

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2024
NAME OF PROVIDER OR SUPPLIER CENTER FOR SPECIAL SURGERY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8805 N MERIDIAN ST , 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
Q0000	INITIAL COMMENTS This visit was for a Recertification survey of an Ambulatory Surgery Center. Facility Number: 003032 Survey Dates: 11-25-2024, 11-26-2024 and 12/10/2024 QA: 12/12/2024	Q0000		
Q0100	ENVIRONMENT CFR(s): 416.44 The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. This CONDITION is NOT MET as evidenced by: Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire barriers that separated other occupancies were protected to maintain the one hour fire resistance rating of the fire barrier; failed to maintain automatic sprinkler systems in accordance with NFPA 25; failed to ensure 1 of 4 battery powered emergency lights were maintained in accordance with LSC 7.9; failed to maintain 1 of 1 piped gas and vacuum systems in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition; and failed to ensure a written record of weekly inspections for the generator was maintained for 40 of 52 weeks. Findings Include: The cumulative effect of these systemic problems resulted in the facility's inability to ensure it had implemented a systemic plan of correction to prevent recurrence, therefore failing to ensure the provision of quality health care in a safe environment.	Q0100		
Q0101	PHYSICAL ENVIRONMENT CFR(s): 416.44(a)(1)	Q0101		

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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Q0101	<p>Continued from page 1</p> <p>The ASC must provide a functional and sanitary environment for the provision of surgical services.</p> <p>Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention.</p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 piped gas and vacuum systems in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition.</p> <p>Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 40 of 52 weeks. 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 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.</p> <p>Findings Include:</p> <p>Based on observations with the ASC Manager, Chief Nursing Officer, the Director and the Supervisor for Cornerstone during a tour of the facility from 1:40 p.m. to 2:25 p.m. on 12/10/24, the wall mounted battery operated emergency lighting system installed inside OR2 above the entrance door to the room failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the</p>	Q0101		

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Q0101	<p>Continued from page 2 observations, the Supervisor for Cornerstone agreed the aforementioned battery operated emergency lighting system failed to illuminate when it's respective test button was pushed multiple times.</p> <p>Based on review of the piped gas system inspection contractor's "Annual Evaluation of Medical Piped Gas Systems" documentation dated 09/11/23 with the ASC Manager, the Chief Nursing Officer and the Director during record review from 10:00 a.m. to 1:40 p.m. on 12/10/24, piped gas system inspection and testing documentation within the most recent twelve month period was not available for review. In addition, deficiencies were noted during the 09/11/23 inspection of the facility's piped gas systems. Review of the 09/11/23 inspection documentation stated "Med Vac receiver not serviceable without shutting down system. Exhaust pipe is PVC. Need drain at bottom of exhaust pipe. Only one Master Alarm. Zone Valve-Bays 1-4 and Pre-op 1-4, no intervening wall between zone valves". Based on interview at the time of record review, the ASC Manager stated annual piped gas system inspection and testing documentation after 09/11/23 was not available for review and documentation of repairs to the facility's piped gas systems on or after 09/11/23 was also not available for review.</p> <p>Based on record review with the ASC Manager, the Chief Nursing Officer and the Director from 10: a.m. to 1:40 p.m. on 12/10/24, weekly generator inspection documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the ASC Manager stated a contractor performs monthly load testing for the facility's diesel fuel fired generator once per month and provided contractor load testing documentation for the most recent twelve month period but agreed weekly generator inspection documentation for the most recent twelve month period was not available for review.</p>	Q0101		
Q0104	<p>SAFETY FROM FIRE</p> <p>CFR(s): 416.44(b)(1)-(3)</p> <p>(b) Standard: Safety from fire. (1) Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Occupancies, regardless of the number of patients served, and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4).</p> <p>(2) In consideration of a recommendation by the State</p>	Q0104		

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Q0104	<p>Continued from page 3 survey agency or Accrediting Organization or at the discretion of the Secretary, may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.</p> <p>(3) The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire barriers that separated other occupancies were protected to maintain the one hour fire resistance rating of the fire barrier. NFPA 101, 2012 edition, Section 8.3.5.6.1 states membrane penetrations for cables cable trays conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a membrane of a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. Section 8.3.5.6.2 states the firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Test of Through Penetration Fire stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops. In addition, doors are self-closing and are kept in the closed position, except when in use. This deficient practice could affect all patients, staff and visitors.</p> <p>Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request.</p>	Q0104		

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Q0104	<p>Continued from page 4</p> <p>Based on review of facility floor plan documentation with the ASC Manager, Chief Nursing Officer and the Director during record review from 10:00 a.m. to 1:40 p.m. on 12/10/24, a one hour fire rated tenant separation wall on the west side of the suite separates the suite from the adjoining tenant, the Center for Pain Management. Based on observations with the ASC Manager, Chief Nursing Officer, the Director and the Supervisor for Cornerstone during a tour of the facility from 1:40 p.m. to 2:25 p.m. on 12/10/24, three separate holes were noted in the tenant separation fire barrier wall for the passage of over ten cables through the holes above the suspended ceiling above the corridor door in the west tenant separation wall by the breakroom. Based on interview at the time of the observations, the ASC Manager and the Supervisor agreed the aforementioned openings in the one hour fire rated tenant separation wall on the west side of the suite did not maintain the minimum fire resistance rating for the tenant separation fire wall.</p> <p>Based on review of the sprinkler system inspection contractor's "Joint Commission Report" documentation dated 10/31/24 with the ASC Manager, the Chief Nursing Officer and the Director during record review from 10:00 a.m. to 1:40 p.m. on 12/10/24, water flow alarm devices and valve tamper switches for the facility's two wet sprinkler systems were listed as failing 10/31/24 inspection and testing. Based on interview at the time of record review, the ASC Manager stated wet sprinkler system repair documentation on or after 10/31/24 was not available for review. Based on interview with the Supervisor for Cornerstone during a tour of the facility at 1:40 p.m. on 12/10/24, the Supervisor stated the 10/31/24 sprinkler system inspection water flow device and valve tamper switch failures were in error and he has requested revised and updated sprinkler system inspection documentation.</p>	Q0104		
Q0242	<p>INFECTION CONTROL PROGRAM</p> <p>CFR(s): 416.51(b)</p> <p>The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevent program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on document review and interview, the facility failed to ensure personnel, upon hire, had proof of</p>	Q0242		

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Q0242	<p>Continued from page 5 required immunization documentation in 2 of 9 personnel files reviewed (H1 and H2).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Facility policy titled, Infection Control Program, last approved 01/31/2022, indicated under Immunization Policy, All new employees should provide a vaccination record. If they are unable to provide a complete vaccination record and/or a documented history of varicella infection, the employee will be sent to an occupational medicine provider to obtain titers for: Hepatitis B, MMR, Varicella. Each clinical staff will be required to have the following: Hepatitis B if not sero-positive for Hepatitis B antibodies. Employees who decline to have the Hepatitis B vaccine will sign a vaccine declination form. MMR vaccine if not sero-positive for MMR antibodies. 2. Review of H1's (Housekeeper) personnel file, indicated H1 was non-immune to Rubella, Rubeola, and Hepatitis B and lacked documentation of receiving Measles, Mumps, Rubella vaccination or Hepatitis B vaccine. 3. Review of H2's (Housekeeper) personnel file indicated the patient was non-immune to Hepatitis B, lacked documentation of a Hepatitis B vaccine or declination form for the Hepatitis B vaccine. 4. Interview with S1 (Operating Room Manager) on 11/25/2024 at approximately 3:30 p.m. confirmed the H1 and H2's files lacked documentation indicating immunity as stated above. 	Q0242		