproof shell in a walled enclosure with a gate. A remote emergency stop, remote from the generator, could not be located. A battery back up light for the generator location could also not be located. Manufacturer's documentation affixed to the generator indicated it was rated at 200 kW and manufactured 08/11/17. Based on interview at the time of the observations, the Maintenance Technician for CBRE Property Management agreed a remote emergency stop and a battery light for the generator could not be located. These findings were reviewed with the DON and the Maintenance Technician for CBRE Property Management during the exit conference.	K0918		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **15C0001011**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/05/2024**

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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: 08/05/24 Facility Number: 005392 Provider Number: 15C0001011 AIM Number: 100274160A At this Emergency Preparedness survey, Surgery Care Center Inc. was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54.	E0000		

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