

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15C0001113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING</b> B. WING	(X3) DATE SURVEY COMPLETED <b>12/10/2024</b>
NAME OF PROVIDER OR SUPPLIER <b>CENTER FOR SPECIAL SURGERY LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8805 N MERIDIAN ST , INDIANAPOLIS, Indiana, 46260</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: 12/10/24</p> <p>Facility Number: 003032</p> <p>Provider Number: 15C0001113</p> <p>AIM Number: 200365010A</p> <p>At this Life Safety Code survey, Center for Special Surgery 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 facility located on the first floor of a two story building was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detectors in the corridors.</p> <p>Quality Review completed on 12/17/24</p>	K0000		
K0131	<p><b>Multiple Occupancies</b></p> <p>CFR(s): NFPA 101</p> <p>Multiple Occupancies - Sections of Ambulatory Health Care Facilities</p> <p>Multiple occupancies shall be in accordance with 6.1.14.</p> <p>Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following:</p> <p>* The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access.</p>	K0131		

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	<p>Continued from page 1</p> <p>* They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating.</p> <p>Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following:</p> <p>* Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab.</p> <p>* Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive latches.</p> <p>* Doors are self-closing and are kept in the closed position, except when in use.</p> <p>* Windows in the barriers are of fixed fire window assemblies per 8.3.</p> <p>Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served.</p> <p>20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44</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>Findings include:</p> <p>Based on review of facility floor plan documentation with the ASC Manager, Chief Nursing Officer and the</p>	K0131		

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K0131	Continued from page 2 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.  These findings were reviewed with the ASC Manager, Chief Nursing Officer and the Director 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 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. This deficient practice could affect one patient and staff.  Findings include:  Based on observations with the ASC Manager, Chief	K0291		

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K0291	Continued from page 3 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 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.  These findings were reviewed with the ASC Manager, Chief Nursing Officer and the Director 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  This STANDARD is NOT MET as evidenced by:  Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 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 14.3.1 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	K0345		

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K0345	Continued from page 4  e. Magnetic hold-open devices  This deficient practice could affect all patients, staff and visitors.  Findings include:  Based on review of the fire alarm system inspection contractor's "Inspection and Test Report" documentation dated 01/11/24 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, semi-annual fire alarm system inspection documentation six months after 01/11/24 was not available for review. Based on interview at the time of record review, the ASC Manager agreed semi-annual fire alarm system inspection documentation six months after 01/11/24 was not available for review.  These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.	K0345		
K0353	Sprinkler System - Maintenance and Testing  CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing  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:	K0353		

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K0353	<p>Continued from page 5</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. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</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> <p>These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.</p>	K0353		
K0712	<p>Fire Drills</p> <p>CFR(s): NFPA 101</p> <p>Fire Drills</p> <p>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</p>	K0712		

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K0712	<p>Continued from page 6 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.</p> <p>21.7.1.4 through 21.7.1.7</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation 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, three of four fire drills conducted within the most recent twelve month period were not conducted at varied times of the day. Fire drills conducted on 03/29/24, 07/29/24 and on 09/30/24 were conducted at, respectively, 7:30 a.m., 7:20 a.m. and 7:32 a.m.. Based on interview at the time of record review, the Chief Nursing Officer and the Director stated the facility operates one shift per day, additional fire drill documentation was not available for review and agreed the aforementioned fire drills were not held at varied times of the day.</p> <p>These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.</p>	K0712		
K0907	<p>Gas and Vacuum Piped Systems - Maintenance Pr</p> <p>CFR(s): NFPA 101</p> <p>Gas and Vacuum Piped Systems - Maintenance Program</p> <p>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.</p>	K0907		

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K0907	<p>Continued from page 7 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 (NFPA 99)</p> <p>This STANDARD is NOT MET as evidenced by:</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. This deficient practice could affect two patients.</p> <p>Findings include:</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>These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.</p>	K0907		
K0918  Bldg. 01	<p>Electrical Systems - Essential Electric System</p> <p>CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing</p> <p>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.</p>	K0918		

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K0918  Bldg. 01	<p>Continued from page 8</p> <p>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.</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 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. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</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>	K0918		

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K0918  Bldg. 01	Continued from page 9  These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.	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: 12/10/24  Facility Number: 003032  Provider Number: 15C0001113  AIM Number: 200365010A  At this Emergency Preparedness survey, Center for Special Surgery was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54.  The facility has 2 certified operating rooms.  Quality Review completed on 12/17/24  The requirement at 42 CFR, Subpart 416.54 is NOT MET as evidenced by:	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:	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>15C0001113</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>12/10/2024</b>	
NAME OF PROVIDER OR SUPPLIER <b>CENTER FOR SPECIAL SURGERY LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8805 N MERIDIAN ST , INDIANAPOLIS, Indiana, 46260</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
E0004	<p>Continued from page 1</p> <p>(a) Emergency Plan. The [facility] must develop and 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 once every two years in accordance with 42 CFR 416.54. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>(3) Address patient population, including, but not limited to, the type of services the ASC has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.</p> <p>(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency</p>	E0004		

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E0004	Continued from page 2 situation  This deficient practice could affect all occupants.  Findings include:  Based on review of "Disaster Preparedness Manual" documentation dated 04/18/22 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, documentation for a complete emergency preparedness program reviewed by the facility within the most recent two year period was not available for review. Based on interview at the time of record review, the ASC Manager agreed the most recent documented emergency preparedness program documentation was not dated as being reviewed within the most recent two year period.  These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.	E0004		
E0006	Plan Based on All Hazards Risk Assessment  CFR(s): 416.54(a)(1)-(2)  §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*  (2) Include strategies for addressing emergency events identified by the risk assessment.  * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency	E0006		

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E0006	<p>Continued from page 3 preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</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. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:</p> <p>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 416.54(a) (1) and 42 CFR 416.54(a) (2). The plan must be reviewed and updated at least every 2 years. In the Survey &amp; Certification memo QSO: 19-06-ALL dated</p>	E0006		

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E0006	<p>Continued from page 4</p> <p>02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Manual" documentation dated 04/18/22 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, a facility-based and community-based risk assessment reviewed within the most recent two year period was not available for review. Based on interview at the time of record review, the ASC Manager agreed the emergency preparedness program documentation did not include a facility-based and community-based risk assessment reviewed within the most recent two year period.</p> <p>These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.</p>	E0006		
E0013	<p>Development of EP Policies and Procedures</p> <p>CFR(s): 416.54(b)</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</p>	E0013		

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E0013	<p>Continued from page 5 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 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 its emergency preparedness policies and procedures every two years in accordance with 42 CFR 416.54(b). This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Manual" documentation dated 04/18/22 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, emergency preparedness policies and procedures based on a documented facility based and community based risk</p>	E0013		

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E0013	Continued from page 6 assessment reviewed within the most recent two year period was not available for review. Based on interview at the time of record review, the ASC Manager agreed emergency preparedness policies and procedures based on a documented facility based and community based risk assessment reviewed within the most recent two year period was not available for review.  These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.	E0013		
E0029	Development of Communication Plan  CFR(s): 416.54(c)  §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).  (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].  This STANDARD is NOT MET as evidenced by:  Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least every 24 months in accordance with 42 CFR 416.54(c). This deficient practice could affect all occupants.  Findings include:  Based on review of "Disaster Preparedness Manual" documentation dated 04/18/22 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, documentation for a complete emergency preparedness program did not include that the communication plan was reviewed within the most recent two year period. Based on interview at the time of record review, the ASC Manager agreed the communication plan was not reviewed within the most recent two year period.  These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit	E0029		

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E0029	Continued from page 7 conference.	E0029		
E0036	<p>EP Training and Testing</p> <p>CFR(s): 416.54(d)</p> <p>§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).</p> <p>*[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.</p> <p>*[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. 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>	E0036		

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E0036	<p>Continued from page 8</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 24 months in accordance with 42 CFR 416.54(d). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Manual" documentation dated 04/18/22 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, the facility's emergency preparedness program documentation did not include an emergency preparedness training and testing program reviewed within the most recent two year period. Based on interview at the time of record review, the ASC Manager stated the facility conducts emergency drills but agreed the the facility's emergency preparedness program documentation did not include an emergency preparedness training and testing program reviewed within the most recent two year period.</p> <p>These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.</p>	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>	E0037		

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E0037	<p>Continued from page 9</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 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</p>	E0037		

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E0037	<p>Continued from page 10 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 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</p>	E0037		

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NAME OF PROVIDER OR SUPPLIER <b>CENTER FOR SPECIAL SURGERY LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8805 N MERIDIAN ST , INDIANAPOLIS, Indiana, 46260</b>	
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E0037	<p>Continued from page 11 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 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</p>	E0037		

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E0037	<p>Continued from page 12 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 the emergency preparedness training and testing program includes a training program. 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 two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 416.54(d)(1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Manual" documentation dated 04/18/22 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, the facility's emergency preparedness program documentation did not include staff training on emergency preparedness policies and procedures. Based on interview at the time of record review, the ASC Manager</p>	E0037		

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E0037	Continued from page 13 stated the facility conducts emergency drills but agreed the the facility's emergency preparedness program documentation did not include documentation of staff training on emergency preparedness policies and procedures.  These findings were reviewed with the ASC Manager, the Chief Nursing Officer and the Director during the exit conference.	E0037		