STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001033	A. BUILDING 01 - MAIN BUILDING 0... B. WING	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY SURGERY CENTER NORTH	8040 CLEARVISTA PKWY STE 150 , INDIANAPOLIS, Indiana, 46256

(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(s): 02/03/25 & 02/04/25 Facility Number: 005973 Provider Number: 15C0001033 AIM Number: 200471420A At this Life Safety Code survey, Community Surgery Center North 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. This facility, located on the 1st floor, 2nd floor and basement of a five story building with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the basement, the corridor in the PreOp area, the second floor and in the Sterile Process Room. The facility has 9 operating rooms. Quality Review completed on 02/11/25	K0000		
K0211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11.	K0211		02/05/2025

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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K0211	Continued from page 1 20.2.1, 21.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 7 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all patients and staff if needing to exit the facility. Findings include: Based on observations with the Director and the Maintenance Tech for VEI during a tour of the facility from 10:15 a.m. to 12:35 p.m. on 02/04/25, the exit vestibule by the Facility Manager's Office and the piped gas storage room on the first floor was marked as a facility exit with an exit sign. One surplus door, rolled flooring, a chair and a portable stainless steel cart were stored in the exit access vestibule. Based on interview at the time of the observations, the Director and the Maintenance Tech for VEI agreed the aforementioned exit access vestibule was not free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Director and the Maintenance Tech for VEI during exit conference.	K0211		
K0311	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Vertical openings shall be enclosed or protected per 8.6, unless one of the following conditions exist: 1. Unenclosed vertical openings per 8.6.9.1 are permitted. 2. Unenclosed openings which do not serve as a required means of egress are permitted. 3. Exit access stairs may be unenclosed if they meet the following conditions: Two stories or less a. Building is protected throughout by a supervised	K0311		02/08/2025

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K0311	Continued from page 2 sprinkler system per 9.7.1.1(1). b. Total travel distance to outside does not exceed 100 feet. Three stories or less a. Occupant load per story does not exceed 15 people. b. Building is sprinkler protected throughout per 9.7.1.1(1). c. Building contains an automatic smoke detection system per 9.6. d. Activation of the sprinkler system or smoke detection system notifies all occupants of the building. e. Total travel distance to outside does not exceed 100 feet. Floors that are below the street level and are used for storage or any use other than a business occupancy, shall not have any unprotected openings to the business occupancy floors. 21.3.1, 39.3.1.1, 39.3.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain protection of 1 of 2 interior stairwell vertical openings. LSC 21.3.1 requires vertical openings shall be protected in accordance with LSC 39.3.1. LSC 39.3.1.1 states vertical openings shall be enclosed or protected in accordance with Section 8.6 unless otherwise permitted by Section 39.3.1.1(1), (2) or (3). LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient practice could affect all patients, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Director and the Maintenance Tech for VEI during a tour of the facility from 10:15 a.m. to 12:35 p.m. on 02/04/25, the basement	K0311		

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K0311	Continued from page 3 stairwell door by the elevator was equipped with a self closing device and latching hardware to latch the door into the door frame but the door failed to fully self close and latch into the door frame when tested to close multiple times. The door was equipped with a 90-minute fire resistance rating label. Based on interview at the time of the observations, the Maintenance Tech for VEI agreed the stairwell door in the basement did not fully self close and latch into the door frame when tested to close multiple times. These findings were reviewed with the Director and the Maintenance Tech for VEI during exit conference.	K0311		
K0323	Anesthetizing Locations CFR(s): NFPA 101 Anesthetizing Locations Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation, deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 21.3.2.3, NFPA 99 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3.4,	K0323		02/08/2025

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K0323	Continued from page 4 6.4.2.2.4.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain emergency lighting in 1 of 9 operating rooms where general anesthesia is administered in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.2.11.1 states one or more battery-powered lighting units shall be provided within locations where deep sedation and general anesthesia is administered. The lighting level of each unit shall be sufficient to terminate procedures intended to be performed within the operating room. The sensor for units shall be wired to the branch circuit(s) serving general lighting within the room. Units shall be capable of providing lighting for 90 minutes and shall be tested monthly for 30 seconds and annually for 30 minutes. Section 3.3.17 defines battery-powered lighting units as individual unit equipment for backup illumination consisting of a rechargeable battery, battery-charging means, provisions for one or more lamps mounted on the equipment, or with terminals for remote lamps, or both, and relaying device arranged to energize the lamps automatically upon failure of the supply to the unit equipment. This deficient practice could affect one patient and staff in Operating Room 3 (OR3) where general anesthesia is used. Findings include: Based on observations with the Director and the Maintenance Tech for VEI during a tour of the facility from 10:15 a.m. to 12:35 p.m. on 02/04/25, battery lighting systems were noted in OR3, OR7 and OR8 and each lighting system operated when its respective test button was depressed except for the battery lighting system installed in OR3 which failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Director stated general anesthesia can be used in each of the 9 operating rooms in the facility. Based on interview at the time of the observations, the Maintenance Tech for VEI stated each lighting system is regularly tested on a monthly basis, the OR3 lighting system functioned during the most recent monthly testing but agreed the battery lighting system installed in OR3 failed to illuminate when its respective test button was pushed multiple times. These findings were reviewed with the Director and the Maintenance Tech for VEI.	K0323		
K0345	Fire Alarm System - Testing and Maintenance	K0345		02/22/2025

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K0345	Continued from page 5 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: 1) 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 and Signaling Code NFPA 72, 2010 Edition, Section 14.2.1.2.1 states the requirements of Section 10.19 shall be applicable when a system is impaired. Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all patients, staff and visitors. 2) 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 and Signaling 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 6 e. Magnetic hold-open devices Findings include: 1) Based on review of the fire alarm system inspection contractor's "Joint Commission Report Element of Performance 3" documentation dated 11/09/24 with the Director and the visiting Maintenance Tech for VEI during record review from 9:10 a.m. to 3:30 p.m. on 02/03/25, the elevator "shunt trip did not operate" for the first floor elevator equipment room during 11/09/24 heat detector testing. Based on interview at the time of record review, the visiting Maintenance Tech for VEI stated shunt trip repair documentation on or after 11/09/24 was not available for review. Based on record review with the Director and the Maintenance Tech for VEI from 9:20 a.m. to 10:15 a.m. on 02/04/25, the Maintenance Tech for VEI confirmed shunt trip repair documentation on or after 11/09/24 and semi-annual fire alarm system inspection documentation six months prior to 11/09/24 was not available for review. 2) Based on review of the fire alarm system inspection contractor's "Inspection and Test Report" documentation dated 11/09/24 with the Director and the visiting Maintenance Tech for VEI during record review from 9:10 a.m. to 3:30 p.m. on 02/03/25, semi-annual fire alarm system inspection documentation six months prior to 11/09/24 was not available for review. These findings were reviewed with the Director and the Maintenance Tech for VEI during the exit conference.	K0345		
K0372	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2 hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K0372		02/19/2025

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K0372	Continued from page 7 21.3.7.5, 21.3.7.6, 8.5 This STANDARD is NOT MET as evidenced by: Based on record review, observation and interview; the facility failed to ensure the penetrations caused by the passage of conduit through 1 of 1 smoke barrier walls was protected to maintain the smoke resistance of each smoke barrier. LSC Section 21.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect 12 patients in the PACU area. Findings include: Based on review of facility floor plan documentation with the Director and visiting Maintenance Tech for VEI during record review from 9:10 a.m. to 3:30 p.m. on 02/03/25, the first floor of the facility's suite measures 36,839 square feet. Review of floor plan documentation indicates a smoke barrier wall divides the first floor of the facility's suite into two separate smoke compartments and runs from the outside wall of Operating Room 9 (OR9) to the suite wall by the employee Lounge. The smoke barrier wall includes the south wall of the PACU area. Based on observations with the Director and the Maintenance Tech for VEI during a tour of the facility from 10:15 a.m. to 12:35 p.m. on 02/04/25, a two inch in diameter open ended copper conduit penetrated the south wall of the PACU area above the suspended ceiling above Bay 1 and was not firestopped to maintain the fire resistance rating of the smoke barrier wall. Based on interview at the time of observations, the Maintenance Tech for VEI stated the open ended conduit was most likely a former water line which was cut within the last year or two and agreed the south wall of the PACU area was not firestopped to maintain the fire resistance rating of the smoke barrier wall. These findings were reviewed with the Director and the Maintenance Tech for VEI during the exit conference.	K0372		
K0761	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to maintain 4 of 23 fire-rated door locations. LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected	K0761		02/11/2025

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K0761	Continued from page 8 by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. In addition, based on record review, observation, and interview; the facility failed to document annual inspection and testing of all fire door assemblies. LSC 21.7.6 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 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	K0761		

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K0761	Continued from page 9 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. Findings include: Based on review of the fire door inspection contractor's "Annual Door Inspection" documentation dated 10/22/24 with the Director and the visiting Maintenance Tech for VEI during record review from 9:10 a.m. to 3:30 p.m. on 02/03/25, 4 of 23 fire door locations failed 10/22/24 inspection and testing. The four fire door locations listed as failing 10/22/24 inspection and testing were identified as 1-002, 1-003, 1-005 and 1-006. In addition, the door to the piped gas room was not included in the 10/22/24 annual fire door inspection and testing documentation. Based on interview at the time of record review, the visiting Maintenance Tech for VEI was not certain fire door repair or replacement documentation on or after 10/22/24 was available for review. Based on record review with the Director and the Maintenance Tech for VEI from 9:20 a.m. to 10:15 a.m. on 02/04/25, the Maintenance Tech for VEI confirmed fire door repair or replacement documentation on or after 10/22/24 was not available for review. Based on observations with the Director and the Maintenance Tech for VEI during a tour of the facility from 10:15 a.m. to 12:35 p.m. on 02/04/25, the corridor door to the piped gas room by the Facility Manager's Office on the first floor was equipped with a 1-hour fire resistance rating label affixed to the hinge side of the door.	K0761		

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K0761	Continued from page 10 These findings were reviewed with the Director and the Maintenance Tech for VEI during exit conference.	K0761		
K0918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of 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 and interview, the facility failed to document the facility's emergency generator was exercised for two of the most recent twelve months to meet the requirements of 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	K0918		02/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001033	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY SURGERY CENTER NORTH	8040 CLEARVISTA PKWY STE 150 , INDIANAPOLIS, Indiana, 46256

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K0918	Continued from page 11 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. This deficient practice could affect all patients, staff and visitors. Findings include: . Based on review of "Generator Transfer Test" documentation with the Director and the visiting Maintenance Tech for VEI during record review from 9:10 a.m. to 3:30 p.m. on 02/03/25, load testing documentation to show the available (actual) load percentage for the diesel powered generator during monthly load testing for two months of the most recent twelve month period was not available for review. Monthly load testing documentation for load testing conducted on 11/28/24 and on 12/21/24 did not state the load percent achieved for the test. Documentation for the two monthly load tests also did not include loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Based on record review with the Director and the Maintenance Tech for VEI from 9:20 a.m. to 10:15 a.m. on 02/04/25, the Maintenance Tech for VEI confirmed additional monthly load testing documentation for November 2024 and December 2024 was not available for review and agreed the 11/28/24 and 12/21/24 monthly load testing documentation did not include the load percent achieved for the test. These findings were reviewed with the Director and the Maintenance Tech for VEI during the exit conference	K0918		
K0920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used	K0920		02/05/2025

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K0920	Continued from page 12 for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure 5 of 5 extension cords including power strips were not used as a substitute for fixed wiring. LSC 21.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect all patients and staff. Findings include:	K0920		

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K0920	Continued from page 13 Based on observations with the Director and the Maintenance Tech for VEI during a tour of the facility from 10:15 a.m. to 12:35 p.m. on 02/04/25, a power strip was placed on a shelf above the head of the patient bed in the patient care vicinity in 5 of 12 patient bay in the PACU area. The patient bays where a power strip was being used for computer equipment in the bays was in Bay 2, Bay 6, Bay 7, Bay 8 and Bay 9. Each power strip was identified as a Tripp Lite Isobar 4 Surge Protective Device (Type 3). The UL listing of the power strips could not be determined. Based on interview at the time of the observations, the Maintenance Tech agreed power strips were being used as a substitute for fixed wiring and in the patient care vicinity in the five PACU bays. An Internet search for the UL listing for the power strips determined the power strips were UL 1449. These findings were reviewed with the Director and the Maintenance Tech for VEI during exit conference.	K0920		
K0923 Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage *Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. *Greater than 300 but less than 3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hour fire protection rating. *Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each	K0923		02/05/2025

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K0923 Bldg. 01	Continued from page 14 door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 4 cylinders of nonflammable gases such as CO2 were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over four staff and visitors in the Lounge. Findings include: Based on observations with the Director and the Maintenance Tech for VEI during a tour of the facility from 10:15 a.m. to 12:35 p.m. on 02/04/25, one of the four CO2 cylinders stored next to one another by the refrigerator in the employee Lounge was freestanding on the floor and was not chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Maintenance Tech for VEI agreed the CO2 cylinder was not properly supported and secured the cylinder with the chain provided for the other three CO2 cylinders by the refrigerator. These findings were reviewed with the Director and the Maintenance Tech for VEI.	K0923		

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	15C0001033	A. BUILDING B. WING	**02/04/2025**

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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(s): 02/03/25 & 02/04/25 Facility Number: 005973 Provider Number: 15C0001033 AIM Number: 200471420A At this Emergency Preparedness survey, Community Surgery Center North was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54. The facility has 9 operating rooms. Quality Review completed on 02/11/25	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