STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001158	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRE HAUTE SURGICAL CENTER LLC	227 MCCALLISTER DR , TERRE HAUTE, Indiana, 47802

(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 Federal Recertification survey of an Ambulatory Surgery Center. Facility Number: 005650 Survey Date: 02/04/2025 to 02/05/2025 & 2/6/2025 QA: 2/19/2025	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 and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3; and failed to conduct quarterly fire drills for 4 of 4 quarters. LSC 21.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. Findings Include: The accumulative effect of these systemic problems resulted in the facility's inability to ensure the provision of quality health care in a safe environment.	Q0100		02/20/2025
Q0101	PHYSICAL ENVIRONMENT CFR(s): 416.44(a)(1) The ASC must provide a functional and sanitary environment for the provision of surgical services.	Q0101		02/20/2025

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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Q0101	Continued from page 1 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power System, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. Based on record review on 02/06/25 between 9:40 a.m. and 12:00 p.m. with the Materials Manager, no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Materials Manager stated the facility does have a diesel generator and the oil quality is tested annually, but not the fuel quality. This finding was reviewed with the Clinical Director and Materials Manager at the exit conference.	Q0101		
Q0104	SAFETY FROM FIRE CFR(s): 416.44(b)(1)-(3) (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). (2) In consideration of a recommendation by the State 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.	Q0104		02/19/2025

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Q0104	Continued from page 2 (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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to conduct quarterly fire drills for 4 of 4 quarters. LSC 21.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. Findings include: Based on record review with the Materials Manager on 02/06/25 at 10:20 a.m., there was no documentation for a fire drill in the third quarter (July, August, September) of 2024. Based on interview at the time of record review, the Materials Manager stated he missed a fire drill in the third quarter and conducted two fire drills in the fourth quarter. This finding was reviewed with the Clinical Director and Materials Manager at the exit conference.	Q0104		
Q0243	INFECTION CONTROL PROGRAM - DIRECTION CFR(s): 416.51(b)(1) The program is - Under the direction of a designated and qualified professional who has training in infection control. This STANDARD is NOT MET as evidenced by: Based on document review and interview, facility failed to designate through job description, a qualified professional trained in Infection Control for 1 Infection Preventionist. (A2 [Clinical Director/Infection Control Preventionist]) Findings include: 1. Facility policy titled Shared Employee Files, Policy # 2.1.171, No Review Date, Page 1, Under Procedure Guidelines: G. Job Description signed at time of hire and reviewed annually, or when position changes or job description changes. 2. Facility policy titled Infection Control/Prevention, No policy number, Last Revised Date 11/2016, Page 2, under Prevention will include: Identification in	Q0243		03/03/2025

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Q0243	Continued from page 3 writing of facility Infection Control Nurse/Preventionist. A job description will be maintained in the employee file and reviewed annually. 3. Personnel file review indicated A2 (Clinical Director/Infection Control Preventionist) lacked documentation of job description for title of Infection Control Preventionist; A3 lacked documentation of continuing education in infection control/prevention from 2023 until present date. 4. Facility lacked documentation of delegating A2 (Clinical Director/Infection Control Preventionist) to be responsible for the facilities infection control program. 5. In interview on 2/5/25 at approximately 1130 hours with A1 (Business Office Manager), he/she indicated A2 is the Infection Control Preventionist; facility lacked documentation delegating A2 responsible for facilities infection control program. A1 confirmed A3 personnel file lacked job description of Infection Control Preventionist and lacked documentation of education/continued education related to infection control/prevention from 2023 until present date.	Q0243		
Q0244	INFECTION CONTROL PROGRAM - QAPI CFR(s): 416.51(b)(2) [The program is -] An integral part of the ASC's quality assessment and performance improvement program This STANDARD is NOT MET as evidenced by: Based on document review and interview, the facility failed to include infection control in quality program. Findings include: 1. Facility lacked Infection Prevention Quality Assurance and Performance Improvement (QAPI) meeting minutes that included evidence of Infection Control activities. 2. In interview on 5/5/25 at 1030 hours with A2 (Clinical Director, Infection Preventionist), he/she confirmed lack of Infection Prevention activities in QAPI meeting minutes.	Q0244		03/03/2025